STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495295	A. BUILDING _____ B. WING _____	C 03/11/2021

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RIVERSIDE HEALTH & REHAB CNTR	2344 RIVERSIDE DRIVE DANVILLE, VA 24540

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/09/2021 through 03/11/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Standard Survey and , Focused Infection Control survey were conducted 3/9/2021 through 3/11/2021. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 143 at the time of the survey. The survey sample consisted of 28 current Resident reviews and 3 closed record reviews.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		4/20/21

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

Electronically Signed | 04/05/2021

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

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F 655	Continued From page 1 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and the review of documents, it was determined the facility staff failed to develop a base-line care plan to address indwelling urinary catheter needs at the time of admission for one (1) of 28 sampled residents (Resident #83). The findings include:	F 655	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all	

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F 655	Continued From page 2 The facility staff failed to develop a base-line care plan, within 48 hours of the resident's admission, to address Resident #83's indwelling urinary catheter. Resident #83 was admitted to the facility with an indwelling urinary catheter in place. Resident #83's minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/3/21 had the resident assessed as able to make self understood and as able to understand others. Resident #83's Brief Interview for Mental Status (BIMS) summary score was documented as 13 out of 15. Resident #83 was documented as requiring assistance with bed mobility, dressing, toilet use, personal hygiene, and eating. Resident #83 was assessed as having an indwelling urinary catheter. Resident #83's diagnoses included, but were not limited to: cardiac dysrhythmias, heart failure, high blood pressure, hemiplegia/hemiparesis, respiratory failure, and urinary retention. Resident #83's clinical record included an "Admission Assessment/Screening" form that indicated the resident had an indwelling urinary catheter at the time of admission. Resident #83's care plan was reviewed with Licensed Practical Nurse (LPN) #21 on the morning of 3/11/21. LPN #21 confirmed Resident #83's indwelling urinary catheter care plan had not been developed until 10 days after the resident's admission. The facility policy and procedure titled "Catheterizations" (with an effective date of 11/1/19) did not provide guidance on the development of resident care plans related to the	F 655	federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F655 1. Resident 83 foley Catheter orders reviewed and updated during Survey. 2. Current residents reviewed for foley catheter orders and care plans to ensure care plans were developed and revised for use of foley catheter.. Completed by 4/5/21 3. Staff education completed by the SDC on order updates and development of initial care plans to address foley catheters. Completed by 4/13/21 4. New admissions and readmits will be monitored to review orders and care plans addressing foley catheters. Will be monitoring 5 times a week for 4 weeks, then monthly for 2 months, then quarterly. 5. Any noncompliance will be reviewed by the QA committee for tracking and trending and progressive disciplinary action as needed. 6. Date of compliance 4/20/2121	

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F 655	Continued From page 3 use of indwelling urinary catheters. The failure of facility staff to ensure Resident #83's base-line care plan addressed the resident's indwelling urinary catheter needs was shared with the facility's Administrator, Director of Nursing, and Nursing Consultant during a survey team meeting on 3/11/21 at 4:45 p.m.	F 655		
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 observation, Resident interview, staff interview and clinical record review the facility staff failed to provide ADL (activities of daily living) care for dependent residents for 2 of 28 residents, Resident #49 and Resident #144. The findings included: 1. For Resident #49 the facility staff failed to provide assistance with oral care. Resident #49's face sheet listed diagnoses which included, but not limited to non-displaced fracture to body of scapula, chronic obstructive pulmonary disease, congestive heart failure, hypertension, rheumatoid arthritis, atrial fibrillation and anemia. Resident #49's admission MDS (minimum data set), with an ARD (assessment reference date) of 01/09/21 assigned the resident a BIMS (brief interview for mental status) score of 15 of 15 in	F 677	F677 1. Resident 49 received oral care and resident 144 was provided nail care during survey. 2. Current residents were audited for oral and nail care to assess for assistance provided. Completed on 4/5/21 3. Staff were educated by SDC on providing oral care and nail care to residents per ADL assistance. Completed by 4/13/21 4. Current residents will be monitored for completion of oral care and nail care per ADL assistance. Will be monitoring 5 times a week for 4 weeks, then monthly for 2 months, then quarterly. 5. Any noncompliance will be reviewed by the QA committee for tracking and trending and progressive disciplinary action as needed. 6. Date of compliance 4/20/2121	4/20/21

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F 677	Continued From page 4 section C, cognitive patterns. Section G, functional status, coded the resident as needing extensive assistance of one person physical assist in the area of personal hygiene. Personal hygiene is listed as combing hair, brushing teeth, shaving, applying make-up, and washing/drying face and hands. Resident #49's CCP (comprehensive care plan) was reviewed and contained a care plan for "the resident has an ADL self-care performance deficit r/t (related to) activity intolerance, weakness, decreased balance/mobility/ ROM (range of motion) to bilateral upper extremities, pain, occasional incontinence, meds, dx (diagnosis) right scapula fx (fracture), multiple falls, hx (history) shoulder replacements". Interventions for this care plan included "Personal hygiene/oral care: Assist with all hygiene needs". Surveyor spoke with Resident #49 on 03/09/21 at approximately 5:20 pm. Resident stated she hasn't had her teeth brushed in two weeks. Also stated that she discussed this with the nurse earlier today, but cannot recall which nurse. Also stated that she is unable to brush her own teeth due to having radial nerve damage in her left arm and right arm being injured from previous fall. Surveyor observed right arm wrapped in bandage and ace wrap, with significant edema. Surveyor spoke with Resident #49 on 03/10/21 at approximately 11:00 AM. Resident stated she had a shower this morning, but still has not had teeth brushed. Surveyor spoke with CNA (certified nurse's assistant) #1 on 03/10/21 at approximately 02:57 PM regarding Resident #49. Surveyor asked CNA	F 677		

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F 677	Continued From page 5 #1 if they brush residents' teeth when providing resident care and CNA #1 stated "sometimes". Surveyor asked CNA #1 specifically about Resident #49 and CNA #1 stated "She can probably brush her own teeth since she has the one good hand". Surveyor asked CNA #1 if they ever asked Resident #49 if she needed help and CNA #1 stated "no". Surveyor spoke with CNA #2 on 03/11/21 at approximately 09:40 AM. CNA #2 stated that if residents need help brushing their teeth, they do so, but try to let them do as much as possible for themselves. CNA #2 stated they provide oral care for residents daily. Surveyor asked CNA #2 if they worked with Resident #49 and CNA #2 stated that they did not. Surveyor spoke with UM (unit manager) on 03/11/21 at approximately 09:50 AM regarding residents oral care. UM stated that they would expect the CNA's to provide oral care for each resident they are providing daily grooming for. UM also stated that they had spoken with Resident #49 on 03/10/21 regarding her oral care, and they were trying to track down which CNA's have been working with the resident. On 03/11/21 at approximately 10:30 AM, Resident #49 stated her teeth have still not been brushed. Surveyor spoke with CNA #3 on 03/11/21 at approximately 10:40 AM. CNA #3 stated they have not brushed Resident #49's teeth. Surveyor asked CNA #3 if they had asked Resident #49 if she wanted her teeth brushed and they stated that they had not, and that Resident #49 normally tells you everything she wants done for her. On 03/11/21 at approximately 01:30 PM, Resident	F 677		

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F 677	Continued From page 6 #49 stated her teeth have now been brushed. Resident also stated that CNA told her that if she wanted her teeth brushed she should have asked. Resident also stated to surveyor that she thought that was just part of personal hygiene and that she shouldn't have to ask. The concern of not assisting Resident #49 with oral hygiene was discussed with the administrative team (administrator, DON [director of nursing], and RNC [regional nurse consultant]) during a meeting on 03/11/21 at approximately 4:45 pm. No further information was provided prior to exit. 2. For Resident #144 the facility staff failed to provide nail care. Resident #144's face sheet listed diagnoses which included but not limited to diabetes mellitus, dementia, hypertension, glaucoma, chronic obstructive pulmonary disease, anxiety and depression. Resident #144's most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 02/24/21 assigned the resident a BIMS (brief interview for mental status) of 3 out of 15 in section C, cognitive patterns. Section G, functional status coded the resident as needing extensive assistance of one person physical assist in the area of personal hygiene. Personal hygiene is listed as combing hair, brushing teeth, shaving, applying make-up, and washing/drying face and hands. Resident #144's CCP (comprehensive care plan)	F 677		

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F 677	Continued From page 7 was reviewed and contained a care plan for "the resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Deconditioning, Gait/balance problems, kyphosis, poor safety awareness, incontinence, combative behaviors, cognitive/vision/communication impairments, meds DX (diagnosis): NSTEMI (non-ST segment elevation myocardial infarction [type of heart attack]), dementia, glaucoma, DM (diabetes mellitus), HTN (hypertension), anemia, depression, anxiety, insomnia, hx (history); CVA (cerebrovascular accident)". Interventions for this care plan include "personal hygiene/oral care: Provide assist w (with)/oral care, nail care, personal hygiene & grooming needs". Surveyor observed Resident #144 on 0310/21 at approximately 11:08 am. Surveyor noted that residents fingernail were extremely long and ragged in appearance. Surveyor attempted to ask resident about fingernails, but due to cognitive impairment, resident was unable to answer surveyor's questions. Surveyor spoke with UM (unit manager) on 03/11/21 at approximately 9:50 am regarding nail care for residents. UM stated that CNA's (certified nurse's aide) are responsible for maintaining nail care. UM also stated, "I'm supposed to do that as well". UM also stated that they check resident nails while making rounds. Surveyor asked UM specifically about Resident #144's nails, and UM stated they had checked Resident #144's nails "last week". Surveyor asked UM if they knew that the resident's nails were extremely long, and UM stated, "I'll take care of that right now". Surveyor observed Resident #144's nails on 03/11/21 at approximately 10:30 am, 1:30 pm,	F 677		

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F 677	Continued From page 8 and 3:55 pm. Resident's nails had not been trimmed and were still long and ragged. The concern of facility staff not providing nail care for Resident #144 was discussed with the administrative team (administrator, DON [director of nursing], and RNC [regional nurse consultant]) during a meeting on 03/11/21 at approximately 4:45 pm. No further information was provided prior to exit.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to follow medical provider orders for treatment and/or care for two (2) of 28 sampled residents (Resident #65 and Resident #83). The findings include: 1. The facility staff failed to ensure Resident #83's blood glucose levels were monitored according to medical provider orders. Resident #83's minimum data set (MDS)	F 684	F684 1. Residents 83 and 65 orders were reviewed and updated for glucose monitoring per the physicians' orders during survey. 2. Current residents were audited for glucose monitoring per physicians' orders and updated as needed. Completed on 4/5/21 3. Staff education provided by SDC on glucose monitoring per physicians' orders and documentation of results. Completed by 4/13/21	4/20/21

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F 684	Continued From page 9 assessment with an assessment reference date (ARD) of 2/3/21 had the resident assessed as able to make self understood and as able to understand others. Resident #83's Brief Interview for Mental Status (BIMS) summary score was documented as 13 out of 15. Resident #83 was documented as requiring assistance with bed mobility, dressing, toilet use, personal hygiene, and eating. Resident #83 was assessed as having an indwelling urinary catheter. Resident #83's diagnoses included, but were not limited to: cardiac dysrhythmias, heart failure, high blood pressure, hemiplegia/hemiparesis, respiratory failure, and urinary retention. Review of Resident #83's clinical record revealed an order dated 1/29/21 for the resident's blood glucose (finger stick blood sugar) to be checked daily before meals and at bedtime. Review of Resident #83's MARs (medication administration records) and TARs (treatment administration records) failed to provide evidence this order had been implemented. On 3/11/21 at 10:18 a.m., Licensed Practical Nurse (LPN) #21 was interviewed about Resident #83's aforementioned finger stick blood sugar order. LPN #21 confirmed the order had been entered into Resident #83's electronic clinical record. LPN #21 reported the order had been enter in a manner that resulted in the order not appearing on the Resident #83's MAR or TAR. No evidence was found by or provided to the survey team to indicate Resident #83's blood sugar had been monitored according the aforementioned medical provider order. The following information was found in a facility policy and procedure titled "Monitoring" related to	F 684	4. Current residents will be monitored for glucose monitoring per physicians' order and documentation of results. Will be monitoring 5 times a week for 4 weeks, then monthly for 2 months, then quarterly. 5. Any noncompliance will be reviewed by the QA committee for tracking and trending and progressive disciplinary action as needed. 6. Date of compliance 4/20/2121	

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F 684	Continued From page 10	F 684		

blood testing (with an effective date of 11/1/19): "Licensed nurses will complete blood glucose monitoring as ordered by the physician or when emergency situations indicate the need ... Blood glucose checks will be document on the eMAR (electronic MAR) ..."

The failure of facility staff to ensure Resident #83's blood sugar levels were monitored as ordered by the medical provider was shared with the facility's Administrator, Director of Nursing, and Nursing Consultant during a survey team meeting on 3/11/21 at 4:45 p.m.

2. For Resident #65, facility staff failed to follow physician's orders for blood glucose monitoring.

Resident #65's diagnosis list indicated diagnoses, which included, but not limited to Cellulitis of Left Lower Limb, Type 2 Diabetes Mellitus with Hyperglycemia, Alzheimer's Disease Unspecified, Peripheral Vascular Disease Unspecified, and Chronic Kidney Disease Stage 3 Unspecified.

The quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/22/21 assigned the resident a BIMS (brief interview for mental status) score of 13 out of 15 in section C, Cognitive Patterns. Resident #65 is also coded as having an active diagnosis of Diabetes Mellitus in section I, Active Diagnoses.

A review of Resident #65's clinical record revealed an active physician's order dated 1/19/21 stating, "Accuchecks before meals and bedtime before meals and at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) Notify MD of BG (blood glucose) less than 60 or greater than 400

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F 684	Continued From page 11 mg/dl". Surveyor reviewed Resident #65's January 2021 through March 2021 MARs (medication administration records) and TARs (treatment administration records) and was unable to locate blood sugar monitoring results obtained before meals or at bedtime. On 3/10/21 at approximately 7:50 am, surveyor spoke with the DON (director of nursing) and asked where were blood sugar results documented and the DON stated "on the TARs". On 3/11/21 at 12:25 pm, surveyor spoke with LPN (licensed practical nurse) #1 and asked how often is Resident #65's blood sugar being checked and LPN #1 stated "I check it once". LPN #1 then reviewed Resident #65's physician's orders and stated the order says before meals and at bedtime and the order was entered and put under "other, no documentation required". LPN #1 stated they would update the order "so it will pop up". On 3/11/21 at 4:55 pm, surveyor notified the administrator, DON, and the Regional Nurse Consultant of Resident #65's blood sugars not being obtained as ordered. No further information regarding this issue was presented to the survey team prior to the exit conference on 3/11/21.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		4/20/21

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RIVERSIDE HEALTH & REHAB CNTR	2344 RIVERSIDE DRIVE DANVILLE, VA 24540

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F 690	Continued From page 12 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and the review of documents, it was determined the facility staff failed to ensure medical provider orders were obtained/provided to address the urinary catheter needs of one (1) of 28 sampled	F 690	F690 1. Resident 83 foley Catheter orders reviewed and updated during Survey. 2. Current residents reviewed for foley catheter orders. Completed by 4/5/21	

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F 690	Continued From page 13 residents (Resident #83). The findings include: Facility staff members failed to ensure Resident #83's clinical record included medical provider orders for an indwelling urinary catheter and medical provider orders for the care of an indwelling urinary catheter. Resident #83's minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/3/21 had the resident assessed as able to make self understood and as able to understand others. Resident #83's Brief Interview for Mental Status (BIMS) summary score was documented as 13 out of 15. Resident #83 was documented as requiring assistance with bed mobility, dressing, toilet use, personal hygiene, and eating. Resident #83 was assessed as having an indwelling urinary catheter. Resident #83's diagnoses included, but were not limited to: cardiac dysrhythmias, heart failure, high blood pressure, hemiplegia/hemiparesis, respiratory failure, and urinary retention. On 3/10/21 at 8:42 a.m., Resident #83 was noted to have an indwelling urinary catheter in use. Review of Resident #83's clinical record failed to reveal a provider order for the indwelling urinary catheter. Review of Resident #83's clinical record failed to reveal evidence of consistent indwelling urinary catheter care. Resident #83 had been at the facility for greater than four (4) weeks without the aforementioned orders. On 3/11/21 at 10:20 a.m., a Registered Nurse (RN) Unit Manager (RN #21) was interviewed about Resident #83's indwelling urinary catheter.	F 690	3. Staff education to be completed by the SDC for obtaining order for foley catheter. Completed by 4/13/21 4. New admissions and readmits monitored to review orders and care plans addressing foley catheters. Will be monitoring 5 times a week for 4 weeks, then monthly for 2 months, then quarterly. 5. Any noncompliance will be reviewed by the QA committee for tracking and trending and progressive disciplinary action as needed. 6. Date of compliance 4/20/2121	

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F 690	Continued From page 14 RN #21 confirmed that Resident #83 did not have orders for an indwelling urinary catheter and did not have orders for indwelling urinary catheter care. Resident #83's care plan for indwelling urinary catheter for urinary retention included the intervention of "Care as ordered and as needed". On 8/11/21 at 10:35 a.m., a Licensed Practical Nurse (LPN) (LPN #21) was observed to call Resident #83's medical provider and obtain orders for an indwelling urinary catheter and orders for indwelling urinary catheter care. The following orders for Resident #83, dated 3/11/21 at 10:52 a.m., were provided to the survey team: - "Foley (catheter) (16F/10ml)" (A 'foley' is an indwelling urinary catheter.) - "Foley care (every) shift" - "Change Foley (catheter) (as needed) for clinical indications such as infection, obstruction, or when the closed system is compromised." The following information was found in a facility policy and procedure titled "Catheterizations" (with an effective date of 11/1/19): "POLICY: Licensed nurses may perform indwelling, in and out catheterization, removal of urinary catheters and application of External Catheters with physician's orders ... PROCEDURE: 1. A licensed nurse will ensure that appropriate medical justification is documented ... 3. Licensed nurses will follow manufacturer's guidelines when preparing and maintaining urinary catheter insertion ..." The following information was found in a facility	F 690		

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F 690	Continued From page 15 policy and procedure titled "Documentation Summary" (with an effective date of 11/1/19): "Document all of the facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviations from standard treatment along with the reason for the deviation." The failure of facility staff to ensure Resident #83 had orders for an indwelling urinary catheter and orders for the care of an indwelling urinary catheter was shared with the facility's Administrator, Director of Nursing, and Nursing Consultant during a survey team meeting on 3/11/21 at 4:45 p.m.	F 690		
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;	F 886		4/20/21

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F 886	Continued From page 16 (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of 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	F 886		

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F 886	Continued From page 17 processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to consistently document in the resident's clinical records that COVID-19 testing was offered, completed (as appropriate to the resident's testing status), and the results of each test for 26 residents. The findings included: The facility staff failed to consistently document that COVID-19 testing was offered to the residents of the facility and failed to document the results of each test in the resident's clinical records. During the record reviews, the survey team were unable to locate results of COVID-19 tests for negative residents. On 03/11/2021 at 1:45 p.m., the administrator, (DON) director of nursing, and (RNC) regional nurse consultant were interviewed regarding the missing COVID-19 testing results. The DON stated they printed off the facility census, identified if anyone was positive and that was marked on the census. They did not mark the negative test results on this census and only documented in the clinical record if the resident was positive. The DON stated they charted by exception. The facility provided the survey team with a copy of their policy titled, "Documentation Summary" with an effective date of 11/01/2019. This policy read in part, "Licensed Nurses ...will document all	F 886	F886 1. Documentation of covid 19 testing and results reviewed and updated during survey. 2. Current residents audited for covid 19 test results documented in clinical record. 3. Staff education will be completed by SDC on documenting resident testing results in clinical record. To be completed by 4/13/21 4. Covid 19 testing and results documented in clinical record. Will be monitoring 5 times a week for 4 weeks, then monthly for 2 months, then quarterly. 5. Any noncompliance will be reviewed by the QA committee for tracking and trending and progressive disciplinary action as needed. 6. Date of compliance 4/20/2121	

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F 886	Continued From page 18 pertinent nursing assessments, care interventions...Document all of the facts and pertinent information related to an event, course of treatment, patient condition ..." No further information regarding the documentation of negative COVID-19 testing results in regards to the residents of the facility was provided to the survey team prior to the exit conference.	F 886		