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BONVIEW REHABILITATION AND HEALTHCARE	**7246 FOREST HILL AVE RICHMOND, VA 23225**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/31/21 through 9/3/21. 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 8/31/2021 through 9/3/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints were investigated during the survey: VA00051421 Substantiated with deficiency, VA00051377- Substantiated with deficiency, VA00050818- Unsubstantiated, VA00050627- Unsubstantiated. The census in this 196 licensed bed facility was 136 at the time of the survey. The survey sample consisted of 46 Resident reviews.	F 000		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to	F 573		

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

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

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by the facility and the individual, within 24 hours (excluding weekends and holidays); and
(ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:
(A) Labor for copying the records requested by the individual, whether in paper or electronic form;
(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and
(C)Postage, when the individual has requested the copy be mailed.

§483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed for 1 resident (Resident #103) in the survey sample of 46 residents, to grant a written request for access to medical records.

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The Findings included:

The facility staff failed to grant Resident #182's Responsible Party's request for a copy of medical records.

Review of the Clinical record was conducted on 9/1/2021 and 9/2/2021.

The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 3/19/2021 was reviewed. Resident #182 was coded as having severely impaired cognition.

Review of the record revealed Resident #182 had a Responsible party listed on the facesheet. Resident # 182 was hospitalized on 3/22/2020 and did not return to the facility. The Responsible Party requested a copy of Resident # 182's medical record Admission paperwork on 3/23/2020.

On 09/03/2021, a review was conducted of facility documentation, revealing a request submitted on 3/23/2020. The Responsible Party alleged that she had not received a copy of the form to request medical records when she was contacted on 4/1/2020 by the Medical Records Coordinator. The Medical records request form was sent to the Responsible Party on 4/2/2020 via email.

On 9/3/2021 at 11:57 A.M., an interview was conducted via telephone with the Medical Records Coordinator who stated that she sent a Medical Records request form to the Responsible Party via email on 3/23/2020.

The Medical Records Coordinator stated she received approval from the legal department on

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6/1/2021, notified the Responsible party that day and released the records on 6/4/2021 as soon as the Responsible Party came to the facility and paid the fee.

The Medical Records Coordinator presented a timeline of the interactions with Resident #182's Responsible party regarding requests for the Medical Record.

The Medical Records Coordinator stated she contacted the responsible party on 4/1/2020 since the signed request form had not been returned. After receiving the email request for medical records on 4/2/2020, the Responsible Party requested that the Medical Records form be resent via email, to which she complied.Then on 5/22/2020, the Responsible Party contacted the Medical Records Coordinator via email stating the Medical Records form had been faxed on 5/19/2020. The Medical Records Coordinator stated she confirmed the form had been received on 5/19/2020 and she forwarded it to the corporate legal department on that same day of 5/19/2020. The Medical Records Coordinator stated, on 5/29/2020, the Legal department denied the request and sent a letter to the Responsible Party asking for more information.

The Medical Records Coordinator stated that almost exactly one year later on 5/25/2021, the Responsible Party sent the additional information to the legal department and they forwarded it to the Medical Records Coordinator to place in Resident #182's record. Then on 6/1/2021, the Legal department sent an email to the Medical Records Coordinator approving the request for the release of Resident #182's medical records. On 6/4/2021, the Responsible Party "arrived at

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the facility and paid cash and was given the records the same day."

The letter from the legal department dated 6/1/2021 authorized release of the medical records after they received the additional documentation 7 days earlier on 5/25/2021.

The facility's policy on Request for Medical Records/Release of Information, Effective date 11/30 2014, Revision date 11/3/2020 stated that "if a current or former resident or their personal Representative makes a request for medical records," a consent form will be filled out."
The policy also stated:
"9. Within 72 hours of receipt of the request, the legal department will contact the Center's Medical Records Custodian advising whether or not a copy of the resident's medical records may be released.

According to the policy, the legal department would make a determination within 72 hours. The request was sent to the legal department on 5/19/2020 but the denial was returned on 5/29/2020. That was ten calendar days and 8 business days after the written request.

The next determination letter from the legal department was received on 6/1/2021, 7 days after supporting documentation was sent on 5/25/2021. Both determination letters from the legal department were received over 72 hours after the requests for release of copies of the medical record.

The Administrator was asked to provide a copy of the Admission paperwork to determine if the Responsible Party was the one who signed the

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F 573	Continued From page 5 documents. A copy of the admission paperwork was not submitted by the end of the survey on 9/3/2021. The facility Administrator was informed of the findings on 9/3/2021. No further information was received.	F 573		
F 583 SS=D	COMPLAINT DEFICIENCY Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		

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of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility documentation review, the facility staff failed to uphold one Resident's (Resident #49) personal privacy during care, in a survey sample of 41 Residents. This failure to uphold a Resident's privacy has the potential to violate the Resident's dignity and cause feelings of embarrassment.

The findings included:

On 9/1/21 at 4:06 PM, Surveyor B knocked on the room door of Resident #49. After hearing no response, Surveyor B opened the door and observed CNA B at the bedside providing care. Resident #49 was exposed and the privacy curtain was not pulled around Resident #49, leaving her exposed to her roommate as well as anyone entering the room. CNA B stated she was changing Resident #49's gown. CNA B was asked if she normally pulls the privacy curtain when providing care, CNA B stated, "normally I do on this side [referring to between Resident #49 and her roommate], but there just isn't room". When asked why the privacy curtain would be used during care, CNA B stated, "For her privacy". Resident #49 was not interviewable to ask how this violation of privacy made them feel.

On 9/1/21 at approximately 4:30 PM, an interview

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F 583	Continued From page 7 was conducted with LPN C. LPN C was asked about the use of a privacy curtain during care, LPN C stated, "Yes it should be pulled at all times for their dignity". On 9/1/21 at 8:18 PM, an interview was conducted with Employee C, the Assistant Director of Nursing (ADON). The ADON was asked, "When do you expect a privacy curtain to be used"? The ADON stated, "Whenever they are giving any kind of patient care, it should be pulled". Review of the facility policy titled "Resident and Patient Rights" stated, "It is the policy of the company that all employees will conduct themselves in a professional manner at all times, respecting the rights of each resident or patient to privacy, personal care, self-respect and confidentiality". The facility staff provided the survey team with a document titled, "Virginia Resident's Rights and Responsibilities" that read on page 5, "Privacy: A. To be treated in a manner and in an environment that maintains or enhances your dignity, and respect in full recognition of your individuality and privacy. C. To have privacy when care or medical treatment is being provided". On 9/1/21 at approximately 8:20 PM, during an end of day meeting, the facility Administrator, ADON and Corporate Nurse Consultant were made aware of the findings. No further information was received.	F 583		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607		

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F 607	Continued From page 8 §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to implement their abuse policy by failing to conduct a post investigation follow-up report after an allegation of abuse involving two Residents (Resident #27 and Resident #70) in a survey sample of 41 Residents. The findings included: On 9/2/21, during a clinical record review, Resident #27's electronic health record revealed a nursing progress note entry dated 7/24/21 at 19:26, which read, "Resident was involved in an incident with another resident. All management, MD/NP [medical doctor/ nurse practitioner], and RP [responsible person/party] have been notified of all recent events, according to facilities policy and procedure guidelines". On 9/2/21, Surveyor B asked the facility staff to provide any FRI's (Facility Reported Incidents) involving Resident #27 for the year 2021. Upon receipt of 2 FRI's, Surveyor B observed that the	F 607		

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F 607	Continued From page 9 Resident to Resident altercation between Resident #27 and #70 on 7/24/21, had no post-investigation follow-up report, to state the investigation findings and steps taken. On 9/2/21 at 10:12 AM, the facility Administrator was asked about the post investigation follow-up report for the above noted incident. The facility Administrator stated, he was out of town at the time of the incident and "Employee E [the corporate nurse] had completed the initial report and honestly there was no follow-up report completed". Review of the facility policy titled "Abuse, Neglect, Exploitation & Misappropriation" read on page 8, "Review of Report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken". On 9/3/21, during an end of day meeting the facility Administrator, Assistant Director of Nursing and Corporate Nurse were made aware that the Resident to Resident altercation on 7/24/21, had no post investigation report completed. No further information was provided.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

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§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility documentation review, the facility staff failed to report to the State Survey Agency the result(s) of an investigation within 5 working days, following an allegation of abuse involving two Residents (Resident #27 and Resident #70) in a survey sample of 41 Residents.

The findings included:

On 9/2/21, during a clinical record review, Resident #27's electronic health record revealed

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a nursing progress note entry dated 7/24/21 at 19:26, which read, "Resident was involved in an incident with another resident. All management, MD/NP [medical doctor/ nurse practitioner], and RP [responsible person/party] have been notified of all recent events, according to facilities policy and procedure guidelines".

On 9/2/21, Surveyor B asked the facility staff to provide any FRI's (Facility Reported Incidents) involving Resident #27 for the year 2021. Upon receipt of 2 FRI's, Surveyor B observed that the Resident to Resident altercation between Resident #27 and #70 on 7/24/21, had no post-investigation follow-up report, to indicate the results of the investigation and steps taken to protect the two Residents.

On 9/3/21 at 10:37 AM, the facility Administrator was asked about the process of reporting following incidents of abuse or abuse allegations. When asked, "What is the purpose of the follow-up report"? The facility Administrator stated, "To notify stake holders in making sure the Resident is protected. It lets you guys [the state survey agency] know the steps that were taken to protect the Resident".

Review of the facility policy titled "Abuse, Neglect, Exploitation & Misappropriation" read on page 8, "Review of Report: Report the results of all investigations to the Executive Director or his or her designated representative and to other officials in accordance with State law, including the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken".

On 9/3/21, during an end of day meeting the

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F 609	Continued From page 12 facility Administrator, Assistant Director of Nursing and Corporate Nurse were made aware that the Resident to Resident altercation on 7/24/21,had no post investigation was was not sent to the State Survey Agency. No further information was provided.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, the facility staff failed to accurately complete MDS assessments for (3) Residents (#'s 51, 55, 57) in a survey sample of 40 residents. The findings included: 1. For Resident #51, the facility staff did not accurately complete the Quarterly MDS (Minimum Data Set) assessment dated 6/28/2 to reflect the status of the Resident. On 8/31/21 at approximately 9 AM an observation was made of Resident #51 lying in bed, the head of bed was elevated to a 45° angle and his tube feeding was infusing. The Resident did not answer to his name being called. The resident opened his eyes however they did not focus on surveyor, and gave no indication that he understood what the surveyor was saying. A review of the MDS revealed that the facility	F 641		

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answered question C0100 Should BIMS be assessed? The answer was marked (1) yes..

For the MDS question C0500 BIMS Score a dash (-) was placed in the box instead of 99 (unable to access).

For section G functional status the following answers were entered in the MDS

A - Bed mobility- (3) Extensive assistance with (3) two or more persons physical assist
B - Transfers (3) extensive assist of (3) two persons physical assist
C- Walk in room (7) happened only 1 or 2 times (2) one person physical assistance
D - Walk in corridor (7) activity only occurred once or twice (2) one person physical assistance
E - Locomotion on the unit he was coded at (7) activity occurred once or twice with (2) one person physical assist
F Locomotion off the unit coded as (7) activity occurred once or twice (2) one person physical assistance
G. Dressing (3) extensive assistance with (3) two person's physical assist
H- Eating (3) extensive assistance with (2) person physical assist
I - Toileting coded as (3) extensive assist with (3) two person physical assist
J - Personal hygiene coded as (3) extensive assist with (3) two person physical assist
G0600 mobility devices - wheelchair

Section H - 0300 (bladder) - and 0400 (bowel) state Resident is "Always incontinent." However this contradicts what is mentioned in section G-Functional Status - I -Toileting.

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On 9/1/21 at approximately 3 PM, an interview was conducted with the MDS nurse. The MDS nurse was new to this position and was not employed at the facility in June when the Quarterly MDS was completed. She stated that the person who signed off on that MDS no longer worked at the facility. When asked about Resident #51 she indicated she was familiar with him. She stated that based on what she knew about Resident #51 he could not answer any questions, therefore the BIMS could not be assessed. When asked what she would do in that case she stated I would score it "99-Unable to assess." She also stated that this resident us unable to stand or bear weight, or sit up in a wheelchair, he has to use stretcher transport if he goes anywhere. She stated that he is always incontinent of bowel and bladder. She stated he has to have a mechanical lift for transfers. She also stated that the coding on this resident's MDS was incorrect in that the resident is totally dependent on staff for all aspects of care. She stated this resident has persistent neurological condition related to accidental lack of oxygen and cannot follow commands and cannot be assessed verbally. When asked why an accurate MDS is important she stated because that is how we know what services the Resident needs and it is especially important when they cannot voice their needs.

On 9/2/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was made available.

2. For Resident #55 the facility staff failed to accurately complete the MDS

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On 8/31/21 during the initial tour Resident #55 was noted to be lying in bed with the head of the bed elevated. An attempt to talk to Resident # 55 and found that she did not speak English. The resident could not answer any questions.

On 9/1/21 a review of the clinical record revealed that the MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/2/21 coded as a quarterly review coded this resident having a BIMS (brief interview of mental status) score of Zero. However, this score is inaccurate in that 99 is the code for unable to assess. (Please see interview below with LPN A)

Section F for preferences for customary routines and activities had all questions left unanswered.

Section G0900 - Functional rehabilitation potential
A. resident believes he or she is capable of increased independence and at least some ADLs (left unanswered)
B direct care staff believe resident is capable of increased independence and at least some ADLs (left unanswered)

On 9/1/21 at approximately 3 PM an interview was conducted with the LPN A who was asked if she was familiar with Resident #55 and she stated that she was. She stated that the Resident was non-English speaking and spoke only her native Korean. When asked if it was possible to interview the Resident in English she stated that the Resident would not understand. When asked if the Resident has dementia she stated that she does indeed have a dementia diagnosis.
When asked how she would do an assessment for BIMS and evaluation for speech clarity if the Resident does not speak English? She indicated

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that the BIMS would be coded as 99 which means unable to assess.

On 9/2/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was made available.

3. For Resident #57, the facility staff failed to accurately code the MDS (minimum data set) assessments for a period of one year with regards to hospice services.

On 9/2/21, a review of the electronic health record for Resident #57 was conducted. This review revealed that Resident #57's payer source was Hospice. A physician order dated 12/23/20, read, "Admit to hospice [hospice company name redacted]". Hospice notes were entered into the clinical record which revealed ongoing hospice services.

On 9/2/21, Resident #57's MDS (Minimum Data Set) (an assessment) with the ARD's (assessment reference dates) of 10/6/20, 1/6/21, 4/8/21, and 7/7/21, were reviewed and revealed that Section O, was not coded as the Resident being on hospice services.

On 09/02/21 at 6:56 PM, an interview was conducted with the MDS nurse/LPN A. LPN A confirmed that the MDS for Resident #57 was not accurate. When asked why the MDS being accurate is important, LPN A stated, "It's a 100% important because you are telling the truth about an assessment". LPN A confirmed that the facility uses the RAI manual as their guide to coding the

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F 641	Continued From page 17 MDS. Review of the Center for Medicare & Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual, Version 1.17.1, Effective October 2019, on page 494 read, "O0100K, Hospice care. Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider". On 9/2/21, during an end of day meeting the facility Administrator and ADON (Assistant Director of Nursing) were made aware Resident #57's MDS not being coded accurately. No further information was received.	F 641		
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		

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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 interview, observation, clinical record review and facility documentation the facility staff failed to review and revise care plans for 1 Resident (#55) in a survey sample of 40 Residents.

The Findings include:

For Resident #55 the facility staff failed to review and revise the care plan to include an actual fall with major injury on 6/4/21.

On 9/1/21 during clinical record review it was discovered that Resident #55's care plan read as follows:

"[Resident name redacted] is at risk for falls/potential for injury r/t confusion unaware of safety needs, psychotropic medication, pacemaker, a fib, Tachycardia and history of pain. Dementia history of falls"

Under interventions from most recent fall (6/4/21) when she broke her hip it listed; send to ER for

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F 657	Continued From page 19 evaluation and X-ray to hip as ordered. On 9/1/21 an interview was conducted with LPN B who was asked the purpose of a care plan, she stated "It directs care of the resident." She was also asked who has access to the care plan, and she stated all nursing staff have access. LPN B was then asked to review Resident # 55's care plan for falls and was asked if there were any issues with that section. LPN B stated that "Send to the ER for evaluation and x-ray to hip as ordered were not interventions. Those are doctors' orders after a fall. Interventions are things to put in place to prevent them from falling." When asked what should happen after a resident falls she stated assess the resident, notify physician and family, fill out a fall investigation and document in the chart, and also update the care plan. When asked if there needed to be a new intervention with each fall she stated "Yes on the day of the fall you should have a new intervention and the care plan should be updated to include the date of the fall." On 9/2/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was made available.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		

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by:
Based on observations, resident interviews, staff interviews, and clinical record reviews, the facility staff failed to provide care and services according to professional standards of care for 1 resident (Resident #288) in a sample size of 46 residents.

The findings included:

1. For Resident #288, the facility staff failed to provide wound treatment on 08/31/2021, 09/01/2021, and 09/02/2021 as ordered by the physician.

On 09/01/2021 at 11:55 A.M., Resident #288 was interviewed. When asked if he had any wounds, Resident #288 indicated he had wounds on his right foot. When asked how he got the wounds, Resident #288 stated that his foot "got all scratched up" and it "got worse and worse." Resident #288 moved the bed covers from his right foot to reveal the right foot with a dressing of kerlix and clear tape. The dressing was not dated or initialed. When asked if the dressing had been changed this day, Resident #288 stated it had not been changed today. Resident #288 indicated that the nurses haven't changed the dressing since his admission to the facility on 08/31/2021." Resident #288 stated that he did the dressings himself every day before arriving [at the facility] and that he "put the new dressing on it last night myself."

On 09/01/2021 at 12:10 P.M., an interview with Registered Nurse A (RN A), an agency nurse caring for Resident #288, was conducted. When asked when Resident #288 was admitted, RN A stated that Resident #288 was admitted "a day and half ago." When asked about wound care for

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Resident #288's right foot, RN A stated that she had been asking staff "since yesterday" for gauze and kerlix [a gauze wrap] to change Resident #288's dressing but did not receive the supplies yet. When asked if Resident #288 changed his own dressing yesterday (08/31/2021), RN A stated, "Yes."

On 09/01/2021 and 09/02/2021, a review of Resident #288's clinical record revealed the following: A physician's order with a start date of 08/31/2021 documented, "Silvadene Cream 1 % (Silver sulfadiazine) [a topical medicated cream]. Apply to right foot topically every day shift for wound care." A physician's order with a start date of 08/31/2021 documented, "Wound Care: Clean with Silvadene apply non-stick gauze and wrap with kerlix once a day."

According to Resident #288's Medication Administration Records and Treatment Administration Records for August and September 2021, the wound treatment (Silvadene, non-stick gauze, and kerlix to the right foot) was not signed off as administered on 08/31/2021. The wound treatment (Silvadene, non-stick gauze, and kerlix to the right foot) was signed off as administered by RN A on 09/01/2021.

On 09/02/2021 at 7:05 P.M., this surveyor observed RN A change the dressing on Resident #288's right foot. After removing the old dressing (gauze and kerlix), RN A applied the silvadene to the wounds, covered the wounds with 4 x 4 gauze (which was not ordered), and wrapped Resident #288's right foot in kerlix. The old dressing did not have not non-stick gauze and RN A did not apply non-stick gauze to the wounds during the

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dressing change as ordered by the physician.

On 09/02/2021 at approximately 7:30 P.M., this surveyor and RN A observed the physician's orders in the electronic health record. RN A stated she did not have the non-stick gauze available to put on the wounds. This surveyor and RN C, the night nurse on the unit, went to the supply room on the unit and verified that non-stick gauze was not in the supply room.

On 09/02/2021 at approximately 8:00 P.M., the administrator and Regional Nurse Consultant were notified of findings. The administrator asked the supply employee, Employee F, to join the meeting. Employee F arrived to the conference room with a box full of non-stick gauze. Employee F stated that RN A requested a box of non-stick gauze be delivered to the unit for the following day 09/03/2021.

On 09/03/2021 at approximately 5:00 P.M., the Regional Nurse Consultant was interviewed. When asked about the expectation for wound care, the Regional Nurse Consultant stated she would expect staff to observe clean technique for dressing changes and to follow wound orders.

According to a Lippincott publication entitled, "Taylor's Clinical Nursing Skills", 5th Edition, 2019, Chapter 8, page 431, an excerpt under the sub-header "Assessment" documented, "Confirm any prescribed orders relevant to wound care and any wound care included in the nursing care plan."

By the end of survey on 09/03/2021 at approximately 5:00P.M., the administrator indicated there was no further documentation or

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F 658	Continued From page 23 information to submit.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review the facility staff failed to provide timely ADL care to 1 dependent Resident (#15) in a survey sample of 40 Residents. For Resident #15 the facility staff failed to provide incontinent care in a timely manner resulting in Resident #15 sitting in a soiled brief for 2 hours. The findings included: On 8/31/21 at approximately 12:15 PM Resident # 15 and his roommate, Resident # 100 were observed in their room. The surveyor began talking to Resident number 100 about care provided at the facility and he stated "Just ask my roommate he rang the bell at 10 o'clock to get changed and its 12:15 and they just changed him." At approximately 12:20pm, an interview was conducted with Resident # 15 who stated, "I can't wait to get out of this place, and yes I did ring at 10 o'clock to get changed. The CNA came into the room told me I have to go get something I'll be right back. She left and came back at 12:00 PM. I just now got changed at 12 o'clock."	F 677		

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F 677	Continued From page 24 At 1:00 PM an interview was conducted with CNA B who stated that she tries to get to everyone as fast as she can but sometimes when she leaves a room someone else needs her and she gets busy and doesn't always get back right away. On 9/2/21 at approximately 2:00 PM an interview was conducted with the ADON who stated that it was his expectation that Residents are provided incontinent care as needed. She also stated that having a Resident wait 2 hours was an excessive amount of time. The Administrator was made aware of the concerns on 9/2/21 and no further information was provided.	F 677		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State.	F 680		

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This REQUIREMENT is not met as evidenced by:
Based on staff interviews and facility documentation review, the facility staff failed to provide a qualified therapeutic recreation specialist or an Activities professional meeting the regulatory requirement to oversee the facility's Activity Program.

The findings included:

On 09/02/2021 at approximately 2:15 P.M., an interview with Employee D, the Community Life Director, was conducted. When asked about her training and qualifications as an Activities professional, the Community Life Director stated that she had her Bachelor's degree in Education and her Master's degree in Business. Employee D also stated that the facility trained her to be the Community Life Director. When asked about previous work experience, the Community Life Director stated that in her previous employment, she was a teacher.

On 09/02/2021 at approximately 2:50 P.M., an interview with Employee G, Human Resources, was conducted. When asked about the employment status of the Community Life Director, Employee G indicated that the Community Life Director was initially hired in January 2020 as a part time receptionist and then her status changed to full time Community Life Director in July 2020. When asked about qualifications for the position of Community Life Director, Employee G stated that "I go by the job description." Employee G also stated that Community Life Director has her Bachelor's degree and she used to work as a teacher. A copy of the job description in Employee D's

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F 680	Continued From page 26 employee file entitled, "Dir. [Director] Therapeutic & Recreational Services I & II" was reviewed. Under the header, "Education", it was documented, "Must posses [sic], as a minimum, a Bachelor's degree in therapeutic recreation or equivalent training/experience. National Certification Council for Activity Professionals (NCCAP) certification required; Applicants/employees that currently do not have the NCCAP certification will be provided a provisional 6 months period to complete that certification while they work." An excerpt under the header, "Experience" documented, "Must possess a minimum of two (2) years experience in therapeutic recreation." On 09/02/2021 at 3:00 P.M., the administrator was notified of findings. At 4:20 P.M., the administrator provided a signed letter dated 09/02/2021 from an education company. An excerpt of the letter documented the following: "At the end of these courses she [the Community Life Director] will be eligible to take the national examination to become a certified Activity Director through the NCCAP." On 09/03/2021 by the end of survey, the administrator stated there was no further information or documentation to submit.	F 680		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including	F 687		

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to prevent complications from the resident's medical condition(s) and
(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and clinical record review and in the course of an investigation the facility staff failed to provide appropriate foot care for 1 Resident (# 12) in a survey sample of 40 residents.

The findings included:

For Resident # 12 the facility staff failed to trim toenails or arrange for podiatry to do so for a Resident who is diabetic.

On 8/31/21, an interview was conducted with resident #12 at approximately 10 AM. Resident # 12 was asked about the ADL care that he received from the facility and he stated he gets his showers but nobody ever cuts his toenails. When asked if he had seen the podiatrist he said, "One time since I've been here." When asked if the surveyor could look at his feet, Resident #12 took off his shoes and the Surveyor observed that both feet had nails that were approximately 1/4 inch of an inch long. According to the Admission MDS, Resident #12 was admitted in April 2018.

During clinical record review, it was found that the resident had only one podiatry visit. The podiatrist saw the Resident on 3/16/21.

Podiatry consult note dated 3/16/21 "Walks with walker; extremely elongated toenails."

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"3/19:21 3:46 PM He is appreciative of the podiatry consult, as his toenails had grown quite long and were hurting when he walked. He reports this has completely resolved after his toenails were trimmed."

"6/15/21 0930 Today [Resident #12's name redacted] appears to be doing well main issues continue to be long toenails (he is on the list to see podiatry)"

A review of resident number 12's care plan revealed:
'[Resident #12's name redacted] has self-care performance deficit requires assistance with ADLs related to diabetes hypertension gastrointestinal stromal tumor COPD and impaired cognition. Date Initiated 11/19/18 Revised on 1/29/20

Check nail length and trim and clean on bath days as and as necessary. Report any changes to the nurse. Date initiated 11/19/18 Revision on 2/4/19.

"[Resident #12's name redacted] has diabetes mellitus."

Inspect feet daily for open areas, sores, pressure areas, blisters edema or redness.

On 9/2/21 at approximately 12:45 PM an interview was conducted with the ADON who stated the podiatrist comes to the facility every 2 weeks. When asked what the procedure was for getting "on the list" to be seen by podiatry she stated that there was a book at the nurse's station. When asked who usually cuts resident's

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F 687	Continued From page 29 nails she stated CNA's unless they are diabetic then it's the Nurses. When asked when they do this she stated usually on the bath days. The Surveyor asked to see all the podiatry notes for Resident #12 since admission, and was provided with one note from 3/16/21. When asked how often Medicare would pay for podiatry services for a diabetic Resident she stated every 3 months. On 9/3/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 687		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		

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quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and facility documentation the facility staff failed to appropriately label and store medications for 2 Residents (#'s 40, 102) in a sample of 40 Residents and failed to remove expired medication from use for one medication cart and one medication room.

The findings included:

1. For Resident # 40 the facility staff failed to date the Resident's eye drops when they were opened.

On 9/1/21 at approximately 8:45 AM while inspecting the medication carts and medication rooms with LPN D, it was noted that there was a bottle of Latanoprost 0.005% eye drops belonging to Resident #40 that was not dated when opened. The pharmacy sticker on the bottle stated "This medication is good for 45 days after opening."

At that time, an interview was conducted with LPN D who stated that the sticker on the bottle was a reminder to nurses that the bottle should be dated when opened since it is only good for 45 days. She stated the importance of dating the eye drop bottle is that so you will not know when they are expired and do not keep using them.

On 9/1/21 at approximately 3:00 PM an interview was conducted with the Regional Nurse consultant who stated it was her expectation that medications that are only good for a certain time period will be dated when they are opened so that the nurses will know when to reorder and when

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the mediation will expire.

On 9/2/21 during the end of day conference the Administrator was made aware of the concerns and no new information was provided.

2. For Resident #102 the facility staff failed to date the Resident's eye drops when they were opened.

On 9/1/21 at approximately 8:45 AM while inspecting the medication carts and medication rooms with LPN D it was noted that there was a bottle of Latanoprost 0.005% eye drops belonging to Resident #102 that was not dated when opened. The pharmacy sticker on the bottle stated "This medication is good for 45 days after opening."

At that time an interview was conducted with LPN D who stated that the sticker on the bottle was a reminder to nurses that the bottle should be dated when opened since it is only good for 45 days. She stated the importance of dating the eye drop bottle is that so you will not know when they are expired and do not keep using them.

On 9/2/21 at approximately 3:00 PM an interview was conducted with the Regional Nurse consultant who stated it was her expectation that medications that are only good for a certain time period will be dated when they are opened so that the nurses will know when to reorder and when the mediation will expire.

On 9/3/21 during the end of day conference the Administrator was made aware of the concerns and no new information was provided.

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3. For the facility Residents, the facility staff failed to dispose of expired medications.

On 9/1/21 at approximately 8:55 AM while inspecting the medication carts and medication rooms with LPN D it was noted that there were 3 bottles of expired medications on a cart.

The medications were as follows:

B-12 100 mcg expired on 7/2021
600 mg Calcium + D expired on 7/2021
acetaminophen 500 mg/15 ml elixir expired on 8/2021

At that time (8:55) an interview was conducted with LPN D who stated that the medications did not have a Resident name on them because they were "house stock." When asked what that meant she stated anyone with an order for that medicine could use that bottle. It was a multi dose bottle that could be used by multiple Residents, they were OTC (over the counter non prescription items). LPN D stated that the carts were supposed to be checked on night shift for expired medications. LPN D removed and disposed of the medications at that time.

On 9/1/21 at approximately 3:00 PM an interview was conducted with the ADON who stated that it was her expectation that medication carts should be checked daily for expired medications and that the nurses should be looking at expiration dates when they are passing medications.

On 9/2/21 during the end of day conference the

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Administrator was made aware of the concerns and no new information was provided.

4. The facility staff failed to appropriately store medications in the medication storage room on the third floor, multiple medications were available for use that had expired.

On 9/1/21 at 10:39 AM, Surveyor B was accompanied by LPN C to the medication room on the third floor. A random sample of medications stored within the room revealed the following: Saline Nasal Spray with an expiration date of 8/21, Calcium 600+ D, expired 6/21. Advanced stress formula plus zinc tablets, two bottles, both with an expiration date of 7/21.

On 9/1/21, LPN C was asked what the risk of giving expired medications to Residents is and she said, "It could have an adverse reaction to the patient; cause more harm than good. They have an expiration date for a reason, they are more potent while good".

On 9/1/21 at 8:18 PM, the Assistant Director of Nursing (ADON)/Employee C was told of the expired medications. When asked what should be done to ensure medications are within their shelf life, Employee C said, "It [the storage room] should be checked at the beginning of each shift, usually the unit manager will go in and check it once or twice a week at least ".

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F 761	Continued From page 34 Review of the facility policy titled, "Storage and Expiration of Medications, Biologicals, Syringes and Needles" revealed that page 2 read, "4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label... are stored separate from other medications until destroyed or returned to the pharmacy or supplier". On 9/1/21, during an end of day meeting the facility Administrator and Assistant Director of Nursing were made aware of the expired medications in the third floor medication storage room being available for use. No further information was received.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		

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F 842	Continued From page 35 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to maintain an accurate clinical record for one resident (Resident #288) in a sample size of 46 residents.

The findings included:

For Resident #288, the nursing admission assessment documented a wound to the right heel when, in fact, Resident #288 had multiple wounds on the top and side of the right foot and no wound on the right heel.

On 09/01/2021 at 11:55 A.M., Resident #288 was interviewed. When asked if he had any wounds, Resident #288 indicated he had wounds on his right foot. When asked how he got the wounds, Resident #288 stated that his foot "got all scratched up" and it "got worse and worse." Resident #288 moved the bed covers from his right foot to reveal the right foot with a dressing of kerlix and clear tape.

On 09/02/2021 at 7:05 P.M., this surveyor observed the wounds on Resident #288's right foot as Registered Nurse A (RN A) performed a wound treatment and dressing change. Resident #288 had 4 open wounds to the top and side of his right foot. There was no wound observed on Resident #288's right heel.

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F 842	Continued From page 37 On 09/02/2021 at 7:30 P.M., an interview with Registered Nurse C (RN C) was conducted. RN C verified she was the night nurse assigned to care for Resident #288. This surveyor and RN C observed Resident #288's admission nursing assessment dated 08/31/2021 at 2:30 A.M. In Section M entitled "Skin", there was one wound listed which documented, "PVD [peripheral vascular disease], resident has ulcer on right heel." RN C stated she didn't know why it says "Heel" because the wounds are on the top of the foot. According to the Lippincott Manual of Nursing Practice, 10th edition, 2014, under the section entitled, "Accountability", it was documented, "The professional nurse must be proactive and take all appropriate measures to ensure that her own practice is not lacking, remiss, or deficient in any area or way. Useful, proactive measures include...examining the quality (accuracy and completeness) of documentation." On 09/03/2021 at approximately 5:00 P.M., the administrator was notified of Resident #288's inaccurate clinical record. The administrator indicated there was no further information or documentation to submit.	F 842		
F 880 SS=F	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	F 880		

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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;
(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

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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, staff interviews, facility document review and clinical record review the facility staff failed to practice and maintain infection control measures to prevent the spread of infections to include Covid-19 while in an active Covid outbreak on 3 of 3 nursing units.

The findings included:

1. For the facility in general, 3 employees failed to maintain infection control measures while working in the Resident rooms.

Observations on 8/31/21:

830 AM all rooms on the second floor had signs posted on the doors that instructed to use 'Gown Gloves N95 and face shield' in room also there

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were signs instructing proper donning and doffing and handwashing.

8:45 AM - CNA C was in room 227 with no gloves, no gown, and no face shield, however she was wearing an N95 mask she exited the room without washing her hands but did use sanitizer in hall.

8:47 AM an interview was conducted with CNA C who stated "I was only going in for a minute. I should have put on gown and gloves though."

12:40 PM observed CNA C again went into patient room with only a mask, no gown no gloves, again she did not wash her hands.

12:44-Employee H (maintenance tech) observed in Resident room 229 fixing TV with no gown or gloves on did not wash hands or use hand sanitizer when exiting the room.

12:47- Employee J (Maintenance Director) also went into room with no gown, and no gloves, just the N-95 face mask, he also did not wash his hands or use sanitizer upon exiting room

12:50 -An interview was conducted with both employees at that time. When asked about the sign on the door employee H said "Oh my bad I should have had on gloves and gown." Employee J stated "Oh I guess I should have gown and gloves on too. Actually they sent me up here with this clipboard to do an in-service on what PPE to wear in resident rooms."

On 8/31/21 at 4:00 PM the ADON was interviewed about the lack of following directions for PPE and handwashing. The ADON stated

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that it was her expectation that all staff follow the protocol for PPE usage and handwashing. She stated that she would be continuing to educate on the importance of both.

On 9/1/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #288, the facility staff failed to adhere to standard infection control practices during a dressing change on 09/02/2021.

On 09/02/2021 at 7:05 P.M., this surveyor observed Registered Nurse A (RN A) perform a wound dressing change for Resident #288 who was on isolation precautions due to COVID-19. RN A gathered supplies from the clean utility room which included reaching her bare hand into a non-sterile package of 4x4 gauze and obtaining several non-sterile 4x4's. RN A then walked down the hall and entered Resident #288's room wearing a gown, N-95, and faceshield but no gloves. RN A used her bandage scissors to cut open two packages of kerlix. RN A touched each of the kerlix wraps with her bare hands and placed the kerlix wraps in their package on Resident #288's tray table. Portions of the kerlix were touching the tray table. RN A placed the non-sterile 4x4's on the tray table. RN A did not clean the tray table prior to placing the gauze and kerlix directly on it. RN A then washed her hands, donned gloves and removed the old dressing. RN A removed her gloves and donned another pair of non-sterile gloves. RN A did not wash her hands prior to donning the new set of non-sterile gloves.

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RN A applied the Silvadene cream to the wounds with her gloved hand, then applied the non-sterile 4x4's to the wounds, and wrapped the right foot in kerlix.

On 09/03/2021 at approximately 5:00 P.M., the Regional Nurse Consultant was interviewed. When asked about the expectation for wound care, the Regional Nurse Consultant stated she would expect staff to observe clean technique for dressing changes and to follow wound orders.

According to a Lippincott publication entitled, "Taylor's Clinical Nursing Skills", 5th Edition, 2019, Chapter 8, page 421, excerpts under the sub-header, "Clean (non-sterile) Technique and Wound Care" documented, "The aim of the use of clean technique in wound care is to ensure that contamination of the wound, any supplies and the environment is minimized." "Clean technique in wound care involves: Meticulous hand hygiene before initiating care and before/after glove changes." "Sterile gloves should be worn if direct contact with the wound is necessary."

On 09/03/2021 by the end of survey, the administrator stated there was no further information or documentation to submit.

3. For Resident #284, the nurse was observed to enter Resident #284's room to administer a medication without the proper personal protective equipment donned on 09/01/2021.

On 09/01/2021 at 11:20 A.M., this surveyor observed Registered Nurse A (RN A) administer a medication to Resident #284 who was on

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isolation precautions due to COVID-19. There were three signs on Resident #284's room door. They were entitled, "Airborne Precautions", "Contact Precautions", and Droplet Precautions." Under the header "Contact Precautions", an excerpt documented, "Put on gloves before room entry. Discard gloves before room exit." RN A entered Resident #284's room wearing a gown, N-95, and faceshield but no gloves. RN A handed Resident #284 the medication cup, washed her hands, and then exited the room. When asked about the practice of wearing gloves during medication administration, RN A stated, "It depends because you don't want the residents to feel germy." RN A also stated that she doesn't need to wear gloves when passing meds unless she is applying a patch." RN A also stated Resident #284 was on contact and droplet precautions "so I want to make sure I wash my hands."

On 09/01/2021 at approximately 5:00 P.M., a clinical record review revealed that Resident #284 was admitted to the facility with COVID-19.

On 09/03/2021, a review of the facility policy revised on 07/28/2021 entitled, "COVID-19 Pandemic Plan" under the header "Emergency Procedure" in Section 18 entitled, "Center will designated a unit/area for residents with a confirmed COVID-19 infection" documented, "Initiate transmission based precautions based on CDC guidance (Standard, Contact, and Droplet and eye protection). Including PPE - Respirator, (or facemask if respirators are not available) eye protection, gown and gloves."

On 09/03/2021 by the end of survey, the administrator was notified of findings and stated

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there was no further information or documentation to submit.

4. The facility staff failed to have knowledge of the isolation status and properly isolate Residents while the facility was in an active COVID-19 outbreak.

On 8/31/21 at 6:36 AM, upon the survey team's entry to the facility, LPN F and LPN G introduced themselves as supervisors. When asked about the COVID status of the facility and required PPE (personal protective equipment) to be worn they stated, "Everyone is required to wear N-95 [medical respirator mask] and goggles. The 2nd and 3rd floors are COVID negative".

On 8/31/21 at 7 AM, Surveyor B talked with LPN F, the third floor supervisor who again said, "no Residents on this floor are on quarantine".

On 8/31/21 at 7:13 AM, Surveyor B conducted general observations and initial tour on the third floor, east wing. Staff were observed to enter and exit out of multiple Resident rooms with no PPE on. Further observations revealed that the room Residents #57 and Resident #112 resided in had a sign on the door for contact precautions. Surveyor B approached the nursing station and spoke with LPN H to inquire why the room of Residents #57 and #112 were on precautions. LPN H stated, "They are not". LPN H accompanied Surveyor B to the room and said, "Someone just put it there [the isolation sign], she is not on isolation". When asked if the sign had been present during her shift, LPN H said "No".

On 8/31/21 at 8:50 AM, when Surveyors B and D

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return to the third floor, it was observed that all rooms had signs on the door for isolation and staff were observed to be donning (putting on) PPE to include isolation gowns and gloves prior to entering every room. LPN B, the unit manager approached the surveyors and stated, "Everyone on the unit is on 14 day isolation. We let our Residents come out [of their rooms] but I prefer for my people [staff] to have gowns on in the rooms. Residents can sit in the hall but they have to be 6 feet apart. I told them we 're going to put the signs back up [isolation signage] and wear PPE until they tell me different". When asked why Residents were not on PPE earlier in the morning and staff were not wearing PPE in the rooms, LPN B stated, "I don't know, there has been a lot of confusion about that".

On 8/31/21 at 8:57 AM, the Facility Administrator, Assistant Director of Nursing and Corporate Nurse met with the survey team. The facility staff were made aware of the variations in practices observed on the third floor and asked for clarification on the isolation/quarantine status of Residents and the requirement of PPE use. The Administrator and Assistant Director of Nursing said Residents on the third floor are not on quarantine. The Corporate Nurse said "they should be [Residents on the third floor should be on quarantine]" and asked the Administrator to step out of the room.

On 8/31/21 at 9:03 AM, LPN B joined the survey team and facility Administrator, ADON and Corporate Nurse. LPN B said, "Clarify for me too, because at one point I was taught, if someone tests positive in our facility everyone in the facility should be on quarantine for 14 days, if that has changed I would like to know because that is my

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unit that I am responsible for so I put the signs back up and told my CNA's to wear everything".

The facility Administrator said, "What [Employee E name's redacted/the corporate nurse] just communicated is that the policy is that the third floor is able to have visitation, but per our pandemic plan the affected unit would remain without visitation for 14 days, so what [LPN B/unit manager's name redacted] is communicating is how the center has been operating and that's what [Employee E's name redacted] was just communicating".

On 8/31/21 at 9:07 AM, the Facility Administrator, ADON, Corporate Nurse and LPN B all concurred that every Resident on the third floor in addition to the second floor is on quarantine and full use of PPE is required to enter the rooms.

On 8/31/21 at 3:41 PM, The facility Administrator was asked if he expected staff to be aware of the quarantine status of Residents, he said, "Yes".

On 9/1/21 at 2:37 PM, an interview was conducted with Employee C, the ADON and Infection Preventionist who confirmed the facility is in an active outbreak situation. She stated, "We had 3 different people test positive, we had a Resident that readmitted on 8/2, went out again on 8/7 tested positive on 8/7 at hospital. Then we had a staff member test positive on 8/26 [Employee Name redacted/LPN J] working 2nd floor, who was tested here at the facility. That put us back in outbreak testing. On 8/30 the staff [Employee name redacted/ LPN K] who was dedicated to the COVID unit, tested positive".

On 9/3/21, the facility Administrator and

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Corporate Clinical Nurse confirmed that they follow CDC (Center for Disease Prevention and Control) and CMS (Center for Medicare and Medicaid Services) recommendations/guidance and said their facility policy is based upon those principles.

Review of the facility policy titled, "COVID-19 Pandemic Plan" defined an outbreak as, "in response to an outbreak, defined as any single new infection in staff or any nursing home onset infection in a resident". The policy further read, "The center will implement the following infection control protocols during outbreak testing (these precautions should continue for residents until no new cases of COVID-19 have been identified for at least 14 days):
" Source control PPE while caring all residents includes, respirator, eye protection, gowns and gloves
" Residents should remain in their rooms
" Communal dining and activities should be restricted center may consider communal dining and activities for those residents/units without COVID-19".

The CDC (Centers for Disease Prevention and Control) provides the following guidance to nursing facilities, "New Infection in Healthcare Personnel or Resident: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident. Because of the high risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak. -Consider increasing monitoring of all residents from daily to every shift to more rapidly detect those with new symptoms.

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Implement facility-wide testing along with the following recommended infection prevention precautions: -HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Residents should generally be restricted to their rooms and serial SARS-CoV-2 testing performed". This guidance was accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

On 8/31/21, during an end of day meeting, the facility Administrator and ADON were made aware of the concerns of facility staff's failure to have knowledge of the isolation status and properly isolate Residents while the facility was in an active COVID-19 outbreak.

No further information was received.

5. The facility staff failed to wear proper PPE (Personal Protective Equipment) to prevent the spread of COVID-19 while the facility was in an active outbreak of COVID-19.

On 9/1/21 at 11:21 AM, CNA D was observed to enter room 321, which had signage for isolation and PPE to be worn. CNA D entered the room without donning (putting on) gloves, she was observed to be in the room tying the neck portion of her isolation gown and adjusting the face shield. When asked about putting on PPE, CNA D said, "I should have put it all on before entering the room".

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On 9/1/21 at 4:06 PM, CNA B was observed in Resident #49's room providing direct patient care. Resident 49's door had signage to indicate they were on isolation and another sign indicating full PPE was required prior to entering the room. CNA B was observed with no isolation gown on and throughout the duration of the observation CNA B's face mask was positioned below her nose. When CNA B was asked about the lack of an isolation gown she said, "I got hot and I'm about to change".

On 9/1/21 at 3:27 PM, CNA E was observed to enter a Resident room on the third floor north hall while only wearing eye protection and an N-95 mask, the mask was positioned below her nose. CNA E then goes through the shared bathroom to the adjoining room, talks to the Residents in that room and then exits. Surveyor B asked why she entered isolation rooms without PPE (isolation gown and gloves on), CNA E said, "I just went to cut the light off it's no excuse".

On 9/1/21 at approximately 3:45 PM, Employee L was observed to exit out of a Resident room that was on isolation. Employee L entered into the hallway in full PPE and began doffing [removing] her isolation gown in the hallway. Employee L then walked through the hall to the nursing station with her soiled isolation gown in hand, Surveyor B asked if she normally brings her used PPE up the hall in her hand, Employee L said, "I don't have a trash can with me".

On 9/1/21 at 4:00 PM, an interview was conducted with LPN C. When asked to verify what PPE is to be worn in Resident rooms on the third floor, LPN C said, "eye protection, masks, gowns and gloves". She was asked to clarify

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when this PPE is needed, LPN C said, "Any time a staff member would be in the room". LPN C was asked if there was any situations why a staff member would be in a Resident room without an isolation gown on and she said, "If the gown got soiled and they were changing".

Review of the facility policy titled, "COVID-19 Pandemic Plan" defined an outbreak as, "in response to an outbreak, defined as any single new infection in staff or any nursing home onset infection in a resident". The policy further read, "The center will implement the following infection control protocols during outbreak testing (these precautions should continue for residents until no new cases of COVID-19 have been identified for at least 14 days):
" Source control PPE while caring all residents includes, respirator, eye protection, gowns and gloves
" Residents should remain in their rooms
" Communal dining and activities should be restricted center may consider communal dining and activities for those residents/units without COVID-19".

The CDC (Centers for Disease Prevention and Control) provides the following guidance to nursing facilities, "New Infection in Healthcare Personnel or Resident: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident. Because of the high risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak. -Consider increasing monitoring of all residents from daily to every shift

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to more rapidly detect those with new symptoms. Implement facility-wide testing along with the following recommended infection prevention precautions: -HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Residents should generally be restricted to their rooms and serial SARS-CoV-2 testing performed". This guidance was accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

On 9/1/21, during an end of day meeting the facility Administrator and ADON were made aware of the concerns of staff not wearing proper PPE.

No further information was provided.

6. The facility staff failed to handle linen in a manner to prevent the spread of infection.

On 9/1/21 at 4:06 PM, Surveyor B knocked on the room door of Resident #49. After hearing no response, Surveyor B opened the door and observed CNA B at the bedside providing care. Surveyor B observed soiled linen in the floor beside the bed of Resident #49. CNA B was asked about the linen and she said, "I just changed her".

On 9/1/21 at approximately 4:30 PM, an interview was conducted with LPN C. LPN C was asked about putting soiled linen on the floor. LPN C said, "That's unacceptable, linen in floor could cause someone to trip and fall, it's a big infection

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F 880	Continued From page 52 control issue. We all know you set up your bag before you provide care so it is available to put soiled linen in". On 9/1/21 at 8:18 PM, an interview was conducted with Employee C, the Assistant Director of Nursing (ADON). The ADON stated soiled linens are to be put into a bag and not put on the floor for risk of spreading infection. On 9/1/21 at approximately 8:20 PM, during an end of day meeting, the facility Administrator, ADON and Corporate Nurse Consultant were made aware of the findings. No further information was received.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control.	F 882		

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§483.80 (c) IP participation on quality assessment and assurance committee.
The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews the facility staff failed to have a designated individual to serve as the Infection Preventionist (IP) who had completed specialized training in infection prevention and control. This has the potential to affect all 106 Residents residing in the facility.

The findings included:

On 8/31/21, during an entrance conference with the facility Administrator, he identified the Assistant Director of Nursing (ADON) as the facilities designated Infection Preventionist.

On 9/02/21 at 11:11 AM, Surveyor B met with Employee C, the ADON/Infection Preventionist. When surveyor B asked to see evidence of her training for the Infection Preventionist role, Employee C stated, "I don't have any real training, I do know I've got to take those modules [referring to the Center for Disease Prevention and Control Infection Preventionist Training modules] but I haven't had any real training".

On 9/2/21, during an end of day meeting with the facility Administrator, ADON and Corporate Nurse, they were made aware that Employee C doesn't have any specialized training in Infection Prevention and Control and therefore doesn't meet the regulatory requirement. They (the

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F 882	Continued From page 54 Administrator and Corporate Nurse) were asked if they have any other facility staff that have had any specialized training that would meet the requirements and they all agreed, "No". The facility Administrator did provide evidence of the previous Infection Preventionist's training, but acknowledged her employment with the facility was terminated and she was no longer an active employee. No further information was received.	F 882		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of	F 886		

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COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation

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review and clinical record review, the facility staff failed to conduct COVID-19 testing of one Resident (Resident #112) who was symptomatic and failed to conduct routine COVID-19 testing of all unvaccinated staff, to prevent the spread of COVID-19 infections within the facility.

The findings included:

1. For Resident #112, the facility staff failed to conduct COVID-19 testing immediately following the Resident presenting with symptoms.

Review of the clinical record for Resident #112 revealed a progress note dated 8/4/21 at 6:45 AM, that read, ".....Stuffy nose with intermittent cough. Large amount of yellow mucus from mouth. Unable to cough out anything from mouth. Afebrile". The clinical record revealed no evidence of COVID-19 testing following the display of COVID symptoms, until 8/7/21, when the facility staff conducted facility wide outbreak testing.

On 09/02/21 at 11:11 AM, Surveyor B met with Employee C, the Infection Preventionist. Employee C was asked to provide the line listing of Resident's and Staff who have had symptoms and/or actual infections of COVID-19. Employee C stated, "This is what I've started for myself, if they had one previously I can't find it, this is not a line listing per se but I wanted to keep track of things". When asked when this log was initiated, Employee C stated, "Honestly I started this log yesterday. There is a log I'm sure I just haven't gotten into the system yet to find where it is located". Employee C, the Infection Preventionist provided Surveyor B with a document that was titled, "LTC [long term care] Respiratory

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Surveillance Line List" which had 3 Resident's names. Resident #112 was listed with a symptom onset date of 8/4/21.

Employee C was asked if Resident #112 was tested since she was noted as having displayed symptoms of COVID-19, which included a cough, myalgia (body aches), and mucous. Employee C stated, ""That's a good question I really don't have an answer to that. They should have been tested. They weren't tested, that [the log] was just for my knowledge something to keep up with". The form/log provided did indicate that Resident #112 was tested via PCR test but didn't indicate a date this occurred.

On 9/3/21, the facility Administrator and Corporate Clinical Nurse confirmed that they follow CDC (Center for Disease Prevention and Control) and CMS (Center for Medicare and Medicaid Services) recommendations/guidance and said their facility policy is based upon those principles.

Review of the facility policy titled "COVID-19 - Pandemic Plan" read, "Symptomatic testing: Test any staff or residents who have signs or symptoms of COVID-19 (regardless of their vaccination status)".

CMS in their QSO-20-38-NH Memo, with a revision date of 04/27/2021, read, "Residents who have signs or symptoms of COVID-19, vaccinated or not vaccinated, must be tested immediately. While test results are pending, residents with signs or symptoms should be placed on transmission-based precautions (TBP) in accordance with CDC guidance. Once test results are obtained, the facility must take the

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appropriate actions based on the results".

The CDC provided nursing home the following guidance, "Testing residents with signs or symptoms of COVID-19: · At least daily, take the temperature of all residents and ask them if they have any COVID-19 symptoms. Perform viral testing of any resident who has signs or symptoms of COVID-19". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

On 9/3/21, during an end of day meeting the facility Administrator, ADON and Corporate Nurse were made aware of the findings.

No further information was received.

2. The facility staff failed to conduct routine COVID-19 testing of all unvaccinated staff based on the county positivity rate for the month of June and July 2021.

On 09/02/21 at 11:11 AM, Surveyor B met with Employee C, the Infection Preventionist. Employee C was asked to provide evidence of COVID-19 testing for staff during June and July. Employee C said, no testing was conducted during those months.

On 9/2/21, the facility Administrator provided the survey team with County positivity rates of COVID during the months of June and July. During the period of 5/26/21-7/6/21, the positivity rate was less than 5%. From 7/7/21-7/27/21, the county positivity rate was 6% and 7.4%.

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On 9/3/21, the facility Administrator and Corporate Clinical Nurse confirmed that they follow CDC (Center for Disease Prevention and Control) and CMS (Center for Medicare and Medicaid Services) recommendations/guidance and said their facility policy is based upon those principles.

Review of the facility policy titled "COVID-19 - Pandemic Plan" read, "Routine Testing: Test all unvaccinated staff based on the extent of the virus in the community, using CMS' published county positivity rate in the prior week as the trigger for staff testing frequency".

CMS in their QSO-20-38-NH Memo, with a revision date of 04/27/2021, read, "Routine testing of unvaccinated staff should be based on the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested. Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency". Table 2 of this document provided the following frequency of testing requirements: "Low, <5%, test unvaccinated staff once a month, Medium 5% - 10%, test unvaccinated staff once a week*. Accessed online at: https://www.cms.gov/files/document/qso-20-38-nh.pdf

On 9/3/21, during an end of day meeting the facility staff were made aware that the facility was not in compliance with COVID-19 testing. No further information was received.