STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	R 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

(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 and an unannounced Emergency Preparedness revisit survey and was conducted onsite 10/26/21 through 10/28/21. The original survey was conducted 09/07/21 through 09/10/21. Although the facility was in compliance with 42 CFR Part 483.473(b)(6), it was not in compliance with other sections of 42 CFR 483.73. No emergency preparedness complaints were investigated during the survey.	{E 000}		
{E 004} SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	{E 004}		11/30/21

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

Electronically Signed | 11/19/2021

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{E 004}	Continued From page 1 State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to maintain a comprehensive emergency preparedness program which was updated every 2 years. The findings included: On 10/26/21, the facility Administrator provided the survey team with the Emergency Preparedness (EP) Binder for review. Review of this binder revealed under the tab labeled E0004 a signature sheet which read, "Monthly Emergency Preparedness Plan Manual Review Log" and the most recent date contained on this document was "11/5/19". Further review of the entire binder revealed no additional evidence that the binder had been reviewed since November	{E 004}	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. E004 1- The Emergency Preparedness Plan is	

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{E 004}	Continued From page 2 2019. On 10/26/21 at 12:33 PM, Surveyor C met with the facility Administrator and explained the last review of the EP Binder was noted as 2019. The facility Administrator was asked if this was the last review of the EP binder and she [the Administrator] stated, the facility has had multiple changes in maintenance directors and is currently without a maintenance director. She said she was going to make a new EP manual but "It was so confusing, we had most of it there but we've been working on this for a lot of weeks now and it is just missing a few more things". The facility Administrator confirmed that the manual remains incomplete at the time of review and the evidence of the most recent EP manual review in the binder was dated November 2019. On 10/28/21, following an end of day meeting, the facility's corporate nurse consultant provided the survey team with a document that read, "Emergency Preparedness Plan Manual Review Log" that contained 4 signatures dated 10/6/21. The corporate clinical consultant/Employee D stated she was unaware of what the document was and would have the Administrator come talk to the survey team. The facility Administrator stated that they reviewed the manual but the form had the wrong information at the top of the form so they had to re-do it and sign again. When asked, when the staff had signed the form and reviewed the EP binder she was unable to provide a direct answer and acknowledged the EP manual remains incomplete at this time. No further information was provided prior to exit.	{E 004}	current/updated and complete. 2- Current residents in the center have the potential to be affected. 3- The Administrator/Maintenance Director will be educated by the VP Of Operations/designee on the requirements for reviewing/revising/updating the Emergency Preparedness Plan annually. 4-The VP of Operations/designee will review the Emergency Preparedness Plan annually/prn to ensure updating/revising of the plan as needed. 5-The review will be discussed and reviewed at the monthly QA meeting to determine if updates and revisions are needed for the Emergency Preparedness plan. The Administrator/DON is responsible for implementation of the plan of correction. Completion date: 11/30/2021	
{F 000}	INITIAL COMMENTS	{F 000}		

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{F 000}	Continued From page 3 An unannounced COVID-19 Focused Infection Control Survey and Medicare/Medicaid revisit to the standard survey conducted 09/07/21 through 09/10/21, was conducted 10/26/21 through 10/28/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. No complaints were investigated during the survey. The census in this 120 certified bed facility was 84 at the time of the survey. The survey sample consisted of 12 resident reviews.	{F 000}		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:	F 576		11/30/21

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F 576	Continued From page 4 (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and facility documentation review, the facility staff failed uphold Resident Rights with regards to receiving mail unopened for 1 Resident (Resident #805) in a survey sample of 12 Residents. The findings included: On 10/26/21 at 2:00 PM, an interview was conducted with Resident #805. During this interview, Resident #805 stated that her wedding ring had been stolen. When asked if it was replaced, Resident #805 said "No ma'am, I never got a penny for it. It was stolen in April when [previous facility Administrator name redacted] was here and I never got a cent". On 10/27/21 at 10:05 AM, during a follow-up interview with Resident #805, she reported she "they lost the ring in April, I reported it to several nurses and said they had it locked in the med cart. The administrator said corporate was going	F 576	F576 1-Resident #805 is receiving her mail unopened. 2-Current residents the center have the potential to be affected. 3-The Business office staff/Activities staff/receptionist will be educated by the DON/designee on the procedures to follow with handling of resident mail. 4-The Administrator/designee will interview 5 alert and oriented residents weekly to ensure their mail is being delivered unopened. 5-The results of the interviews will be discussed at the monthly QAPI meeting for review. Once the committee determines the problem no longer exists, the interviews will be conducted on a random basis. 5-The Administrator/DON are responsible for implementation of the plan of correction.	

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F 576	Continued From page 5	F 576	Completion date: 11/30/2021	

to cut a check and send it, I never received anything. Then these people took over [referring to the change in facility ownership] and [the current Administrator name redacted] said the same thing, they were going to cut a check. That's all they ever tell me".

On 10/27/21, a review of the Facility Reported Incidents (FRI's) was conducted. This review revealed that the facility staff did complete a FRI report on 5/31/21. This report had a statement attached that indicated Resident #805 had removed her wedding rings due to her finger being swollen on 5/21/21. Then on 5/30/21, when the Resident requested the ring it was not able to be located/recovered. The facility conducted an investigation and on 6/4/21, filed a follow-up FRI report which indicated, "We concluded that a misappropriation of patient property had occurred. ...The facility has agreed to reimburse [Resident #805's name redacted] for the missing ring".

On 10/27/21, Surveyor C asked the facility Administrator to provide evidence of Resident #805 being reimbursed for the ring. During investigation of this, it was noted that the reimbursement check got applied to the Resident's account/bill at the facility and was not given to the Resident. The check was made payable to Resident #805. Upon Surveyor B questioning how this happened, it was determined that the facility receptionist opened the Resident mail, then wrote out a receipt for the payment.

On 10/27/21 at 2:28 PM, an interview was conducted with Employee K the receptionist. She was asked about the process when mail is

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F 576	Continued From page 6	F 576		

received. Employee K said, "I meet him (mail man) in the vestibule and give him going out mail. Resident mail goes into activity mail box and they distribute it. Payments, I open and write in the receipt book and mail them [the sender] a receipt". She was shown a copy of the reimbursement check dated 7/30/21, and asked if she would open mail addressed like this, Employee K said, "I would open it and write a receipt for it". She was asked, even though it is in the Resident's name? Employee K said, "All payments are opened and written in the receipt book".

Review of the "Business Contract"/Admissions Agreement for Resident #805 revealed a copy of Resident Rights which noted "15. To have immediate access and visitation rights and to communicate privately with persons of his/her choice, and send and receive his/her personal mail unopened..." Resident #805 signed the agreement along with a facility representative/Employee M on 12/12/20. Review of the 6 pages of "General Acknowledgements" within this same Contract, revealed no authorization for the facility staff to open Resident #805's mail.

On 10/27/21, in the afternoon, a follow-up conversation was held with Resident #805. Resident #805 was unaware that she had ever been mailed a reimbursement check and that the facility staff had opened her mail and applied this reimbursement check to her bill/account at the facility which created a credit on her account. Resident #805 said she had not given authorization for the facility to do this.

On 10/28/21, during an end of day meeting the

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F 576	Continued From page 7 facility Administrator was made aware that the facility had opened Resident #805's mail without authorization. No further information was received.	F 576		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and facility documentation review, the facility staff misappropriated a refund check for 1 Resident (Resident #805) in a survey sample of 12 Residents. The findings included: On 10/26/21 at 2:00 PM, an interview was conducted with Resident #805. During this interview, Resident #805 stated that her wedding ring had been stolen. When asked if it was replaced, Resident #805 said "No ma'am, I never got a penny for it. It was stolen in April when [previous facility Administrator name redacted] was here and I never got a cent". On 10/27/21 at 10:05 AM, during a follow-up interview with Resident #805, she reported she "they lost the ring in April, I reported it to several	F 602	F602 1- Resident #805 received the refund check on 10/28/2. 2- Current residents in the center have the potential to be affected. 3- The Business office staff/Activities staff/receptionist will be educated by the DON/designee on the procedures to follow with handling of resident mail. In addition, facility staff will be educated on abuse/neglect which includes misappropriation of resident□s property. 4-The administrator/designee will review the deposits made to resident accounts are accurate and ensure it has been deposited appropriately. 5-The results of the review will be discussed at the monthly QAPI meeting for review. Once the committee determines the problem no longer exists, review will be conducted on	11/30/21

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F 602	Continued From page 8 nurses and said they had it locked in the med cart. The administrator said corporate was going to cut a check and send it, I never received anything. Then these people took over [referring to the change in facility ownership] and the [current Administrator name redacted] said the same thing, they were going to cut a check. That's all they ever tell me". On 10/27/21, a review of the Facility Reported Incidents (FRI's) was conducted. This review revealed that the facility staff did complete a FRI report on 5/31/21. This report had a statement attached that indicated Resident #805 had removed her wedding rings due to her finger being swollen on 5/21/21. Then on 5/30/21, when the Resident requested the ring it was not able to be located/recovered. The facility conducted an investigation and on 6/4/21, filed a follow-up FRI report which indicated, "We concluded that a misappropriation of patient property had occurred. ...The facility has agreed to reimburse [Resident #805's name redacted] for the missing ring". On 10/27/21, Surveyor C asked the facility Administrator to provide evidence of Resident #805 being reimbursed for the ring. During Surveyor C's investigation/questioning of this, the facility staff identified that the reimbursement check got applied to the Resident's account/bill at the facility, which created a credit balance. Resident #805 did not receive the reimbursement from the previously misappropriation of her wedding ring. The check was made payable to Resident #805. Upon Surveyor B questioning how this happened, it was determined that the facility receptionist opened the Resident mail, then wrote out a receipt for the payment. The	F 602	a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date: 11/30/2021	

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F 602	Continued From page 9 business office manager/Employee O then indicated in writing for the corporate staff to apply the payment towards her patient liability. Review of the facility policy titled, "Manual Section: Abuse/Neglect/Misappropriation/Crime, Policy Name: Administrative Reference Guide", it read, "... Misappropriation of Personal Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent". On 10/27/21, in the afternoon, a follow-up conversation was held with Resident #805. Resident #805 was unaware that she had ever been mailed a reimbursement check and that the facility staff had opened her mail and applied this reimbursement check to her bill/account at the facility which created a credit on her account. On 10/28/21, during an end of day meeting the facility Administrator was made aware that the facility had misappropriated Resident #805's reimbursement check. On 10/28/21, the corporate clinical director provided Surveyor C with a copy of a second reimbursement check that the company's corporate office had written and was sending overnight to Resident #805. No further information was received.	F 602		
{F 623} SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	{F 623}		11/30/21

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{F 623}	Continued From page 10 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	{F 623}		

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{F 623}	Continued From page 11 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	{F 623}		

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(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
{F 623}	Continued From page 12 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident and family interviews, staff interviews, facility documentation review and clinical record review, the facility staff failed to provide notice in writing before a facility transfer or discharge of a Resident to the Resident and Resident Representative (RP) and send a copy to the Office of the State Long-Term Care Ombudsman for 3 Residents (Resident #802, #803, and #807) in a survey sample of 12 Residents. The findings included: On 10/26/21, the survey team requested a listing of facility discharges since 10/15/21. A review of the listing was conducted, and 3 Residents were selected for review of notice of discharge/transfers compliance. 1. Review of the clinical record for Resident #802 revealed on the census tab of the electronic health record (EHR), Resident #802 had discharged on 10/17/21. There was no further	{F 623}	F623 1- Residents #802, #803, and #807 have been notified of the reason for recent transfers. This information has been documented in the clinical record for the residents indicated. The Office of the State Long Term Care Ombudsman has been notified in writing of the hospital discharges of Resident # 802, 803 and 807. 2- A review of residents discharged for the past 30 days was conducted to ensure written notification was provided for the Residents/RP of the transfer from the facility. In addition, the review included notification to the state ombudsman. 3-The Admissions Director/Discharge Planner will be educated by The Administrator/designee will educate on providing proper written notification to the resident/resident□s representative of the reason for the transfer/discharge. The education will include notification to the	

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	495193	A. BUILDING _____ B. WING _____	R 10/28/2021

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{F 623}	Continued From page 13 indication in the clinical record to indicate Resident #802 and her representative had received reason for the transfer in writing prior to or at the time of transfer/discharge. There was also no evidence of the State Long-Term Care Ombudsman being notified in the clinical record. Review of the miscellaneous tab of the EHR revealed no evidence of a transfer/discharge notice. On 10/27/21 at 12:31 PM, an interview was conducted with Employee L, the discharge planner for the facility. When asked about discharge notices she indicated she keeps a binder of them in her office. Employee L was able to retrieve the notices and provide the survey team with a copy of the transfer/discharge notice for Resident #802. Review of this notice revealed that it was completed on 10/22/21. When asked about the timing of notices, Employee L stated she completes them when she returns to work following the transfer/discharge. She provided a fax confirmation of the notice being sent to the Ombudsman on 10/22/21. Employee L also had a certified mail receipt that she mailed the notice to Resident #802's responsible person. This notice had no post mark to indicate when it was mailed but Employee L confirmed it was mailed 10/22/21. On 10/28/21 at 9:45 AM, Surveyor C interviewed Resident #802. Resident #802 stated she recalled going to the hospital and facility staff told her where she was going and why, but didn't give her anything in writing. On 10/28/21 at 10:51 AM, Surveyor C spoke with the Responsible Person/Mother of Resident #802 via telephone. Resident #802's mother stated	{F 623}	Office of the State Long Term Care Ombudsman weekly. 4-The Administrator/designee will audit transfer/discharges weekly to ensure proper written notification was completed to the resident/resident□s representative. The audit will also include verification of notification to the Office of the State Long Term Care Ombudsman weekly. 5-The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the audits will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date: 11/30/2021	

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{F 623}	Continued From page 14 she received a phone call to notify her the facility was sending her daughter to the hospital and why but she had not received anything in writing about this as of the time of the call. 2. Review of the clinical record for Resident #803 revealed on the census tab of the electronic health record (EHR), Resident #803 had discharged on 10/15/21. There was no progress note to indicate the Resident was or their representative had received reason for the transfer in writing, prior to the transfer/discharge. There was also no evidence of the State Long-Term Care Ombudsman being notified in the clinical record. Under the assessment tab of the EHR there was a Interact form indicating transfer to the hospital with the "date transferred to hospital" noted as "7/31/2020 11:00". This Interact form was signed as being completed on 10/15/21. On 10/27/21 at 12:31 PM, an interview was conducted with Employee L, the discharge planner for the facility. Employee L was able to retrieve the notices and provide Surveyor C team with a copy of the transfer/discharge notice for Resident #803. Review of this notice revealed that it was completed on 10/26/21, and faxed to the Ombudsman on 10/26/21. This notice listed the discharge date as 10/16/21. Employee L also had a certified mail receipt that she mailed the notice to Resident #803's RP. This certified mail receipt had no post mark to indicate when it was mailed. 3.	{F 623}		

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{F 623}	Continued From page 15	{F 623}		

Review of the clinical record for Resident #807 revealed on the census tab of the electronic health record (EHR), Resident #807 had discharged on 10/22/21. There was no further indication in the clinical record to indicate Resident #807 and their representative had received reason for the transfer in writing, prior to the transfer/discharge. There was no evidence of the State Long-Term Care Ombudsman being notified in the clinical record.

On 10/27/21 at 12:31 PM, an interview was conducted with Employee L, the discharge planner for the facility. When asked about discharge notices she indicated she keeps a binder of them in her office. Employee L was able to retrieve the notices and provide the survey team with a copy of the transfer/discharge notice for Resident #807. Review of this notice revealed that it was signed by Employee L on 10/24/21, and signed by the facility Administrator on 10/28/21. This notice was faxed to the Ombudsman on 10/25/21.

On 10/28/21 at 10:44 AM, Surveyor C spoke to the responsible person (RP) for Resident #807. The RP for Resident #807 said she was made aware of the transfer as she had requested it but was not given anything in writing and had not received anything.

On 10/28/21 at 11:07 AM, RN C, the Unit Manager was interviewed regarding Resident #807's transfer. RN C stated she was involved in the transfer of Resident #807. RN C said no written notice was provided to the Resident or RP regarding the reason for transfer, "we just notify by telephone usually".

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{F 623}	Continued From page 16	{F 623}		

On 10/27/21 at 10:30 AM, an interview was conducted with LPN C. LPN C was asked about the process when a Resident is transferred/discharged. She gave no indication/description of any forms being provided to the Resident or RP.

On 10/27/21 at 10:38 AM, LPN B was interviewed. LPN B described the forms nursing staff completes when a Resident is transferred out and made no indication of a transfer/discharge notice being completed. When asked if anything is given to the Resident or family she indicated only that they are notified of the transfer verbally.

On 10/27/21 at 10:48 AM, an interview was conducted with RN B. When asked if a Resident and their RR receive any documents prior to or at the time of transfer, to notify them of the transfer and why, RN B stated no.

On 10/27/21 at 12:31 PM, an interview was conducted with Employee L the discharge planner. When asked about transfer/discharge notices, Employee L said, "I notify the ombudsman if they discharge to the hospital unexpectedly but not the ones that leave for insurance purposes. I only do transfer/discharge notices in cases of Residents going to hospital and not returning that day/unscheduled discharges. If a resident is a planned discharge or leaves due to insurance cuts, etc. I don't send the notice of discharge or notify ombudsman". Employee L said, "when they go out, the next day I verify that they didn't come back before midnight, I fill out the form, I sign and the administrator signs, I fax it to the state long-term care ombudsman and send it to the family".

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{F 623}	Continued From page 17 Employee L was asked if the form goes into the clinical record, she said "no I don't upload it, I was instructed to keep it in the binder as a record". Review of the facility policy titled, "Notice of Discharge /Transfer," read "When the Center initiates a notice of transfer/discharge to a patient and/or responsible party, discharge planning will pursue timely and appropriate transfer/discharge notifications as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center ... Provide designated copies of the completed Notice of Transfer/Discharge form to each of those specified on the form, which includes the Ombudsman . . . Scan a copy of the Notice of Transfer/Discharge into the patient's medical record in PCC [Point Click Care-electronic medical record] under the "Misc." [Miscellaneous] tab. Once the document has been scanned into PCC, complete a Discharge Planning Progress note confirming the following: Date Patient and/or RP were given the notice and the method in which they received the notice. Date the notice was sent to the ombudsman and the method by which it was sent (The Ombudsman should be notified as close as possible to the actual time of a facility-initiated transfer or discharge) ...". On 10/28/21, during an end of day meeting the facility Administrator and Corporate Clinical Director were made aware that the facility is not providing notices of transfer/discharge to Residents and RP's at the time of or prior to the transfer/discharge. No further information was received.	{F 623}		
{F 625} SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr	{F 625}		11/30/21

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{F 625}	Continued From page 18 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on Resident and family interviews, staff interviews, facility documentation review and clinical record review, the facility staff failed to provide written bed hold notice before, or at the time of transfer, for 3 Residents (Resident #802, #803, and #807) in a survey sample of 3 Residents reviewed for bed hold notification.	{F 625}	F625 1-Resident #802, 803 and 807 have been provided information on the facility Bed Hold Policy regarding hospital transfers. 2-A review for the past 30 days was conducted for residents discharged from the facility to ensure written notification	

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{F 625}	Continued From page 19 The findings included: On 10/26/21, the survey team requested a listing of facility discharges since 10/15/21. A review of the listing was conducted, and 3 Residents were selected for review of notice of discharge/transfers compliance. 1. Review of the clinical record for Resident #802 revealed on the census tab of the electronic health record (EHR), Resident #802 had discharged on 10/17/21. There was no further indication in the clinical record to indicate Resident #802 or their representative had received written bed hold notice prior to, or at the time of transfer/discharge. On 10/27/21, Employee M/the Admissions Director provided a copy of a "Voluntary Bed Retention Agreement" for Resident #802 that he had signed 10/18/21, and noted he spoke to the RP for Resident #802 on that day to discuss the bed hold. On 10/28/21 at 9:45 AM, Surveyor C interviewed Resident #802. Resident #802 stated she recalled going to the hospital and facility staff told her where she was going and why, but didn't give her anything in writing. On 10/28/21 at 10:51 AM, Surveyor C spoke with the Responsible Person/Mother of Resident #802 via telephone. Resident #802's mother stated she received a phone call on 10/18/21, from Employee M/the Admissions Director about the bed hold policy. They later received a copy of the bed hold policy in the mail.	{F 625}	was provided for the resident/resident□s representative for the Bed Hold. 3- The Admissions Director will be educated by the DON/designee on the process for providing written notification to the resident/resident□s representative regarding the Bed Hold at the time of transfer/discharge from the facility. 4- The DON/designee will complete weekly audits of residents who transfer to the hospital to ensure that there was documentation of the provision of the Bed Hold Policy to the resident or resident representative at the time of the transfer to the hospital. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines no longer exists the audits will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date: 11/30/2021	

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{F 625}	Continued From page 20	{F 625}		

2.
Review of the clinical record for Resident #803 revealed on the census tab of the electronic health record (EHR), Resident #803 had discharged on 10/15/21. There was no indication in the EHR that Resident #803 or their representative had received information about the bed hold policy.

On 10/27/21, Employee M provided Surveyor C with a copy of the bed hold notice for Resident #803. This notice indicated a phone message was left with the RP of Resident #803 on 10/18/21. There was also a note that they returned the call and did not desire to hold the bed while Resident #803 was hospitalized.

3.
Review of the clinical record for Resident #807 revealed on the census tab of the electronic health record (EHR), Resident #807 had discharged on 10/22/21. There was no further indication in the clinical record to indicate Resident #807 or their representative had received any information about bed hold.

On 10/27/21, Employee M provided Surveyor C with a copy of the bed hold notice for Resident #807. This notice had notes that the RP for Resident #807 was contacted and Employee M signed and dated the form 10/23/21.

On 10/28/21 at 10:44 AM, Surveyor C spoke to the responsible person (RP) for Resident #807. The RP for Resident #807 said she received a phone call from Employee M "a few days after

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{F 625}	Continued From page 21	{F 625}		

she had been in the hospital to discuss all of that [the bed hold policy]".

10/26/21 at 4:18 PM, an interview was conducted with Employee M/the Admissions Director. Employee M acknowledged he is the person responsible for bed hold notices. Employee M said "let's say someone went out today, then I call the next day and explain it and see if they want to hold the bed. I explain the pricing, what it means, they say yes or no, I ask if they can come in and sign the form, and I document their response on the bed hold form". When asked if he documents the discussion in the EHR he said he doesn't have access to document in the EHR. Employee M said, "I keep a copy of the bed hold form, give a copy to the Administrator for the POC (plan of correction) book, and the business office gets a copy. I have been seeing a few that they have scanned in under the miscellaneous documentation in [the EHR software name redacted] and I mail a copy to the family". Employee M said he doesn't have access to the EHR to document the discussion.

On 10/27/21 at approximately 10 AM, Surveyor C observed at the nursing station a stack of manila envelopes that had the bed hold policy taped to the front.

On 10/27/21 at 10:30 AM, an interview was conducted with LPN C. LPN C was asked about the process when a Resident is transferred/discharged. " We call the physician to get order to send out, notify the DON [director of nursing], notify the family member if not their own RP Make sure get facesheet, medication list and the bed hold policy to send with them, we document the bed hold policy was given to them,

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{F 625}	Continued From page 22	{F 625}		

and who was notified that they were sent out". Surveyor C asked if they have a discussion about the bed hold? LPN C said, "Not from us, we just send the yellow folder with them and its on the front of the yellow folder".

On 10/27/21 at 10:38 AM, LPN B was interviewed. LPN B described the forms nursing staff completes when a Resident is transferred out and indicated the bed hold contract is provided. When asked if she fills out any of the blanks on the form she said, "No. I know there is a fee but I don't know any of the details. We tell them it is in the contract and then we put in the chart that you have reviewed the bed hold policy with the resident or RP or both".

On 10/27/21 at 10:48 AM, an interview was conducted with RN B/unit manager. RN B said nursing doesn't fill anything out on the bed hold form, the nursing staff just give the envelope which has the bed hold policy on the front to the transportation staff to give to the hospital staff, because they put the facesheet and medication list inside the envelope that the hospital will need.

Review of the facility policy titled "Bed Reserve Documentation" read, "The Admissions Director must establish contact with the patient and/or responsible agent to determine bed retention arrangements once the patient's hospitalization has been confirmed".

On 10/28/21, during an end of day meeting the facility Administrator and Corporate Clinical Director were made aware that the facility is not providing notices of bed hold to Residents and RP's at the time of or prior to transfer/discharge.

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{F 625}	Continued From page 23 No further information was received.	{F 625}		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility documentation review and clinical record review the facility staff failed to administer medications in accordance with physician orders and professional standards of practice for one Resident (Resident #806) in a survey sample of 12 Residents. The findings included: On 10/26/21 at 2:04 PM, an interview was conducted with Resident #806. During the interview RN B responded to Resident #806's call light. Resident #806 reported tightness in his chest and said "they didn't give me my medicine last night, I think that may be the problem. I didn't get my gabapentin last night. I missed it once before and I got sick". On 10/26/21 at 2:14 PM, Surveyor C approached RN C at the nursing station. RN C and Surveyor C conducted a narcotic count of Resident #806's gabapentin and the count matched the quantity of pills present. A copy of the narcotic count sheet was obtained. On 10/26/21, a review of the electronic health	F 658	F658 1-Resident #806 is receiving his medications as ordered. 2-Current residents in the facility have the potential to be affected. 3-Licensed Nurses will be educated by the DON/designee will educate Nurses on the 5 Rights of Medication Administration and proper transcription of medication orders. 4-The DON/designee will complete weekly audits of residents with new medication orders to ensure that the residents are receiving the correct medication dose and that the medication order was transcribed correctly. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists, the audits will be competed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date: 11/30/2021	11/30/21

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F 658	Continued From page 24	F 658		

record for Resident #806 was conducted. This review revealed physician orders dated 4/6/21, for Gabapentin that read, "Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for Neuropathy" and another order dated 4/6/21, that read, "Gabapentin Capsule 300 MG Give 2 capsule by mouth at bedtime for neuropathic pain". Review of the narcotic count sheet revealed that only 1 Gabapentin had been signed off as being provided on 10/25/21.

On 10/27/21 at 12:04 PM, a meeting was held with the DON (Director of Nursing) and facility administrator. The DON said following the surveyor's request for records and asking if any medication errors had been identified she said, "I do now have a medication error I've had to complete on his gabapentin". The DON said, "It is an order entry error, the NP (nurse practitioner) put two separate orders under one entry, it repeats that one, at 9pm he should have been given 2 tablets and he was only given one". When asked what systems are in place to prevent such errors from occuring, the DON said, "Doing those chart checks but that would have required someone to definitely know when you see those orders that say give this tab and that that is typically where 2 orders have been put in under one entry. Also, they now the 6 rights of medication pass, if she had read that order she would have saw where it says 2 tabs at bedtime". The DON stated their professional standards of practice they follow is: Lippincott.

According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, "Common Departures from the Standards of Nursing Care. Claims most frequently made

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F 658	Continued From page 25 against professional nurses include failure to ... follow physician orders....". Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com) "Rights of Medication Administration .....2. Right medication: Check the medication label. Check the order. 3. Right dose: Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well.....5. Right time: check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. 6. Right documentation: Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.....". Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. Accessed online at: www.nursingcenter.com. No further information was provided prior to the end of survey.	F 658		
{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	{F 880}		11/30/21

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{F 880}	Continued From page 26 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	{F 880}		

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{F 880}	Continued From page 27 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 interview and facility documentation review, the facility staff failed to follow infection control practices to prevent the spread of COVID-19 within the facility, in accordance with CMS (Centers for Medicare and Medicaid Services) and CDC (Centers for Disease Prevention and Control) in 2 areas (the designated COVID quarantine unit and the general/reception area) in a survey sample of 4 areas of the facility. 1. The facility staff handled biohazard bags of regulated medical waste without wearing any PPE (personal protective equipment) and then transported the waste in a personal vehicle, this deficient practice of not following infection control increased the potential for infection transmission within the facility.	{F 880}	F880 1- Staff member J was educated on the proper handling the biohazard bag, including the proper PPE to worn when handling biohazard waste. Visitors and vendors are being screened prior to entering the facility. In addition, visitors and staff are wearing the proper PPE when in the facility. A sign was posted on the back entrance of the facility notifying staff, visitors and vendors of the COVID outbreak status and PPE requirements. A sign was also posted at the back entrance doors to direct all visitors to enter through the main lobby for screening before entering the facility.	

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{F 880}	Continued From page 28 2. The facility staff failed to perform COVID-19 screening of visitors and vendors. 3. The facility staff failed to provide signs and direction to notify facility staff, visitors, and vendors of the PPE requirements and COVID status of the unit or Resident they were entering/providing care to. The findings included: 1. The facility staff handled biohazard bags of regulated medical waste without wearing any PPE (personal protective equipment) and then transported the waste in a personal vehicle, this deficient practice of not following infection control increased the potential for infection transmission within the facility. On 10/27/21 at 3:45 PM, Surveyor C was on the designated COVID unit of the facility. Observations revealed that the facility staff place all soiled linen and trash outside of the unit for facility housekeeping staff to retrieve to prevent them entering the COVID unit and in a effort to minimize the facility staff's exposure to the COVID-19 virus. On 10/27/21 at 3:53 PM, Surveyor C and CNA C and CNA D observed Employee J, the housekeeping manager gathering the medical waste, which was in biohazard bags with his bare/un-gloved hands. Employee J was also observed to not have any PPE (personal protective equipment) (no mask, no isolation gown, no eye protection and no gloves) on. Employee J then put the biohazard bags into the trunk of a personal vehicle and drove off.	{F 880}	2- Current residents in the centers have the potential to be affected. 3-Facility staff will be educated by the DON/designee on the proper infection control practices when handling biohazard waste. In addition, education will be provided to the Business office staff/receptionists ensuring visitors/vendors are screened prior to entering the facility and wearing the proper PPE. 4- The DON/designee will observe via direct observation of staff during daily rounding to ensure biohazard waste is handled appropriately and the appropriate PPE is worn. The Administrator /designee will monitor the screening process daily to ensure that visitors and vendors are completing the screening when entering the facility. The Administrator will check facility entrances on a weekly basis to ensure that the proper signage is in place. 5- Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists, the observations and monitoring will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction Completion date: 11/30/2021	

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On 10/28/21 at 10:02 AM, an interview was conducted with Employee C, the facility infection preventionist. Employee C defined biohazard waste as "things contaminated with blood, bodily fluids sharps, etc.". When asked what PPE is to be worn when handling biohazard waste, Employee C said, "When handling need to wear PPE, gloves, masks, eye protection, gown". Employee C said Housekeeping staff are responsible for boxing up biohazard waste for pick-up/disposal and are to "put on full PPE and to be aware of what they are collecting, hey this is going to have sharps in it, and to know what the risks are". Employee C was asked if biohazard waste should ever be put into a person's personal vehicle, Employee C said, "No, because biohazard waste is regulated and it is dangerous". The risks of doing this is "Risk exposure to what ever blood born pathogens may be in the waste. They aren't exactly able to see what is in it but it is my understanding they were taught to handle it like it is all dirty needles, treat it as if it has the potential to cut them and infect them".

On 10/28/21 at 9:48 AM, an interview was conducted with Employee J, the housekeeping supervisor. Employee J was asked about biohazard waste and to describe how it is handled. Employee J said, "We set up a biohazard container outside [outside the COVID unit] and after every shift we go and pick it up. The guys picking it up always have on gloves.... Everything in a red bag is biohazard. Biohazard is more contaminated, when getting biohazard we have on mask, goggles and gloves, we don't have on gowns when we pick it up". Employee J was asked about the observations on 10/27/21, of him putting biohazard waste into a personal vehicle

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and he said, "I had my vehicle on that side and I had a plastic bag in my car, I put it in there and I drove it around, made 2 boxes up and sealed it and put in the biohazard area". Employee J confirmed he wasn't wearing any PPE and said, "You right, I wasn't thinking".

On 10/28/21, a facility policy for regulated medical waste/biohazard waste was requested and received. This policy was reviewed and did not address the handling of biohazard waste.

Review of the job description for the housekeeping and laundry director revealed job responsibilities included but were not limited to: "Maintains knowledge of OSHA standards regarding blood borne pathogens...".

On 10/28/21, during an end of day meeting the facility Administrator and DON were made aware of concerns regarding infection control and the handling of waste.

No further information was received.

2. The facility staff failed to perform COVID-19 screening of visitors and vendors.

On 10/26/21 at approximately 11:15 AM, Surveyor C arrived onsite to conduct the inspection. Surveyor C was permitted entry into the facility by the receptionist/Employee K. Surveyor C was offered to have a seat to wait for the facility Administrator. Employee K made no attempt to screen Surveyor C without the surveyor's intervention/prompting.

On 10/27/21 and 10/28/21, Surveyor C and

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Surveyor D both had to prompt facility staff to be screened for COVID-19 symptoms.

On 10/28/21 at approximately 12:20 PM, Surveyor C observed 3 medical transport providers in the facility. Two of the transportation employees was observed to be talking to a staff member in the front lobby/reception area, while the third stood in the hallway between nursing units. Observations of the 2 in the lobby revealed no screening being conducted. Upon questioning of the medical transport staff by Surveyors C and D, it was determined that they had entered through the rear entrance/ambulance entrance and performed no COVID-19 screening. They indicated they were there to perform a non-emergency transport for a Resident who was discharging home. The 3 all confirmed they were not asked or prompted to perform any type of screening for COVID-19 symptoms, exposure or have their temperature taken even after talking to facility staff in the lobby/reception area.

The CDC provides the following guidance in their document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic". It read, "....Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work. -Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility...". Accessed online

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{F 880}	Continued From page 32 at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html 3. The facility staff failed to provide signs and direction to notify facility staff, visitors and vendors of the PPE requirements and COVID status of the unit or Resident they were entering/providing care to. On 10/28/21 at approximately 12:20 PM, Surveyor C observed 3 medical transport providers in the facility. All three were observed wearing only a procedure mask, no eye protection and no other PPE. Upon questioning of the medical transport staff, by Surveyors C and D, it was determined that they had entered through the rear entrance/ambulance entrance and were not aware of the COVID outbreak status within the facility and had not been informed of any required PPE. The transportation providers also indicated the facility staff had directed them to the other side of the facility, which was the COVID exposed/quarantine unit, but they were not told it was a quarantine unit. Observations of the facility grounds revealed 2 signs in the parking lot to direct any ambulance/transportation companies to access the facility through the rear entrance. The rear entrance to the facility had no signs to indicate the COVID outbreak status of the facility nor any required PPE. Entrance into the COVID exposed/quarantine/warm unit had no signs to indicate such, or what PPE was required. Surveyors C & D were able to open the door to the COVID quarantine unit/warm unit to gain access without any assistance of staff.	{F 880}		

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The transportation staff stated that they were providing transportation to a Resident to home and were not notified that the Resident was on any type of TBP (transmission based precautions) or was under quarantine. The transport staff showed Surveyors C and D their transport order which indicated "No COVID, no quarantine". They indicated that when staff told them where to go to get to the Resident facility staff had not mentioned that this was a quarantine unit.

On 10/28/21 at approximately 1 PM, Surveyors C and D conducted interviews with Employee L, the discharge planner. Employee L confirmed she had called the transportation company on 10/27/21, to arrange for the transport of the Resident home. Employee L stated this was her first time setting up transportation and she thinks they did ask about COVID status because they wanted the Resident tested for COVID-19 prior to transport but "I can't remember if I told them she is on a warm unit".

On 10/28/21 at approximately 1:05 PM, Surveyors C and D conducted an interview with RN C, the unit manager. RN C said she had conducted a COVID test of the Resident that morning. RN C confirmed that the Resident was on the quarantine unit and her quarantine would continue until November 2.

CDC guidance read, "In healthcare settings, patients under quarantine are typically isolated in a single-person room and cared for by healthcare personnel using all PPE.....In general, transport and movement of a patient with suspected or confirmed SARS-CoV-2 infection outside of their

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{F 880}	Continued From page 34 room should be limited to medically essential purposes....transport personnel should wear all recommended PPE (gloves, a gown, respiratory protection that is at least as protective as a fit tested NIOSH-certified disposable N95 filtering facepiece respirator and eye protection [i.e., goggles or disposable face shield that covers the front and sides of the face]). This recommendation is needed because these interactions typically involve close, often face-to-face, contact with the patient in an enclosed space (e.g., patient room). Once the patient has been transferred to the wheelchair or gurney (and prior to exiting the room), transporters should remove their gown and gloves and perform hand hygiene. The transporter should continue to wear their respirator. The continued use of eye protection by the transporter is also recommended if there is potential that the patient might not be able to tolerate their facemask or cloth face covering for the duration of transport. Additional PPE should not be required unless there is an anticipated need to provide medical assistance during transport (e.g., helping the patient replace a dislodged facemask)...". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control On 10/28/21, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	{F 880}		
{F 885} SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility	{F 885}		11/30/21

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{F 885}	Continued From page 35 must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on Resident interviews, staff interviews, and facility documentation review, the facility staff failed to notify 5 Residents (Resident #805, Resident #806, Resident #808, Resident #809, and Resident #810) when staff members and Residents tested positive for COVID-19 for the current outbreak dated 10/13/2021. The findings included: On 10/26/21 at 11:30 A.M., an entrance conference was held with the Administrator and the Corporate Nurse Consultant. The	{F 885}	F885 1-Residents #806, 805, 808, 809 and 810 were all notified of the current COVID status of the facility. 2-Current residents in the center have the potential to be affected. 3- The receptionist will be educated by the DON/designee on proper documentation of notification to the resident and the resident representative of the current COVID status of positive	

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{F 885}	Continued From page 36 Administrator indicated the facility census was 84 and there were "13 active COVID cases" (Residents). On 10/27/2021 at 10:05 A.M., Surveyor C met with Resident #805. When asked if the facility notified her of the COVID status in the building, Resident #805 stated, "This past weekend one of the aides said there is COVID in the building when I asked why we can't go in the hall". Resident #805 indicated she received no details and no written communication about it. A review of Resident #805's quarterly Minimum Data Set with an Assessment Reference Date of 08/30/2021 coded the Brief Interview for Mental Status as "14" out of possible "15" indicative of intact cognition. On 10/27/2021 10:20 AM, Surveyor C met with Resident #808. When asked if the facility had notified her of the COVID status in the building, Resident #808 stated, "One day last week, a staff member said there was a case on the other side so people can't bring no food in here no more". She doesn't recall who told her this. They didn't say how many cases were in the facility. A review of Resident #808's quarterly Minimum Data Set with an Assessment Reference Date of 08/27/2021 coded the Brief Interview for Mental Status as "13" out of possible "15" indicative of intact cognition. On 10/27/2021 at 10:25 A.M., an interview with Resident #806 was conducted. When asked if there were currently any Residents in the facility that tested positive for COVID-19, Resident #806 stated, "Not to my knowledge." A review of Resident #806's quarterly Minimum Data Set with	{F 885}	cases in the facility. 4-The DON/ designee will complete a weekly audit of resident records to ensure documentation of notification of the COVID status of positive cases in the facility. Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists, audits will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date: 11/30/2021	

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an Assessment Reference Date of 08/26/2021 coded the Brief Interview for Mental Status as "13" out of possible "15" indicative of intact cognition. There was no evidence in Resident #806's clinical record of notification of the COVID status in the facility.

On 10/27/2021 at 10:30 A.M., an interview with Resident #809 was conducted. When asked if staff had notified him of the COVID status in the facility, Resident #809 stated, "Not directly." Resident #809 indicated he did not receive any formal verbal or written communication about it but when he attempts to leave his room, sometimes it is allowed and sometimes he is told Residents must stay in their rooms. A review of Resident #809's quarterly Minimum Data Set with an Assessment Reference Date of 08/18/2021 coded the Brief Interview for Mental Status as "15" out of possible "15" indicative of intact cognition. There was no evidence in Resident #809's clinical record of notification of the COVID status in the facility.

On 10/27/2021 at 11:30 A.M., an interview with the Infection Preventionist, Employee C, was conducted. The corporate nurse consultant was also present for the interview. When asked about the timeline for the current COVID outbreak, the Infection Preventionist stated that one Resident tested positive on 10/13/2021 and another Resident and one staff member tested positive on 10/17/2021. When asked about how Residents and families were notified about the COVID status, the Infection Preventionist stated that a report is sent to the corporate office and the corporate office posts the COVID status on their website. When asked about notifying Residents and families that may not have internet access,

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the Infection Preventionist indicated she didn't know. The Corporate Nurse Consultant then stated that the Director of Nursing (DON) has a binder with the phone numbers of all the Responsible Parties and record of notification. The Corporate Nurse consultant also stated that each notification is documented in the clinical record.

On 10/27/2021 at 4:30 P.M., the administrator and the DON were notified of findings. When asked whose responsibility is was to notify Residents and families of the COVID status in the facility, the DON stated that the receptionist notifies families and keeps a log book. The DON also stated that a letter is sent to families. Copies of the letters were requested.

On 10/27/2021 at 4:40 P.M., an interview with the receptionist, Employee K, was conducted. When asked about notifying Residents and families of COVID status in the facility, the receptionist stated she calls every week. When asked what she tells the family when she calls, the receptionist stated that she tells them only what the administrator and the DON want her to tell them. When asked what that was, the receptionist then stated that her 'script' was written on the top of the page where the calls are listed. This surveyor and the receptionist observed a page dated 10/19/2021 with a list of names. At the top of the page, it was documented, "Facility outbreak status, COVID testing today, no food/laundry (back and forth), door dash ok." There was no evidence Residents and families were notified of the occurrence of confirmed COVID-19 infections as well as all mitigating actions taken to reduce the risk of transmission.

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On 10/28/2021 at 9:45 A.M., an interview with Resident #810 was conducted. When asked if staff had notified her of the COVID status in the facility, Resident #810 indicated that she was not told but her daughter did receive a phone call about it. Resident #810 then stated that "but by then we already knew about it." When asked how she knew about it, Resident #810 stated that another Resident told her about it. Resident #810 did not know how many Residents had COVID-19 and wondered when the quarantine would be lifted so she could leave her room. A review of Resident #810's quarterly Minimum Data Set with an Assessment Reference Date of 09/02/2021 coded the Brief Interview for Mental Status as "15" out of "15" indicative of intact cognition. There was no evidence in Resident #810's clinical record of notification of the COVID status in the facility.

On 10/28/2021 at 10:20 A.M., a follow-up interview with the receptionist, Employee K, was conducted. The surveyor and the receptionist observed the names of Resident #806 and Resident #809 in her notification log book. When asked if she notified Resident #806 and Resident #809 of the COVID status in the facility, the receptionist indicated she does not talk with Residents about it but calls their emergency contact.

On 10/28/2021, the facility staff provided a copy of two letters regarding family notification of the COVID status. A letter dated 10/13/2021 and signed by the administrator documented, "Dear Family, We are writing to inform you that [facility name] is in an outbreak status for the next 14 days. We will be doing our weekly testing starting

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{F 885}	Continued From page 40 today, October 13, 2021 and then on Friday October 15, 2021 this week, then twice a week. Our goal is the safety of our residents and our staff, we appreciate your cooperation with this matter." A letter dated 10/25/2021 and signed by the administrator documented, "Dear Family, We are writing to inform you that [facility name] is in an outbreak status. We will be doing weekly testing starting today October 26, 2021 and then on Friday October 29, 2021 this week then every 3-7 days. Our goal is the safety of our staff, we appreciate your cooperation with this matter." There was no evidence Residents and families were notified of the occurrence of confirmed COVID-19 infections as well as all mitigating actions taken to reduce the risk of transmission. On 10/28/2021 at approximately 1:15 P.M., the administrator and DON were notified of findings. A copy of their policy regarding notification of Residents and Responsible Parties of the COVID status was requested. At 4:20 P.M., the corporate nurse consultant stated there was no policy regarding the notification of Residents and Responsible Parties of the COVID status in the facility. By the end of survey, the administrator stated there was no further information or documentation to submit.	{F 885}		
{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:	{F 886}		11/30/21

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{F 886}	Continued From page 41 §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: (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	{F 886}		

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{F 886}	Continued From page 42 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 observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to perform COVID-19 testing in a manner to prevent or minimize the spread of COVID-19 for 2 out of 2 COVID-19 testing occurrences and the facility staff failed to document required COVID-19 testing data in 4 out of 4 resident records reviewed.(Resident #801, #804, #805 and #806) The findings included: 1. The facility staff failed to perform COVID-19 testing in a manner to prevent or minimize the spread of COVID-19 within the facility. On 10/26/21 at 3:24 PM, Surveyor C observed Employee P conduct COVID-19 testing of 2 staff members. Employee P was observed to have on an isolation gown, performed hand hygiene using ABHR (alcohol based hand rub) and then donned (put on) gloves. She then approached CNA K to	{F 886}	F886 1-Testing data was documented in the clinical record for Residents #801, 804, 805 and 806. Employee P was educated on the proper infection control measures required when conducting COVID testing including the use of PPE. 2-Current residents in the center have the potential to be affected. 3-The DON/Nursing Leadership will be educated by the Regional Director of Clinical Services on documenting COVID test results in the EHR and notification to the resident/resident□s representative of the results. In addition, Nursing staff will be educated on the proper infection control measures required when conducted COVID testing including the use of PPE. 4-The DON/designee will audit COVID testing completed for the week to ensure proper notification and documentation has been completed. In addition, the	

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{F 886}	Continued From page 43 perform testing. During the testing, Employee P stood directly in front of CNA K to perform nasal swabbing. Upon completion, Employee P doffed (removed) her gloves and performed hand hygiene with ABHR again. Employee P then prepared the test kit for LPN P's COVID-19 test. Employee P did not don a new isolation gown or perform any disinfecting of the testing area. Following the observation of COVID-19 testing, Surveyor C interviewed Employee P. Employee P confirmed she had not changed isolation gowns during the testing between CNA K and LPN P. When Surveyor C explained she was in close contact and her isolation gown touched the clothing of the employees during the testing, Employee P said, "that's a good point, I hadn't thought of that". Employee P further confirmed that the purpose of COVID testing is because the facility is in an outbreak status of COVID and testing was being conducted to identify non-symptomatic staff that may be carriers of the virus. Review of the facility policy titled "COVID-19 Testing" was reviewed and read, "....Personal Protective Equipment (PPE) to be worn when obtaining the specimen: i. gown, ii. gloves, iii. N-95 Respirator or facemask if N-95 respirator is not available, iv. Goggles or Face Shield". There was no mention in the facility policy regarding consecutive testing events and the changing of any PPE. Review of the CDC guidance for "Specimen Collection & Handling of Point-of-Care and Rapid Tests" for COVID-19 was conducted. It read,	{F 886}	DON/designee will via direct observation during COVID testing to ensure proper infection control measures are being utilized including the proper use of PPE. 5-Results of the audit will be discussed at the monthly QAPI meeting for review. Once the committee determines the problem no longer exits the audit will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date: 11/30/2021	

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{F 886}	Continued From page 44 "...Proper specimen collection and handling are critical for all COVID-19 testing, including those tests performed in point-of-care settings. A specimen that is not collected or handled correctly can lead to inaccurate or unreliable test results. For personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which could include an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a lab coat or gown..... Disinfect surfaces within 6 feet of the specimen collection and handling area before, during, and after testing and at these times: · Before testing begins each day · Between each specimen collection · At least hourly during testing · When visibly soiled · In the event of a specimen spill or splash · At the end of every testing day". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/lab/point-of-care-testing.html QSO-20-38-NH, Revised 9/10/21, gives guidance regarding testing to Nursing Facilities. This document read on page 9, "...During specimen collection, facilities must maintain proper infection control and use recommended personal protective equipment...". On 10/26/21, during an end of day meeting the facility Administrator was made aware of the findings. No additional information was provided.	{F 886}		

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2. The facility staff failed to document COVID-19 testing data in the clinical record for Residents #801, #804, #805, and #806.

On 10/26/21, an interview was conducted with the facility Administrator regarding COVID-19 testing for residents and staff. Facility resident and staff COVID-19 testing logs from 10/14/21 to 10/26/21 were requested and received.

On 10/26/21, Surveyor C conducted an interview with the Director of Nursing (DON), who verified that COVID-19 testing occurrences and test results were expected to be documented within the residents' clinical record.

On 10/27/21, the COVID-19 testing logs were reviewed and revealed testing for facility residents occurred on 10/15/21, 10/19/21, 10/20/21, and 10/22/21.

Clinical record review was performed for Residents #801, #804, #805, and #806 and revealed no documentation of the COVID-19 testing occurrences, type of COVID-19 test utilized, or test results within the residents' clinical record.

On 10/27/21, an interview was conducted with the facility's Infection Preventionist (IP, Employee C). The IP verified the COVID-19 testing dates per facility testing logs for Residents #801, #804, #805, and #806. The IP verified there was no documentation for the COVID-19 testing occurrences, test type, or test results within the clinical record for the 4 referenced residents.

A review of the facility's policy entitled, "COVID-19 Testing", effective date 09/21/21, read, "POLICY:

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{F 886}	Continued From page 46 COVID-19 testing will be performed by trained personnel following CMS recommendations for testing". The CMS (Centers for Medicare & Medicaid Services) recommendations found in Ref: QSO-20-38-NH, revised on 9/10/21, page 11, revealed, "....the results of tests must be done in accordance with standards for protected health information. For residents, the facility must document [COVID-19] testing results in the medical record".	{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 provided with current information regarding those additional doses, including any changes in the	F 887		11/30/21

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F 887	Continued From page 47 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 interview and facility documentation review, the facility staff failed to document the COVID-19 vaccination status for 27 out of 85 staff members. The findings included:	F 887	F887 1-The facility obtained and documented the COVID-19 vaccination status for the 27 staff members. 2-An audit was conducted of current staff of the facility to ensure vaccination status	

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F 887	Continued From page 48 The facility staff failed to obtain and document the COVID-19 vaccination status for 27 out of 85 staff members. On 10/27/21, a copy of the facility's documentation for the COVID-19 Immunization status staff members was requested and received from the Facility Administrator. Review of the document revealed that from a list of 85 staff members, the COVID-19 immunization status was unknown for 23 staff members as noted with blank spots in both the "1st vaccine" and "2nd vaccine" columns and 4 additional staff members that only had a first dose date recorded with a blank spot noted under "2nd vaccine" column. On 10/27/21, an interview was conducted with the facility's Infection Preventionist who verified the list for staff members COVID-19 vaccine status was current and the immunization status was unknown for 23 staff members listed and incomplete for 4 members listed. The Infection Preventionist further stated, "I do not have a vaccination status list for agency staff as well as dietary and housekeeping staff, I am unaware of their [COVID-19 immunization] status ....there is no written [COVID-19] vaccination policy that I'm aware of". On 10/28/21 at approximately 10:30 AM, a group interview was conducted with the Infection Preventionist and the facility Staff Development Coordinator, both whom verified there were no additional updates made to the COVID-19 vaccine status list for staff members previously	F 887	is documented. 3-The DON/ designee will educate the Human Resource Director on obtaining and documenting COVID vaccine status information for staff members. 4-The Human Resources Director will complete weekly audits of newly hired staff members to ensure that the COVID vaccination status is obtained and documented. 5-Results of the audits will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists, the audits will be conducted on a random basis. The Administrator/DON are responsible for implementation of the plan of correction. Completion date: 11/30/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	R 10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

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F 887	Continued From page 49 submitted the day before. On 10/28/21 at approximately 2:00 PM, a group interview was conducted with the Facility Administrator, Director of Nursing, and Corporate Clinical Consultant and updated on the findings. The Corporate Clinical Consultant verified she was aware of the current regulations for COVID-19 Immunizations that were updated by CMS (Centers for Medicare & Medicaid Services) on 5/11/21. The CMS (Centers for Medicare & Medicaid Services) recommendations found in Ref: QSO-21-19-NH, revised on 5/11/21, page 5, read, "The facility must document the vaccination status of each staff member (i.e., immunized or not), including whether fully immunized (i.e., completed the series of multi-dose vaccines)".	F 887		