STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING _____ B. WING _____	C 04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WILLIAMSBURG, LLC	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted 4-27-2021 through 4-30-2021. The facility was in compliance with 42 CFR Part 483.73 emergency preparedness regulations, and implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control and Abbreviated Complaint survey was conducted onsite 4-27-2021 through 4-30-2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and and implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 130 certified bed facility was 91 at the time of the survey. The survey sample consisted of 19 resident reviews.	F 000		
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	F 680		5/20/21

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

Electronically Signed | 05/18/2021

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F 680	Continued From page 1 (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. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, and staff interview, the facility staff failed to employ a qualified activities professional for the facility. The Findings included: On 4/27/2021 at 12:03 pm the Assistant Activities Director was interviewed. She introduced herself as the activities assistant, and stated she supervised the smoking cart which is at 9am, 12noon, 3pm, and 6pm. She was asked if that was all she did and she said no, "if I have snacks, I pass out snacks." On 4/28/2021 at 5:21 pm, the April activity calendar was observed and included the following on each of the 30 days of the month: "Every day 9 am Resident independent activities/coffee break". "Every day 2 pm, resident room rounds." "Every Monday 10 am Resident room rounds/spa Mondays" "4/6/21 resident council 10am" "Every Wednesday 1 pm nacho bar in the dining room Colonial Hall" On 4/28/21 at 5:25 p.m., the Social Worker's was	F 680	1. An activity professional was hired on May 18, 2021. 2. All residents have the potential to be affected. 3. Executive Director was re-educated by the RDCS on 5/17/21 on ensuring the facility employs an activity professional. 4. The Executive Director will ensure that an activity professional is employed at the facility. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary. Variances will be reported to QAPI with the follow up as indicated. 5. Allegation of compliance date of May 20, 2021.	

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F 680	Continued From page 2	F 680		

interviewed and asked who was charge of activities. He stated "I think they have left for the day." He was asked if that person would be in the faiclity tomorrow and he replied "yes". He gave the name of the staff member who was in charge he was asked if she was the staff supervising the smoking earlier, and he said "yes that's her."

On 4/28/21 at 5:29 p.m., the Director of Human Resources (HR) was interviewed. She was asked who was in charge of activities, and she gave the same staff name, and stated "She got off at 5pm." The HR Director stated "Right now its just her" when asked if she was the only activity person for the entire building.

The HR Director was asked if this staff was the Activities Director. The HR Director responded "She is an activities Coordinator." The Director of HR stated "She was out on Family Medical Leave Act (FMLA), and she just returned to work last week."

The HR Director further stated, "I had to send her back out because she didn't have a full release to work yet. Her last work day prior to being out was 1/28/21, but she was working some in between then and now." "She worked 2/22/21, she was back and forth, she was also here on 3/10/21, it was intermittent, and she worked 3/18/21."

The Activities Assistant's time card was reviewed from 1/1/21 to present. She went on Leave of Absence (LOA) at the end of March. The HR Director was asked how long she had been the only one in that department, and she replied "another activity assistant was there but her last day was 2/15/21. The former actual director's

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F 680	Continued From page 3	F 680		

last day was 2/15/21."

The HR Director stated, "We had a part-time assistant in activities who worked a weekend here and there, her last date worked was 2/28/21." When asked if that meant no Certified Activities Professional Director worked at the facility since 2/15/21, the other week end activity staff left on 2/28/21, and this assistant was on medical leave and only came in 3 times since 2/15/21, until she returned this week 4/26/21, the HR Director responded "yes".

On 4/29/21 at 8:28 am, an interview was conducted with the Activities Assistant. She was asked how many people worked in the Department. She replied "One, myself." She was asked, how long and stated "It's been quite a while." She went on to state, "...so I've been in and out, when I came back...everyone was gone. When I came back he (the previous Administrator) let everyone go. So I've been by myself. It's been months."

The Activities Assistant was asked what the facility administration was doing to hire an Activities Director. She stated "They told me they are interviewing. I'm just an assistant. I've been here several years". She stated "I don't have the qualifications, I wanted to do the class but he (the former administrator) never said anything to me about it. I can try it, but I don't have the qualifications. I've been doing this for almost 3 years, but..." When asked about the activity calendars, she stated "(name) the former Director made the calendars before she left, I've never made the calendars." The Activities Assistant provided copies of Feb, April and May of 2021.

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F 680	Continued From page 4 On 4/29/21 the Administrator was interviewed, and stated the former activity director had been terminated, and a new replacement had not yet been hired for activities. At the end of day debriefing, the Administrator and ADON were made aware of the staff failure to provide a qualified activities professional for the residents. No further information was provided by the facility.	F 680		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		5/20/21

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F 755	Continued From page 5 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure medications were available for administration for 1 resident (Resident #12) in a survey sample of 19 residents. Findings Included: Resident #12 was admitted to the facility on 01/27/2020 and readmitted on 3/19/2021. Diagnoses included but were not limited to Diabetes, Epilepsy, cerebral infarction with hemiplegia, dysphagia, Hypertension, Bipolar Disorder, Heart Failure, Gastroesophageal Reflux Disease, contractures multiple sites and Chronic Obstructive Pulmonary Disease. Resident #12's most recent Minimum Data Set with an Assessment Reference Date of 02/23/2021 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicating no cognitive impairment. Review of the electronic clinical record for Resident # 12 was conducted on 4/27/2021 and 4/28/2021. The following physican's medication orders were observed: Gabapentin Capsule 300 MG (milligrams) Give 2 capsules by mouth at bedtime for neuropathy. ALPRAZolam Tablet 0.5 MG Give 1 tablet by	F 755	1. Facility has verified medications are available for Resident #12. 2. All residents have the potential to be affected. An audit will be conducted by the DCS or designee to ensure all residents medications are available by May 19, 2021. 3. Licensed nurses to be re-educated by DON/ Designee on ensuring medications are available for administration. MARs will be monitored during clinical meeting to ensure medications are available for administration. 4. DON/Designee will conduct a quality review of 10 residents' MARs to ensure medications are available for administration 2 x week for 2 weeks, 1 x week for 4 weeks, then monthly for two months. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary. 5. Allegation of compliance date of May 20, 2021	

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mouth two times a day for anxiety
Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for neuropathy

According to the April 2021 MAR (medication administration record), a total of 17 doses of Gabapentin including 4 consecutive days were omitted and 6 doses of ALPRAZolam were omitted due to "med not on hand, awaiting pharmacy, on order and unavailable" for administration.

Gabapentin Capsule 300 MG (milligrams) Give 2 capsules by mouth at bedtime for neuropathy
-Start Date-03/19/2021 2100
2100 (9 PM) - Not available 6 doses including 4 consecutive days in April 2021: 4/8, 4/10, 4/19. 4/20, 4/21, and 4/22 at 9 PM.

ALPRAZolam Tablet 0.5 MG (milligrams Give 1 tablet by mouth two times a day for anxiety -Start Date- 03/20/2021 0900
Not available for 6 doses including 4 consecutive days in April 2021: 4/16 at 9 AM, 4/17 at 9 PM, 4/18 at 9 AM and 9 PM, 4/19 at 9 AM and 9 PM

Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth two times a day for neuropathy
-Start Date- 03/20/2021 0600
0600 (6 AM) and 1400 (2 PM)
Not available for 11 doses including 4 consecutive days in April 2021: 4/8 at 2 PM, 4/9 at 6 AM and 2 PM, 4/10 at 6 AM and 2 PM, 4/19 at 6 AM and 2 PM, 4/20 at 6 AM and 2 PM, 4/21 at 6 AM, 4/22 at 6 AM.

Review of the clinical record revealed several notes regarding medications being unavailable including:

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F 755	Continued From page 7	F 755		

4/18/2021 18:05 eMar - Medication Administration Note - Note Text: Type: eMar - Medication Administration Note Focus: Effective Date: 4/18/2021 08:46:00 Created Date: 4/18/2021 09:17:32 - Note Text: ALPRAZolam Tablet 0.5 MG Give 1 tablet by mouth two times a day for anxiety on order

eMar - Medication Administration Note Focus: Effective Date: 4/19/2021 05:07:00 Department:: Nursing
Created Date: 4/19/2021 05:07:49 - Note Text: Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for neuropathy- not available; awaiting del (delivery) from pharmacy; MD aware

4/19/2021 09:53 eMar - Medication Administration Note - Note Text: Med on order

4/19/2021 13:32 eMar - Medication Administration Note - Note Text: med not on hand/ on order

4/19/2021 21:15 eMar - Medication Administration Note - Note Text: awaiting pharmacy

4/19/2021 21:16 eMar - Medication Administration Note - Note Text: awaiting pharmacy

4/20/2021 06:07 eMar - Medication Administration Note - Note Text: Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for neuropathy awaiting del from pharmacy; MD aware

4/20/2021 14:03 eMar - Medication Administration Note - Note Text: med on order

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F 755	Continued From page 8 4/20/2021 20:24 eMar - Medication Administration Note - Note Text: Medication en-route per pharmacy 4/21/2021 06:50 eMar - Medication Administration Note - Note Text: Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for neuropathy reordered from pharmacy Mar - Medication Administration Note - Effective Date: 4/22/2021 14:30:00 - Created Date: 4/22/2021 14:31:01 Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for neuropathy on order On 4/28/2021 at 2:19 PM, an interview was conducted with the Director of Nursing who stated the expectation was that medications should be reordered as needed and administered as ordered. During the end of day debriefing on 4/29/2021, the facility Administrator, Director of Nursing, Assistant Director of Nursing and Regional Nurse Consultant were informed of the findings. The Assistant Director of Nursing stated medications should be available for administration and administered as ordered by the physician. No further information was provided.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		5/20/21

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F 760	Continued From page 9 Based on staff interview, and clinical record review, the facility failed to ensure 1 of 19 residents in the survey sample (Resident # 12) was free from a significant medication error. For Resident # 12, facility staff failed to administer physician ordered nerve pain medication Gabapentin. The findings included: Resident #12 was admitted to the facility on 01/27/2020 and readmitted on 3/19/2021. Diagnoses included but were not limited to Diabetes, Epilepsy, cerebral infarction with hemiplegia, dysphagia, Hypertension, Bipolar Disorder, Heart Failure, Gastroesophageal Reflux Disease, contractures multiple sites and Chronic Obstructive Pulmonary Disease. Resident #12's most recent Minimum Data Set with an Assessment Reference Date of 02/23/2021 was coded as a Quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicating no cognitive impairment. Review of the electronic clinical record for Resident # 12 was conducted on 4/27/2021 through 4/29/2021. The physicians order documented the following: Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth two times a day for neuropathy -Start Date- 03/20/2021 0600 Gabapentin Capsule 300 MG (milligrams) Give 2 capsule by mouth at bedtime for neuropathy -Start Date-03/19/2021 2100	F 760	1. Facility has verified medications are available for Resident #12. 2. All residents have the potential to be affected. An audit will be conducted to ensure medications are administered per physician's orders by May 19, 2021. 3. Licensed nurses to be re-educated by DON/ Designee on administering medications per MD/NP orders. MARs will be monitored during clinical meeting to ensure medications are administered per physician's orders. 4. DON/Designee will conduct a quality review of 10 residents' MARs to ensure medications are administered per physician's orders 2 x week for 2 weeks, 1 x week for 4 weeks, then monthly for two months. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary. 5. Allegation of compliance date of May 20, 2021.	

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F 760	Continued From page 10	F 760		

Review of the clinical record revealed the following regarding the Gabapentin not being available or administered:

Effective Date: 4/9/2021 06:08 Type: eMar - Medication Administration Note
Note Text : Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth two times a day for neuropathy. "Pharmacy stated that medication cannot be sent that it's too soon and will not be sent out until 4/10/21; MD made aware."

Effective Date: 4/9/2021 13:38 Type: eMar - Medication Administration Note med ordered, awaiting pharmacy.

Effective Date: 4/10/2021 06:20 Type eMar - Medication Administration Note Gabapentin Capsule 300 MG - Give 1 capsule by mouth two times a day for neuropathy awaiting delivery from pharmacy, continues to state medication too early to send; MD aware.

4/10/2021 06:22 Type: Nursing Progress Note Continuing to await delivery of scheduled Gabapentin for neuropathy, continuing to state that medication is too soon and will not be sent out until 4/10/21; MD made aware.

Effective Date: 4/10/2021 15:29 (3:29 p.m.) Type: eMar - Medication Administration Note Awaiting arrival from pharmacy.

Effective Date: 4/10/2021 21:21 (9:21 p.m.) Type: eMar - Medication Administration Note awaiting arrival from pharmacy

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F 760	Continued From page 11	F 760		

Review of the MAR evidenced the following:

Gabapentin Capsule 300 MG (milligrams) Give 2 capsules by mouth at bedtime for neuropathy
-Start Date-03/19/2021 2100
2100 (9 PM) - Not available 6 doses including 4 consecutive days in April 2021: 4/8, 4/10, 4/19. 4/20, 4/21, and 4/22 at 9 PM.

Gabapentin Capsule 300 MG (milligrams) Give 1 capsule by mouth two times a day for neuropathy
-Start Date- 03/20/2021 0600
0600 (6 AM) and 1400 (2 PM)
Not available for 11 doses including 4 consecutive days in April 2021: 4/8 at 2 PM, 4/9 at 6 AM and 2 PM, 4/10 at 6 AM and 2 PM, 4/19 at 6 AM and 2 PM, 4/20 at 6 AM and 2 PM, 4/21 at 6 AM, 4/22 at 6 AM.

On 4/28/2021 at 2:19 PM, an interview was conducted with the Director of Nursing who stated the expectation was that medications should be reordered as needed and administered as ordered. The Director of Nursing stated the pharmacy was expected to deliver the medications that were ordered. The Director of Nursing was asked to provide a copy of the Stat Box contents.

On 4/28/2021 at 4:34 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated the expectation was for facility staff to reorder medications timely so that residents would not miss any scheduled doses. The ADON stated there were two different ways to order medications. One way was to contact the pharmacy directly while in the Electronic Medical Record (EMR), here is a button that says "reorder". The other method for reordering was

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"when a blister pack is received there is a sticker on the top that can be pulled and placed on a sheet of paper to FAX to the Pharmacy." The ADON stated that if the medication was preordered through PCC (Point Click Care), then the facility could see if an audit was done.

On 4/28/2021 during the end of day debriefing, the facility Administrator, the Assistant Director of Nursing, the Regional Vice President and the Regional Nurse Consultant were informed that Resident # 12 did not receive medication as prescribed several times. The Assistant Director of Nursing and Regional Nurse Consultant were asked to describe the process of reordering medications. The ADON stated there had been a problem with the pharmacy recently specifically with narcotics. The process had changed and now required the use of hard scripts. In the month of April, prescriptions were sent to be filled and the pharmacy did not send the medications. The facility had to redo the prescriptions, and add that piece to the process. The ADON also stated "Our physicians usually used the prescriptions in PCC. That has changed now."

On 4/29/2021 at 10:51 AM, the Nurse Practitioner (NP) was interviewed. The NP stated she was not aware of Resident # 12 not receiving her Gabapentin as prescribed. The NP was asked what it meant if Resident # 12 did not receive her Gabapentin as prescribed. The NP stated "Absolutely, she should receive her Gabapentin. That is not a medication that you would want to stop abruptly. That medication was actually prescribed by her neurologist. He has been managing her doses."

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The NP stated "the nurses let us know, they print the prescriptions out, and put them on our desk for us to sign to be refilled. I do know that there has been an issue with the pharmacy recently that had been identified. The prescriptions have been printable from the Electronic Medical Record used at the facility with the facility address on top and then lists the medication and instructions." The NP stated now the pharmacy stated that they need the provider's address on the prescription as well. The NP stated she "could attest to the fact that the pharmacy has been kind of difficult and the facility is trying to work through that."

The NP stated that she had begun writing over the facility address with the provider address also so the pharmacy would know that it was the same address. She stated "I usually give the prescription to the Nurse Manager who has been responsible for faxing them. We get the response that the fax has gone through but the pharmacy will say that they have not received the fax."

The NP was asked why Gabapentin should not be stopped abruptly. The Nurse Practitioner stated that "Gabapentin can have some withdrawal effects. Not only is she on it for pain but she also has a history of convulsions. I've never witnessed any kind of seizure or convulsions from her. I am assuming it is from her initial head injury that she sustained and why she is even in the facility. I have never seen her have any seizure or convulsion activity, usually her pain is very well controlled."

The NP stated "Gabapentin is something that you are not supposed to stop abruptly. You are

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F 760	Continued From page 14 supposed to wean and taper down slowly. If she is missing multiple doses of Gabapentin, that could be a problem. Sometimes she does have behaviors. She is followed by Psych but then again too, it could be maybe from withdrawal which she could be starting to have if she is not getting the Gabapentin like she should. I can't say that for sure. It would be hard to say for sure. But it is a possibility." On 04/29/2021 at 11:41 AM, an interview was conducted with the Medical Director who stated that he was not informed that Gabapentin had not been available for administration several times. The Medical Director stated he was new in his role as the Medical Director for the past couple of months. Gabapentin was ordered for neuropathy pain for Resident # 12 and the concern would be not treating her neuropathy pain. The Medical Director stated that the expectation would be that all medications would be available and administered as ordered. During the end of day debriefing on 4/29/2021, the facility Administrator, Director of Nursing, Assistant Director of Nursing and Regional Nurse Consultant were informed of the findings. The Assistant Director of Nursing stated medications should be available for administration and administered as ordered by the physician. A copy of the memo from Pharmacy regarding the changes was requested. No further information was provided.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		5/20/21

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F 761	Continued From page 15 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 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to lock and secure five out of seven medication carts located at the nursing station on the Liberty and Colonial nursing units. The findings include: On 04/28/21 at approximately 7:27 PM, licensed practical nurse (LPN) C was observed sitting at the desk behind the nursing station on the Liberty nursing unit. Two (2) unsecured medication carts were observed located in the hallway near the	F 761	1. Medication Carts were locked and secured immediately. 2. All residents have the potential to be affected. 3. Licensed nurses will be re-educated on ensuring medication carts are locked and secured. 4. DON/Designee will conduct rounds to ensure medication carts are locked and secured 2 x week for 2 weeks, 1 x week	

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nursing station, and also on the Liberty nursing unit.

At 7:39 PM, accompanied by the Facility Administrator (Employee A) and the Corporate Regional Director (Employee R), the Liberty Unit nursing station was observed and both medication carts were locked. LPN C, was interviewed and asked if she had locked both of the med carts. LPN C replied, "yes ma'am".

At 7:42 PM, the the nursing station on the Colonial Nursing Unit was observed with the Facility Administrator and Corporate Regional Director. Three unsecured medication carts were observed with no nursing staff present. The Facility Administrator was obsered engaging the lock on one of the med carts, while the Corporate Regional Director engaged the locks on the remaining 2 med carts. LPN D was observed exiting and resident room and acknowledged that the med carts were not locked stating, "I was just right there", pointing to a resident room.

On 04/29/21 at 11:51 AM, rDirector of Nursing (DON, Employee B) was interviewed and asked what her expectations were for locking medication carts to which the DON replied, "when they [nursing staff] are not by them [med carts]." The DON was asked if medication carts should be locked if nursing staff were seated behind the desk at the nursing station or within vision of them to which the DON replied, "it is good practice."

On 04/30/21, a copy of the facility policy regarding medication storage was requested and received. Review of the facility's policy entitled "Storage and Expiration Dating of Medications, Biologicals,

for 4 weeks, then monthly for two months. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary.

5. Allegation of compliance date of May 20, 2021

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F 761	Continued From page 17 Syringes, and Needles", revision date 10/28/19, item 3.3 read, "Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors". No further information was received.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to provide beverages in a form to meet individual needs for 2 of 19 residents (Resident #16 and Resident #17). 1. For Resident #16, the facility staff failed to provide thickened liquids on her breakfast tray. 2. For Resident #17, the facility staff provided beverages in a varying consistency, and nursing staff were unaware of the fluid consistency this resident required. The findings included: 1. Resident #16 was admitted to the facility on 9/29/11, with a readmission date of 12/5/18. Diagnoses for Resident #16 included but were not limited to: cerebral infarction, dysphagia,	F 805	1. Resident #16 thickened liquid consistency was corrected on April 29, 2021. Resident #17 liquid consistency was corrected on April 29, 2021 to reflect thin consistency. The yellow sign outside the door was removed. 2. All residents have the potential to be affected. A full diet audit will be completed utilizing the meal tracker direct and PCC by the DM and DO by May 18, 2021. 3. Dietary staff and nursing staff will be re-educated on ensuring residents are provided beverages/food in a form to meet individual needs. Tray accuracy will be monitored by the FSM/designee during meal times. 4. FSM/Designee will conduct tray	5/20/21

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F 805	Continued From page 18 unspecified dementia without behavioral disturbance, vascular dementia and hypertension. Resident #16's most recent minimum data set (MDS) (an assessment tool) with an assessment reference date (ARD) of 4/1/21, was coded as an annual assessment. Resident #16 was coded as having had short and long-term memory impairment and severely impaired daily decision making skills. On 4/29/21 at 8:11 AM, Resident #16 was observed laying in bed, being fed by certified nurses assistant (CNA) G. The breakfast tray for Resident #16 had a cup of coffee which was of a thin/regular consistency. On 4/29/21, a review of the electronic health record (EHR) for Resident #16 was conducted. This review revealed an active physician order that read, "regular diet, dyshagia puree texture, nectar thickened fluid consistency". Resident #16's careplan revealed an active careplan with a revision date of 1/25/21, that read, "[Resident #16's name] has potential for nutrition problems and wt [weight] changes related to disease process AEB [as evidenced by] dementia, depression, dysphagia with need for altered liquids and altered texture diet". This careplan listed an intervention that read, "Nectar thick liquids, pureed regular diet". On 4/29/21 at 8:11 AM, during the observation, CNA G was asked about the coffee. CNA G confirmed it was of thin consistency and stated, "I usually don't give it to her because I used to work in dietary, so I only give her the liquids which are thickened."	F 805	accuracy audits to ensure residents are provided beverages/food in a form to meet individual needs of 10 residents' meals 2 x week for 2 weeks, 10 residents' meals 1 x week for 4 weeks, then 10 residents' meals monthly for two months. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary. 5. Allegation of compliance date of May 20, 2021	

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On 4/29/21 at 8:45 AM, an interview was conducted with licensed practical nurse (LPN) E. LPN E was asked about thickened liquids. LPN E confirmed that the facility uses pre-thickened liquids and nursing staff do not thicken liquids at the bedside. LPN E was asked the risk of a resident who requires thickened liquids drinking beverages that are not thickened, LPN E stated, "they can choke or aspirate".

2. Resident #17 was admitted to the facility on 1/25/20, with a readmission date of 9/14/20. Diagnoses for Resident #17 included but were not limited to: Alzheimer's, schizoaffective disorder, acute on chronic diastolic heart failure, atrial fibrillation, and anxiety.

Resident #17's most recent MDS with an ARD of 4/9/21, was coded as a quarterly assessment. Resident #17 was coded as having had a BIMS (brief interview for mental status) score of 3, of a possible 15. This indicated Resident #17 had severe cognitive impairment.

On 4/27/21 at 11:52 AM, Resident #17 was observed in her room. Outside of the door, by the name plate, there was a yellow paper with a cup that had the letter "N" on it and had the room number and bed number written on it, to signify Resident #17. In the room Resident #17 had a water pitcher of thin/regular water, as well as, a cooler which contained 2 containers of pre-thickened nectar water.

On 4/27/21 at 12:18 PM, Resident #17 was observed with her lunch tray which contained tea of a regular/thin consistency. CNA C was asked about this and stated, "She [Resident #17] is

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supposed to have nectar thick liquids to make her swallow food easier and make sure she doesn't choke." CNA C then exited the room and exited the nursing unit.

On 4/27/21 at 12:35 PM, Resident #17 was observed in her room eating her lunch, with her thin consistency beverages still on the tray.

On 4/27/21 at 2:46 PM, Resident #17 was observed to still have a water pitcher of thin consistency water and a cooler which had thickened water in it.

On 4/29/21 at approximately 7:50 AM, Resident #17 was observed in her room, yellow sign to indicate thickened liquids is still outside of her room/name plate. Resident #17 had a water pitcher and a cooler of thickened liquids still in the room and accessible to the Resident.

On 4/29/21 at 8:42 AM, Resident #17 was provided her breakfast tray. The breakfast tray contained a carton of milk and a cup of coffee, both of thin/regular consistency. Additionally, the tray had a cup of thickened juice.

On 4/29/21, a review of the EHR for Resident #17 was conducted. Resident #17 had a physician diet order dated 1/27/20, that read, "Regular diet Dysphagia Advanced texture, Regular/Thin Liquids consistency." Review of the nutrition assessments revealed no evidence of any swallowing difficulty. The careplan for Resident #17 had a dietary intervention that read, "Provide diet as ordered."

On 4/29/21, the facility staff were asked to provide any evidence from speech therapy or

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another provider recommending the need for thickened liquids for Resident #17. The facility staff stated they had no such documentation.

On 4/29/21 at approximately 8:45 AM, an interview was conducted with LPN E. LPN E was asked about the yellow sign outside the door, she stated, "she is on nectar thick liquids." LPN E was asked to clarify which of the 2 Residents within the room this referred to and she confirmed Resident #17. LPN E told CNA H that Resident #17 could only have the juice, she would have to go to the kitchen to get additional beverages that were thickened. LPN E added, "we have to tell them in the kitchen they have to be consistent."

On 4/29/21 at 11:51 AM, an interview was conducted with the facility director of nursing (DON). The DON was asked about the use of thickened liquids and she stated, "it has to be an order for it and it used if they can't tolerate thin consistency. Every liquid they receive should be thickened."

On 4/30/21, the facility policy titled "Thickened Liquids", was reviewed. This policy stated, "Obtain written order from the physician for the thickened liquids that specifies the consistency: Nectar or 2-Mildly Thick, Honey or 3-Moderately thick, Pudding or 4-Extremely thick. Notify the dietary department of the order and consistency. The Center may serve commercially pre-thickened liquids. Dietary will provide single use thickener packets for thickening as needed, if commercially pre-thickened liquids are not available. Licensed nurses will thicken liquids as needed. Bedside water pitchers for residents with thickened liquids will be removed and resident will be provided with a thickened beverage at

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F 805	Continued From page 22 bedside". On 4/29/21 at 11:51 AM, and again at 4:22 PM, during an end of day meeting, the facility administrative staff were made aware of the various liquid consistencies provided to Residents. No further information was received.	F 805		
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:	F 880		5/20/21

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F 880	Continued From page 23 (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 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:	F 880		

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F 880	Continued From page 24 Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to wear personal protective equipment (PPE) in accordance with The Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control (CDC) recommended practices to manage COVID-19 in 4 of 4 facility areas. The facility staff failed to properly wear PPE within the 3 facility nursing units and the kitchen, to prevent the transmission of COVID-19. The findings included: On 4/27/21 at 11:00 AM, the Administrator and Employee C, the Assistant Director of Nursing and Infection Preventionist were interviewed. During this conversation Employee C confirmed the facility had 3 employees test positive for COVID-19 in the last week. When asked what personal protective equipment (PPE) was required within the facility, Employee C stated, "everyone is wearing N95 masks and eye protection throughout the facility." On 4/27/21 the following observations were made: At 11:22 AM, Employee F, a dietary aide was observed working the tray line with her mask below her nose. At 11:24 AM, Employee D, the dietary manager was observed working in the kitchen setting up trays with his N-95 mask on upside down. The metal nose piece was observed below his chin. At 11:55 AM, Employee F, a dietary aide	F 880	1. Employee D, Employee F, CNA A, CNA B, RN A, LPN A, LPN C and LPN D will be re-educated by the Infection Preventionist on how to properly wear PPE and staff following proper precautions by May 19, 2021. 2. Residents have the potential to be affected. 3. The Director of Clinical Services and or designee will re-educate staff on properly wearing PPE and staff following proper precautions by May 19, 2021. 4. The Director of Nursing and or designee will round for observation of staff properly wearing PPE and staff following proper precautions 2 x week for 2 weeks, 1 x week for 4 weeks, then monthly for two months. The ED and or designee will report observations to the Quality Assurance Performance Improvement Committee (QAPI) and revise the plan as necessary 5. Allegation of compliance date of May 20, 2021	

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delivered a cart of meal trays to the nursing unit and was observed with her mask below her nose.

At 12:01 PM, certified nurses assistant (CNA) A entered a resident room, which had 3 signs on the door to indicate the rsidents were on droplet precautions. CNA A entered the room to deliver a meal tray and failed to put on an isolation gown or gloves. When CNA A was asked about the signage on the door, CNA A said, "I think that was left from before, neither of them are on precautions."

At 12:25 PM, CNA B entered a room which had signage on the door to indicate the residents were on droplet precautions. CNA B failed to put on an isolation gown or gloves prior to entering the room. When CNA B was asked about the signage and PPE on the door, she stated, "I didn't know, they must be on precautions but no one told me". CNA B went to the nursing station and returned and stated, "they refuse COVID testing so we have to gown up, now I know."

At 3:23 PM, registered nurse (RN) A entered a room which was on droplet precautions. RN A entered without doning an isolation gown. RN A exited the room, poured a cup of water at the nursing station, returned to the room to provide the resident with water and failed to put on any gloves or isolation gown. At 3:27 PM, RN A entered the room for a third time and took an isolation gown from the door and once inside the room proceeded to put it on as well as a pair of gloves.

At 3:34 PM, licensed practical nurse (LPN) A was observed at the nursing station with her N-95 mask (medical respirator) on with the lower

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straps of her mask broken, fully severed, with the 2 separate pieces dangling from the mask. When LPN A was asked about her mask she stated, "it just popped I promise you. I think they [the straps] are dry rotted."

Throughout the day clinical staff, to include CNAs and nurses, were observed entering multiple resident rooms to provide care without doning isolation gowns.

On 4/28/21 the following observations were made:

At 7:27 PM, LPN C was observed sitting at the nursing station without a facemask on. LPN C stated, "you just caught me taking a drink" as she began drinking a beverage she had sitting on the desk.

At 7:42 PM, LPN D was observed coming out of a resident room to the nursing station, LPN D had on a surgical mask on that did not cover her nose. When asked LPN D why she had a surgical mask on versus an N-95 mask, she stated, "because honest to goodness, I just de-briefed and was going to eat." LPN D confirmed her mask wasn't covering her nose. LPN D was asked if staff are going on break is it ok to be on the nursing unit and in resident's rooms without an N-95 on? LPN D said, "well we aren't supposed to." LPN D was asked by Employee R, the Regional Director to please change masks to an N-95. LPN D made no mask change and returned into the resident room to let her co-workers know she was going on break, then she proceeded to walk down the hallway past 21 resident rooms to exit off of the nursing unit.

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On 4/28/21 at 7:48 PM, an interview was conducted with CNA E. CNA E was asked about the use of PPE. She stated, "we put it on before we enter the room." When asked if it is dependent upon what task they are going to perform or when does she use it, CNA E stated, "we always put it on, even if we are just going to say hi, we have to have it on." When asked, what is the importance of wearing PPE? CNA E stated, "to protect us and the resident.'

On 4/29/21 at 11:51 AM, an interview was conducted with the facility Director of Nursing (DON). The DON was asked the expectation regarding the use of PPE. The DON stated that all staff are to wear a "N-95 and eye protection, goggles or face shield when in the facility." The DON was asked about resident rooms on precautions. The DON stated, "staff are to put on an isolation gown and gloves prior to entering the room."

On 4/29/21, a review of the facility submitted COVID-19 line listing revealed that on 4/13/21, a resident tested positive for COVID-19. On 4/19/21, three staff tested positive for COVID-19. This confirmed that at the time of survey, the facility was considered to be in an active COVID-19 outbreak status.

Review of the facility policy titled, "COVID-19 Pandemic Plan" with a revision date of 4/14/21, was reviewed. This policy read, ..."5. The Pandemic COVID-19 Plan has been established and will be initiated when a novel virus is increasing and sustaining human-to-human transmission in the United States, and cases are occurring in the facility's state. 6. The Infection Preventionist will monitor the CDC, and state and

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local health departments for information and guidance on the virus...."

Review of the facility policy titled, "Emergency Procedure - Pandemic COVID-19" read, ..."8. Implement Universal Source control for all staff per CDC guidance: Moderate to substantial community transmission (Yellow or Red) Respirator or Facemask, Eye protection, Respirator for all aerosol generating procedure...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."

Review of the Center for Disease Control and Prevention (CDC) guidance titled, "COVID-19, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" with a revision date of 3/29/21, read on page 8, "Implement Universal Use of Personal Protective Equipment.... The fit of the medical device used to cover the wearer's mouth and nose is a critical factor in the level of source control (preventing exposure of others) and level of the wearer's exposure to infectious particles". Page 15 read, "New Infection in 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 [healthcare personnel] or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential

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F 880	Continued From page 29 outbreak.... 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...". On 4/2921 at 4:22 PM, during an end of day meeting, the facility DON confirmed the facility follows CDC guideance in regards to COVID-19. The facility staff were made aware of the above noted observations. No further information was received by the survey team. Complaint related deficiency.	F 880		