STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495248	A. BUILDING _____ B. WING _____	C 10/21/2021

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BURKE HEALTH & REHABILITATION CENTER	9640 BURKE LAKE ROAD BURKE, VA 22015

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 09/21/2021 and continued with offsite review through 9/23/2021. The facility was in substantial compliance with 42 CFR Part 483.475(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 120 certified bed facility was 91 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted onsite 10/19/2021 and continued with offsite review through 10/21/2021. Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The survey sample consisted of 13 residents. Four complaints were investigated during the survey. (VA00052526- Unsubstantiated; VA00053012- Substantiated with deficiency; VA00053363- Substantiated with deficiency; VA00053415- Unsubstantiated.) The census in this 120 certified bed facility was 91 at the time of the survey. The survey sample consisted of 13 resident reviews and 5 employee reviews.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		11/22/21

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

Electronically Signed | 11/13/2021

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F 658	Continued From page 1 §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 by: Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to follow professional practice standards in the administration of medications for 1 Resident, Resident #101, in a survey sample of 13 Residents. The findings included: For Resident #101, the facility staff failed to administer 2 medications, Cardizem and hydrochlorothiazide, as ordered by the physician on 6/30/21. Resident #101 was admitted to the facility on 6/29/21 and discharged on 8/4/21. In the course of a complaint investigation, on 10/20/21, the closed clinical record for Resident #101 was reviewed in its entirety, with particular attention given to physician orders and medication administration. A physician's order was placed on 6/30/21 at 01:11 AM for "Cardizem LA [long acting] Tablet Extended Release 24 hour 360mg...give 1 tablet by mouth one time a day for HTN [hypertension, high blood pressure]". The Medication Administration Record (MAR) indicated the Cardizem was scheduled to be given at 09:00 AM beginning on 6/30/21, however a chart code, "9=Other/See Progress Notes" was documented.	F 658	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F658 1. Resident #101 was discharged on 8/4/2021. 2. All residents have the potential to be affected. Nursing will review the medication administration records of all residents to ascertain that they have no missing medication administration of prescribed medications because of the unavailability of the said medications. Result of the review will be used to provide an individualized in-service to the identified nurses involved in the missed med administration and remediation to the other nurses.	

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F 658	Continued From page 2 A physician's order was placed on 6/30/21 at 01:22 AM for "hydrochlorothiazide Tablet 25mg...give 1 tablet by mouth in the evening for fluid retention". The MAR indicated the hydrochlorothiazide was scheduled to be at 18:00 PM beginning on 6/30/21, however a chart code, "9=Other/See Progress Notes" was documented. Review of Progress Notes revealed an entry on 6/30/21 at 15:44 PM that read, "Cardizem LA Tablet Extended Release 24 hour 360mg...new order awaiting from pharmacy at this time". There was no Progress Note on 6/30/21 that referenced the hydrochlorothiazide as noted on the MAR. An interview was conducted with the Director of Nursing (DON) who confirmed the ordered doses of Cardizem and hydrochlorothiazide were not given to Resident #101 on 6/30/21. The DON stated, "the nurse made a mistake, the nurse did not document a reason for not giving the medications, I'm not sure why but I would have expected to see a nurse note for a reason and also for notification to the doctor about this situation". The DON cited Lippincott as the resource used for professional nursing standards. Guidance was given from Lippincott, Fundamentals of Nursing, which reads: "To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights: 1. The right medication 2. The right dose	F 658	3. The SDC in consultation with the DON will in-service all licensed nurses as follows: a) Managing medications for newly admitted patients b) New admissions: Protocol on medication delivery by pharmacy c) Utilizing the Stat Box/Omnicell to include facility policy on unavailable medications. 4. DON/ADON/UM will review medication variance report for all residents monthly x3 months. Any anomaly identified will be immediately rectified as appropriate and then forwarded to the weekly risk meeting for further review and guidance. 5. Date of compliance: 11/22/2021	

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F 658	Continued From page 3 3. The right patient 4. The right route 5. The right time 6. The right documentation" Review of the facility's policy entitled, "Administration Procedures for All Medications", revision date 08-2020, subheading "Procedure", item III read, "At a minimum, review the 5 rights at each of the following steps of medication administration".	F 658		
F 761 SS=E	COMPLAINT RELATED DEFICIENCY 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	F 761		11/22/21

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F 761	Continued From page 4 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 interviews, and facility documentation review, the facility staff failed to secure 1 out of 3 treatment carts and 2 out of 3 medication carts, located on the first floor, within resident care areas. The findings included: The facility staff failed to secure 1 treatment cart and 2 medication carts, on the first floor, within resident care areas. On 10/19/21 during initial tour of the facility, Surveyor C and Surveyor D made the following observations: At approximately 1:12 PM, Surveyor C observed an unattended and unlocked treatment cart located on Hall 2 of the 1st floor. Surveyor C opened a drawer and found a variety of treatment items including labeled prescription ointments and creams. An interview was conducted with RN B who stated, "The cart should be locked". RN B also stated, "The risk of leaving it unlocked is that residents who are cognitively impaired could access treatment medications". At approximately 1:15 PM, Surveyor D observed an unattended and unlocked medication cart located on Hall 3 of the 1st floor with a medication card laying on top of the cart containing 24 tablets labeled "Senna 8.6mg". An interview was conducted with RN B who stated, "Medications	F 761	F761 1. The two medication and 1 treatment carts were immediately locked post observed unlocked status by the surveyors on 10/19/2021. Medication noted on cart along Hall 3 was immediately returned to the said cart by the assigned nurse on 10/19/2021. Assigned nurses to the three carts will receive an individualized in-service on the appropriate storage of drugs/biologicals. 2. All residents have the potential to be affected. Nursing management will audit all medication and treatment carts on both Units at the facility to ascertain that none was left unlocked and/or with medication on top of them unsafely. Any noted deficient practice will be rectified immediately as appropriate. Affected nurses working on the carts will receive remediation based on the outcome of the review. 3. SDC/Designee in consultation with the DON will in-service all licensed nurses on the following: a) Storage and management of drugs/biologicals 4. DON/UMs to complete a 25% sample audit of all the current med/treatment carts at the facility weekly x1 month, and monthly x3 months to ascertain that none is left unlocked and/or with medication on top of it unsafely. Any deficient practice	

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F 761	Continued From page 5 should be secured because residents with cognitive impairments could get them with them laying on top of the cart, the cart should also be locked up". At approximately 1:30 PM, Surveyor C observed an unattended and unlocked medication care located on Hall 1, 1st floor. An interview was conducted with RN D who confirmed the observation and stated the medication cart should be locked at all times while unattended to prevent unauthorized access to the medications. Review of the facility policy entitled, "Storage of Medications", revision date 08-2020, "Policy" read, "Medications and biologicals are stored safely, securely, and properly ....the medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications". The same policy with subheading, "Procedures", item 2 read, " ....Medication rooms, carts, and medication supplies are locked when they are not attended by persons with authorized access". The Facility Administrator and Director of Nursing were notified of the findings. No further information was provided.	F 761	noted will be rectified accordingly and as appropriate and then forwarded to the Risk Meeting for further review and recommendation as applicable. 5. Date of compliance: 11/22/2021	
F 880 SS=E	Complaint related deficiency 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	F 880		11/22/21

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(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

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F 880	Continued From page 7 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review, and review of facility documents, the facility staff failed to implement infection control practices as recommended by CDC (Center for Disease Control) to prevent the transmission and spread of COVID-19 within the facility. The facility staff failed to 1) utilize appropriate source control while in an active COVID outbreak, 2) failed to properly don [put on] and doff [take off] PPE (personal protective equipment) when providing care to Residents on isolation for COVID-19, and 3) failed to properly wear N95 masks to prevent the spread of infection. The findings included.	F 880	F 880 1. Employees J, K, L, and M received individualized in-service on appropriate source control, including N95 mask, during a Covid-19 outbreak. CNA B will receive an individualized in-service on appropriate donning and doffing of PPE when transporting a newly positive patient to the Hot-Zone. LPNs C & D will receive an individualized remediation on the donning and doffing of PPEs on a Warm/Hot Zone. 2. All residents have the potential to be affected. IP/UMs/DON/ADON/Designee will audit PPE compliance at the Center among current staff to determine a	

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F 880	Continued From page 8 1. Facility staff failed to implement CDC and CMS source control during an active COVID-19 outbreak. On 10/20/21 at approximately 11 AM, Surveyors C & E went to the laundry room. Upon entrance to the laundry room, Employee K, the Housekeeping/laundry supervisor was observed to be wearing a procedure mask and no eye protection. Surveyors C & E questioned him about it, and he indicated this was permissible. Around the corner, observation of the clean laundry area revealed 5 employees standing in close proximity, not socially distanced and 4 of the 5 were not wearing PPE. Three employees (Employee J, the maintenance assistant, and 2 housekeeping/laundry workers, Employee L and Employee M) were all observed with no mask. When asked they stated they were on break. On 10/20/21 at approximately 11:32 AM, the DON (Director of Nursing) and the Corporate Clinical Director/Employee E approached the Surveyors in the lobby. When questions were asked N95 mask use, Employee E stated they are worn in patient care areas. When asked about employees gathering in laundry, not socially distanced, and not wearing masks, Employee E stated, "we allow fully vaccinated staff mask breaks". On 10/20/21 at 2:20 PM, an interview was conducted with RN E, the infection preventionist and Employee C, the staff development coordinator. They were asked about mask use. Employee C stated, "we've talked to everyone there was a time that just on the COVID units we required N95's, but now all clinical staff should be	F 880	baseline for compliance. Any noted lack of compliance during the audit will be rectified immediately and a 1-1 individualized remediation provided to the affected staff. 3. SDC in consultation with the IP will in-service all staff at the Center on the following: a) Appropriate PPEs during a Covid-19 outbreak b) Donning and Doffing PPEs 4. DON/UMs will audit staff compliance of the appropriate utilization of PPEs weekly x1 month and monthly x3 to determine compliance among the current staff. Any noted deficient practice noted will be immediately rectified accordingly and then forwarded to the QAPI committee for further review and guidance. 5. Date of compliance: 11/22/2021.	

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wearing a N95". When asked about non-clinical staff, Employee C said "We recommend N95's but some wear a surgical mask, if they are not in a mask they are to be socially distanced". Employee C confirmed that laundry for the COVID positive/hot unit and the COVID exposed/warm unit are laundered in the same laundry area.

Review of the CDC community transmission rate for the County, revealed the County was at a "substantial level". Accessed online 10/20/21, at: https://covid.cdc.gov/covid-data-tracker

The CDC guidance read, "Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

2. Facility staff failed to properly don and doff PPE when caring for Residents under isolation for COVID-19 and;
3. Failed to wear N95 properly.

On 10/19/21 at 1:15 PM, CNA B was observed in the hallway on the first floor/hall 3, with an isolation gown on. Upon approach and inquiry by Surveyor D, CNA B stated that Resident #106, whom she had been providing care to, had tested positive for COVID-19. CNA B confirmed she should have doffed her isolation gown before

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exiting the room. During this interview, it was observed that CNA B had no eye protection on. When asked, CNA B said "my face shield is down there [pointing towards the nursing station]. CNA B confirmed she had been providing care to Resident #106, who was COVID positive without the eye protection. CNA B acknowledged she should have had eye protection on. CNA B was also observed to have a procedure mask underneath of her N95. Surveyor D asked why she was wearing 2 masks and CNA B said "for my own protection I double mask". Continued observations of CNA B throughout the day revealed no correction to the order of which she had masks on.

On 10/19/21 at 1:41 PM, LPN C was observed standing at a medication cart on the second floor in the "warm zone" which housed Residents who had a direct exposure to COVID-19, with an isolation gown on. LPN C confirmed that hall 3 was the "hot" unit and contained COVID positive Residents and she had been working the hot unit and was still wearing the isolation gown she had worn in the hot unit and should have doffed it before entering the warm area of the unit.

On 10/20/21 from 10:14 AM until 10:35 AM, observations were made of LPN D, who was observed at a medication cart on the 2nd floor/hall 2. LPN D confirmed this hall was the warm unit and housed COVID exposed Residents. Signage was noted outside of each room to indicate the Residents were on transmission based precautions. LPN D was observed to have a procedure mask on under her N95 mask, and had no eye protection on. LPN D was observed to enter rooms 213 and 210 during the observation period. LPN D did not don [put

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on] eye protection or make corrections of her mask while providing medication to the Residents and being in close contact with the Residents.

On 10/20/21 at 1:34 PM, a telephone interview was conducted with the public health nurse with the local Department of Health, [further identified as: Other B]. Other B stated for source control, the health department has recommended "all staff to wear masks at all times", but "consistent adherence to PPE use has been an ongoing challenge" for facility staff to comply with.

On 10/20/21 at 2:20 PM, an interview was conducted with RN E, the infection preventionist. RN E was asked about double masking and said, "We don't recommend 2 masks. If I see it I tell them not to, the N95 and eye protection is enough". Employee C, the staffing coordinator said "wearing the procedure mask under the N95 breaks the seal. We have talked to them [the staff] so much about this". Employee C and RN E both confirmed that Residents on the 2nd floor hall 2 are in the warm zone and are on TBP. Employee C stated that staff compliance with donning proper PPE and proper wearing of N95 masks has been an ongoing challenge. RN E confirmed the observations noted above were not compliant with facility requirements or CDC guidance.

The CDC gives the following guidance regarding PPE to be worn: "HCP [health care personnel] caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator)". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/l

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F 880	Continued From page 12 ong-term-care.html CDC guidance on wearing an N95 stated, "The respirator must fit snugly against the user's face to ensure that there are no gaps between the user's skin and respirator seal". Accessed online at: https://www.cdc.gov/niosh/npptl/pdfs/KeyFactorsRequiedResp01042018-508.pdf Additional CDC guidance read, "How to Properly Put On and Take off a Disposable Respirator: Do not allow facial hair, hair, jewelry, glasses, clothing, or anything else to prevent proper placement or come between your face and the respirator". Accessed online at: https://www.cdc.gov/niosh/docs/2010-131/ No further information was provided prior to the conclusion of the survey.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		11/22/21

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F 883	Continued From page 13 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by:	F 883		

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F 883	Continued From page 14 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to implement their immunization policy and ensure each Resident is offered an influenza and pneumococcal immunization, unless medically contraindicated or they have already been immunized for 2 Residents (Resident #106 and #107), in a survey sample of 13 Residents. The findings included: Review of clinical records for Residents revealed the following immunization information: 1. Resident #106 had been a Resident of the facility since 10/5/21. The immunization tab of the EHR (electronic health record) there was no record of pneumonia vaccine being offered or administered. Under the misc. (miscellaneous) tab there was an immunization record from VIIS (Virginia Immunization Information System) scanned in. Review of this document revealed no evidence of Resident #106 receiving a pneumonia vaccination. 2. Resident #107 had been a Resident of the facility since 10/8/21. The immunization tab of the EHR there was no record of influenza or pneumonia vaccines being offered, education provided, consent or refusal of the immunizations. Under the misc. (miscellaneous) tab there was an immunization record from VIIS scanned in. Review of this document revealed no evidence of Resident #107 receiving an influenza or pneumonia vaccination previously. Review of the entire EHR, to include but not limited to Medication Administration Records (MAR's), Treatment Administration Records	F 883	F883 1. Resident #106 received her pneumonia vaccine on 11/4/2021. Resident # 107 has been offered flu and pneumonia vaccines and declined both. 2. All residents have the potential to be affected. ADON/UMs/IP to review current patients immunization records to ascertain they have been offered and administered as consented both flu and pneumonia vaccines. Any patient noted not to have been offered the PNA and flu vaccines will receive one as consented. 3. IP/SDC will conduct education for all nurses on the following: a) Managing flu and pneumonia vaccines administration: Offering, administration, and Documentation. 4. DON/IP to complete 10% of current patients immunization records weekly x1 month and monthly x3 months to ascertain that flu and pneumonia vaccines have been offered and administered as consented. Any patient identified as not been offered and administered flu/PNA vaccines will be offered and administered one as consented. The result will also be forwarded to the QAPI Committee for further review and recommendation as appropriate. 5. Date of compliance: 11/22/2021	

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F 883	Continued From page 15	F 883		

(TAR's), nursing notes, and care plans for each of the Residents noted above, revealed no further information in regards to their immunization status, the immunization being offered and education provided. Both Residents (#106 and #107) had physician orders on the day of admission that read, "Flu vaccine annually as indicated" and "Pneumonia vaccine per protocol".

On 10/20/21 at 10:26 AM, RN F was asked where immunization records/information is found for Residents. RN F said that they are found, under the immunization tab in the EHR. Employee G, the Assistant Director of Nursing and Employee C were at the nursing station and demonstrated where in the EHR the immunization tab. When asked, what if nothing is recorded there? Employee C stated, "If they are admitted and we don't know their vaccination status we treat them as if they are not vaccinated. We have an infection control nurse and she comes and looks at it".

On 10/21/21 at 8:13 AM, the facility Administrator was made aware of the inability to find the above noted vaccine information for Resident #106 and #107 as aforementioned. The Administrator emailed Surveyor D and stated, "[Resident #106 name redacted]: The pneumonia vaccine has not been offered yet but it will be. [Resident #107 name redacted]: Pneumonia is the same as above".

On 10/21/21 at 9:19 AM, the facility provided the survey team with a document that Resident #107 was educated about the influenza vaccine and declined it on 10/19/21. This document was not in the EHR for Resident #107.

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F 883	Continued From page 16	F 883		

On 10/21/2021 at approximately 10 AM, Surveyor D met with Employee C, the staff development coordinator and previous infection preventionist for the facility, and RN E, the current Infection Preventionist. RN E accessed Resident #106 and #107's EHR and was unable to find information about the above noted immunizations being offered to the Residents, it being administered or declined, or education being provided.

On 10/21/21, Employee C and RN E stated that the facility was giving flu vaccines to Residents on 10/19/21. RN E stated, they were still working on pneumococcal vaccines.

Review of the facility policy titled, "Influenza and Pneumococcal Vaccinations was conducted. Excerpts from this document read, "1. Influenza Vaccination, c. ..."The center will check the immunization status of patients admitted during the flu season. Those who have not had a flu shot will be offered one upon admission". Section 2 read, "Pneumococcal Vaccination. f. A patient pneumococcal vaccine tracking log will be maintained by the infection preventionist.... New patients names will be placed on the log at the time of admission and offered the pneumococcal vaccination if not received as indicated".

On 10/21/2021 at approximately 11:40 AM, during an end of day meeting the facility Administrator, Director of Nursing and Corporate Clinical Director were made aware of the facility staff's failure to determine vaccine status and offer the influenza and pneumococcal vaccines and education to Residents and document such in Resident records.

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F 883	Continued From page 17 No further information was provided.	F 883		
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 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:	F 886		11/22/21

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F 886	Continued From page 18 (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, clinical record review and facility documentation, the facility staff failed to conduct COVID testing of a symptomatic Resident (Resident #107) as per physician orders and failed to document COVID-19 testing and results of such testing in the clinical record for 5 Residents (Resident #106, #107, #108, #109 and #110). 1. For Resident #107, the facility staff failed to obtain COVID-19 testing as per physician orders.	F 886	F886 1. Clinical records for residents 106, 107, 108, 109, 110, were reviewed and updated to accurately reflect covid testing including test results. 2. All residents have the potential to be affected. IP/ADON/UMs will review the COVID-19 testing and resulting process to ascertain that results are documented in current patients medical records promptly for all Covid-19 tests completed. Any noted anomaly in documenting in a	

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F 886	Continued From page 19 2. For Residents #106, #107, #108, #109 and #110, the facility staff failed to document COVID-19 testing and the results of testing, in the clinical record. The findings included: 1. For Resident #107, the facility staff failed to obtain COVID-19 testing as per physician orders. During a clinical record review, Resident #107 was noted to have several physician orders for COVID testing. The orders were as follows: 1. On 10/8/21, "COVID 19 POC (Point of Care) test by BinaxNOW, BD Veritor or Sofia. Every 24 hours as needed for Test for COVID 19 Document Results. 2. On 10/8/21, an order was entered that read, "COVID-19 TESTING PER MD OR CDC RECOMMENDATION every 24 hours as needed for COVID 19 testing COVID-19 TESTING PER MD OR CDC RECOMMENDATION 3. On 10/17/21, the order entered read, "Repeat Rapid COVID-19 Test ASAP-notify provider of results once completed one time a day". There was no end date on the physician order. The order dated 10/17/21, was initiated following an elevated temperature on two occasions during that day. The review of the "vitals" tab in the EHR (electronic health record) revealed 2 instances of elevated temperature recordings on 10/17/21. They were recorded as 99.0 at 2 AM and 99.3 at 7:05 PM. Review of the MAR (Medication Administration	F 886	promptly manner the Covid-19 test results in current patients medical records will be rectified accordingly as applicable. 3. DON/SDC will re-educate all nurses, IP, and UMs on the following: a) Managing COVID-19 test results b) Documenting COVID-19 test results in patients medical records. 4. DON/IP/Designee will complete a 10% audit of all COVID-19 tests on current patients weekly x1 month and monthly x3 months to ascertain that the results are documented in the respective patients medical records accordingly. Any deficient practice identified will be corrected as appropriate and then forwarded to the QAPI committee for review/recommendation as necessary. 5. Date of compliance: 11/22/2021	

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Record) revealed the COVID testing orders with no indication that testing had been conducted as ordered on 10/8/21. The MAR revealed that the 10/17/21, order for COVID testing was to occur daily and had only been signed off as being done on 10/18/21 and 10/19/21. This remained as an active order at the time of survey.

The MAR had an additional entry that read, "Repeat Rapid COVID-19 Test ASAP-notify provider of results once completed every shift for Fever for 2 Days". The MAR for this order entry had an entry on 10/18/21, with the code "9". According to the legend contained within the MAR, 9 was referenced as "Other/See progress notes".

Review of nursing notes revealed an entry dated 10/19/2021 at 01:47 AM, which read, "not done". No further notes were entered into the clinical record to indicate why "not done", was noted.

The Centers for Medicare & Medicaid Services (CMS) document, Ref: QSO-20-38-NH, revision date 09/10/21, read ". . . Conducting testing: In accordance with 42 CFR 483.50(a)(2)(i), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law, including the scope and practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing... "

On 10/21/21, the Corporate Clinical Director/Employee E and the DON (director of nursing) were unable to provide any further information regarding COVID testing as per physician orders for Resident #107.

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On 10/21/21, RN F provided the survey team the COVID-19 testing logs for Residents and there was no indication of Resident #107 having had COVID-19 testing conducted as per the MD orders noted above.

No further information was received.

2. For Residents #106, #107, #108, #109 and #110, the facility staff failed to document COVID-19 testing and the results of the testing, in the clinical record.

On 10/19/21, at the time of survey entry the facility Administration notified the survey team that they were in a current COVID-19 outbreak. Further notification was provided that 3 Residents had tested positive for COVID-19 as recent as 10/19/21. The facility Administrator and Director of Nursing indicated the COVID-19 outbreak began in August and was ongoing.

On 10/20/21 and 10/21/21, clinical record reviews were conducted for Residents #106, #107, #108, #109 and #110. This review consisted of review of nursing notes, results tab for labs, nursing notes, assessments tab, misc. tab and the care plan. The survey team was not able to find documentation of Resident COVID-19 testing and results.

On 10/21/21 at 10:35 AM, an interview was conducted with Corporate Clinical Director/Employee E and the DON (director of nursing). When asked about COVID testing results documentation both confirmed that results would be under the misc. tab within the EHR.

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Several of the sampled Residents records were reviewed with testing results unable to be found. The DON then took the surveyor to Medical Records Coordinator who confirmed she had no COVID-19 testing information waiting to be uploaded into the EHR.

On 10/21/21 RN E, the Infection Preventionist, was able to provide the survey team with COVID testing logs which she maintained on her computer. The following Resident information was noted:

1. Resident #106 was recorded on the logs as being tested for COVID-19 on 10/7/21, 10/12/21, 10/14/21, and on 10/19/21 the Resident tested positive for COVID.

2. Resident #107 was recorded on the testing logs as having been tested for COVID-19 on 10/12/21, 10/14/21, and 10/19/21.

3. Resident #108 was noted to have had COVID-19 testing on 10/1/21, 10/5/21, 10/7/21, 10/14/21, and 10/19/21.

4. Resident #109 was noted as having been tested for COVID-19 on 10/1/21, 10/5/21, 10/7/21, 10/14/21, and 10/19/21.

5. Resident #110, was not noted on the log as having been tested for COVID-19. Resident #110 was admitted to the facility on 10/15/21.

RN E stated she was not aware if all of the tests were recorded in the EHR for Residents.

The facility policy titled "COVID-19 Testing" was reviewed and did not indicate facility staff are to

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F 886	Continued From page 23 document the COVID testing or results in the EHR. The Centers for Medicare & Medicaid Services (CMS), Memo: QSO-20-38-NH, revision date 09/10/21, read ". . . Facilities may document the conducting of tests in a variety of ways, such as a log of community transmission levels, schedules of completed testing, and/or staff and resident records. . . For residents, the facility must document testing results in the medical record... " No further information as received prior to the end of survey.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is	F 887		11/22/21

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F 887	Continued From page 24 provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review, the facility staff failed to have policies for COVID immunizations and failed to offer the COVID vaccine to 2	F 887	F887 1. Covid-19 vaccinations policy and procedures have been developed effective 11/2/2021 that covers	

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	495248	A. BUILDING _____ B. WING _____	C 10/21/2021

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F 887	Continued From page 25 Residents (Resident #110 and #113), in a survey sample of 13 Residents. The findings included: 1. The facility failed to have a policy and procedure regarding the administration of COVID-19 vaccine administration with regards to the vaccine the facility was eligible to receive and have administered. On 10/20/21, Surveyor D reviewed the policy and procedures provided regarding COVID-19 vaccines. The facility provided policy was titled, "Janssen COVID-19 Vaccination". Surveyor D asked the facility Administrator and Corporate Clinical Director if they have policies for the other COVID vaccines that are available. Review of the COVID immunization log of Residents revealed that 2 Residents who were immunized at the facility (Resident #108 and #109) received the Pfizer vaccine. On 10/21/21 at 10:35 AM, the Corporate Clinical Director/Employee E and the DON (director of nursing) stated, "We only have a policy for the Janssen (J&J) and there is good reason. When the vaccines were gradually being approved, J&J was the one with the potential for us to store here and give here, so we developed a policy for that. It had the best potential for us to manage internally because we had the resources to do so. We were able to manage the acquisition, storage, mixing and administration of the others. We have never given Pfizer or Moderna internally, the health department gives it and we follow their instruction. We don't have the resources to keep the Pfizer and Moderna the storage is the barrier,	F 887	Pfizer-BioNTech, Moderna, Johnson & Johnson□s Janssen vaccines. Resident #110 was discharged on 10/29/2021 □ received Covid-19 vaccine on 10/27/2021. Resident #113 discharged on 10/31/2021 □ received COVID-19 vaccine on 1/15/21 and 2/05/2021 before admitting to the Center. 2. All residents have the potential to be affected. IP/UMs/ADON to review the Covid-19 immunization record of all current patients. Any noted deficient practice will be corrected immediately and as appropriate. The result of the review will also be used to provide in-service to the nurses. 3. SDC will in-service all nurses and IP on the following: a) Managing COVID-19 vaccination for all residents. 4. DON/UMs will audit 10% of all current new admissions weekly x1 month and monthly x3 months to ensure that vaccinated patients have their records uploaded and unvaccinated patients have been offered COVID-19 vaccine and administered as consented. Any noncompliance noted will be rectified accordingly/as appropriate and then forwarded to the QAPI Committee for further review and recommendation as necessary. 5. Date of compliance: 11/22/2021	

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the storage is the greatest challenge".

On 10/21/21 at 11:47 AM, a phone call was placed to the facility's contracted pharmacy. Surveyor C spoke with the Pharmacy Corporate Director of Quality Assurance/Other Staff C, who stated, "we have all 3 vaccines in stock and available, however I have to call the Maryland office to find out what vaccine is assigned to that region".

On 10/21/21 at 12:00 PM, Other Staff C called the survey team and said, "I checked with the Maryland office and they have told me that in that area the Federal mandates say that Moderna vaccine is allocated for that area. The management of storage of vaccine is not difficult because we only deliver on the day of the clinic. We do not just send the vaccine you must let us know first the date and time of your clinic and we will arrange for the transportation of the vaccine".

On 10/21/21 at 1:39 PM, Other Staff C emailed Surveyor D and provided a document titled, "Nurse Guide - Phase 2 COVID Vaccination Portal". The text of the email from Other Staff C stated, "Please see attached Nurse/Facility guide that we provide to the facilities we service. Additionally, I confirmed with their assigned [pharmacy name redacted] Pharmacy Rep that the facility has been instructed on how to schedule a vaccine clinic with us but has not scheduled one to date".

No further information was provided to the survey team prior to exit.

2. For Residents #110 and #113, who were

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eligible to be vaccinated, the facility staff failed to document in the clinical record evidence that they provided education and offered the COVID vaccination.

On 10/20/21 at 11:28 AM, Surveyor D asked for a copy of the immunization logs for staff and Residents with regards to COVID immunizations.

Review of the EHR for Residents #110, and #113 revealed the following:

1. Resident #110 had no indication in the EHR (electronic health record) of being immunized for COVID-19, no record of being offered the vaccine or provided education of the vaccine. Hospital records prior to admission to this facility, revealed the hospital communicated Resident #110's unvaccinated status for COVID-19, to the facility.

2. Resident #113 had no indication in the EHR (electronic health record) of being immunized for COVID-19, no record of being offered the vaccine or provided education regarding the vaccine.

Review of the entire EHR, to include but not limited to Medication Administration Records (MAR's), Treatment Administration Records (TAR's), nursing notes, and care plans for each of the Residents noted above, revealed no further information in regards to their immunization status, the immunization being offered and education provided.

On 10/20/21 at 10:26 AM, RN F was asked where immunization records/information is found for Residents. RN F said, under the immunization tab in the EHR. Employee G, the Assistant

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Director of Nursing and Employee C were at the nursing station and demonstrated where in the EHR the immunization tab. When asked, what if nothing is recorded there? Employee C stated, "If they are admitted and we don't know their vaccination status, we treat them as if they are not vaccinated. We have an infection control nurse and she comes and looks at it".

On 10/21/21 at 10:35 AM, the Corporate Clinical Director/Employee E and the DON (director of nursing) described the facility process for vaccinating Residents. They (Employee E and the DON) stated, RN E creates a list of Residents needing the vaccine and then calls the health department discuss the list. A conversation isn't held with the Resident until we get a date from the health department that they are coming. They (Employee E and the DON) confirmed that no documentation is made into the Resident's clinical record during this process.

On 10/21/2021 at approximately 11 AM, Surveyor D met with RN E/the infection preventionist, and asked to review of the log of Resident's needing vaccines that she maintains. RN E provided a listing of current Resident's vaccination status log.

The vaccination status log revealed the following:

1. Resident #110 was noted as "consented" to receiving the vaccine but the vaccine had not been administered. Nor was RN E able to provide evidence that they had communicated this request to the health department for administration of the vaccine. RN E stated that a staff member had shared with her that Resident #110 had consented but she still had to go talk to

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him before notifying the health department.

2. Resident #113 was noted on this log as "none", no additional notes gave any indication that a conversation had been held with the Resident to discuss vaccination.

Review of the facility policy titled "COVID-19" stated, "...the center should continue to encourage vaccination among new admissions.... 13. Education. c. Educate and re-educate as needed regarding benefits of becoming vaccinated".

On 10/21/2021 at approximately 11:30 AM, during an end of day meeting, the facility Administrator confirmed that the health department had been at the facility just the week prior administering COVID-19 vaccine boosters. They were made aware that Resident's vaccination status was not available in the clinical record and there was no evidence of the vaccine being offered. The DON and Corporate Clinical Director/Employee E acknowledged understanding of the concern regarding the delay in offering vaccines and the lack of documentation in the clinical record of COVID vaccination status.

No further information was provided to the survey team prior to exit.