STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495345		02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANCASHIRE NURSING & REHABILITATION CENTER	287 SCHOOL STREET KILMARNOCK, VA 22482

(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 An unannounced Emergency Preparedness survey was conducted 02/01/22 through 02/03/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. The census in this 120 certified bed facility was 73 at the time of the survey. The survey sample consisted of 38 resident reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/01/2022 through 02/03/2022. 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 73 at the time of the survey. The survey sample consisted of 38 resident reviews.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those	F 582		3/18/22

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

Electronically Signed | 02/23/2022

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

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F 582	Continued From page 1 services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of	F 582		

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F 582	Continued From page 2 these regulations. This REQUIREMENT is not met as evidenced by: Based on Staff interview and facility documentation review, the facility staff failed to complete a skilled nursing facility (SNF) Advanced Beneficiary Notice (ABN) for two residents, (Resident #32, and #53), in a sample of 3 ABN resident reviews. 1. For Resident #32, no SNF/ABN was signed prior to discharge from skilled services. 2. For Resident #53, no SNF/ABN was signed prior to discharge from skilled services. The findings included: 1. Resident #32 was initially admitted to the skilled nursing facility on 2-5-2020. The last Medicare covered day for the Resident's most recent stay was 9-3-2021. The Resident's benefit days had not been exhausted, however, the Resident had reached a plateau, and the facility felt that she no longer required skilled nursing care and that level of care was discontinued without the Resident signing a notice of the change. 2. Resident #53 was initially admitted to the skilled nursing facility on 6-25-2021. The last Medicare covered day for the Resident's most recent stay was 1-30-2022. The Resident's benefit days had not been exhausted, however, the Resident had reached a plateau, and the facility felt that he no longer required skilled nursing care and that level of care was discontinued without the Resident signing a notice of the change.	F 582	1) Residents #32 and #53 received a copy of the original SNF/ABN notice that documents the verbal notice. This was documented in their medical record. 2) All residents who received a SNF/ABN in the last 45 days will be reviewed by the Social Worker to ensure that appropriate signatures were obtained on the SNF/ABN. Any variances will be addressed as needed. 3) Director of Counseling and Support Services/Designee will provide education to the social worker on the requirements for issuing a SNF/ABN notice, to residents including getting resident□s signature, or if unable, what are the proper steps. 4) Director of Counseling and Support Services/Designee will review 100% of SNF/ABN notices issued weekly for 6 weeks to ensure they have to the proper signatures. Any trends or variances will be reported to the Quality Assurance and Performance Improvement Committee.	

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F 582	Continued From page 3 On 2-3-2022, a review of the facility's ABN/NOMNC forms issued during the last six months was conducted. Three discharged residents were chosen for review. Of the 3 chosen, two residents, (Resident #32 and # 53), did not have a signed SNF/ABN available. The facility social worker was interviewed and was asked why the Residents were not issued these documents for their signatures, and she stated "I just verbally told them when their skilled time was ending." On 2-3-2022, at 4:00 p.m. the Facility Administrator was informed that the two documents for Residents #32, and #53 were not completed. The facility Administrator provided no further information.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		3/18/22

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F 584	Continued From page 4 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility documentation review, the facility staff failed to maintain a safe and homelike environment for 2 Residents (Residents #6 and #31), in a survey sample of 38 Residents. For Residents #6 and #31, the facility staff failed to repair a sink cabinet located within the Resident's room, to maintain a safe and homelike environment. The findings included: On 02/01/22 at 04:21 PM, an observation was made in the room of Residents #6 and #31, which revealed the sink cabinet side support, dislodged from underneath the sink and pulled away on the	F 584	1) Resident #6 and #31 received the needed repair to the sink cabinets. 2) All resident rooms were evaluated by the Director of Maintenance for maintenance needs using a comprehensive checklist tool to evaluate needs for a safe, clean, homelike environment. Any maintenance needs identified will be corrected. 3) Administrator/designee in-serviced 100% of staff on the process of reporting maintenance needs/concerns to include, but not limited to, writing maintenance needs in the facility maintenance log book and effective utilization of the VHS Work	

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F 584	Continued From page 5 side. On 2/3/22 at 9:01 AM, Resident #31 was observed ambulating in the room. The sink was still noted to be in need of repair as noted above. On 2/3/22 at approximately 9:05 AM, CNA G accompanied Surveyor C to the room of Residents #6 and #31. CNA G reported that she was unaware of how the long the sink wall had been dislodged from under the sink. CNA G said, "I never noticed it". On 2/3/22 at 9:13 AM, RN D/the Assistant Director of Nursing (ADON) entered the room of Residents #6 and #31. RN D said "I wasn't aware of the sink issue". On 2/3/22 at 9:22 AM, Employee P/the Maintenance Director came to the room of Residents #6 and #31. The Maintenance Director reported he has two maintenance work order books, one at each nursing station that staff use to communicate maintenance repairs needed. The maintenance director looked at the sink and said he wasn't aware of it being broken previously and acknowledged he needed to "shoot some screws in it". On 2/3/22 at 9:25 AM, the maintenance director showed Surveyor C the maintenance work order book at the nursing station and said he checks the book each morning to see what repairs are needed. Review of the maintenance book revealed an entry made on 2/3/22, by RN D for the sink needing repair. On 2/3/22 at 9:28 AM, Surveyor C observed the maintenance work order book which had work	F 584	Request Portal. 4) Administrator/designee will audit 25% of resident rooms weekly for six weeks using the comprehensive checklist to ensure they are clean, safe, and provide a homelike environment. Administrator/designee will report any trends or variances to the Quality Assurance and Performance Improvement Committee.	

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F 584	Continued From page 6 orders dating 11/5/21-2/3/22. This review revealed that prior to the surveyor bringing the sink to the attention of the staff, no entry had been made into the maintenance work order book. On 2/3/22 at 5:20 PM, a telephone interview was conducted with Employee P, the maintenance director. The maintenance director confirmed that he doesn't conduct rounds, checking each Resident room for needed repairs. He relies on the staff to indicate repairs needed in his work order book. Employee P said, "I only know if they write it in the book". On 2/2/22, a request for the facility policy regarding maintenance work orders/repairs was requested. This policy was not received prior to the end of survey. On the afternoon of 2/3/22, the survey team was provided with a 7 page document that read, "Maintenance Request Process, New Initiative beginning 2/1/22". This document outlined how staff would submit maintenance repairs electronically. On 2/3/22 at approximately 5:30 PM, Surveyor C met with the facility Administrator and Director of Nursing and discussed the above findings. No further information was provided prior to the end of survey.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		3/18/22

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F 657	Continued From page 7 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to develop and implement an accurate and complete comprehensive care plan for 1 Resident (#46) in a survey sample of 38 Residents. The findings included: For Resident # 46 the facility failed to include right hand contractures and the wearing of a soft splint on the care plan.	F 657	1) Resident # 46□s care plan was updated to include right hand contractures and the wearing of a soft splint per schedule. 2) The comprehensive care plans for all residents with contractures and splints/devices were reviewed to ensure the care plan was accurate and comprehensive related to the splint/device. Any issues notices will be care planned immediately.	

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F 657	Continued From page 8 On 2/1/21 at approximately 2:30 PM an observation was made of Resident # 46 lying in bed, asleep, her right hand was visibly contracted, and a splint fastened with the Velcro strap around the bed rail at the head of the bed and not on the resident. On 2/2/22 at approximately 2:30 PM another observation was made of Resident #46 who was in bed resting eyes closed. The splint was not on the resident but instead was fastened around the rail at the head of the bed. A review of the MAR and TAR revealed no set time for donning and doffing the splint. A review of the notes written by Occupational Therapy revealed the following note written by Employee L (Occupational Therapy Assistant) "Pt will be fitted for appropriate resting hand splint for R UE and tolerate for x 6-8 hours daily in order to prevent further contractures without s/s of discomfort and skin breakdown. [Name Redacted] (Occupational Therapy Assistant) 1/26/2022 3:11 PM" (Next to the above note was the box for "Goal Completed" was checked.) A review of Resident #46's Care plan revealed that there was no mention of the right hand contracture or the use of a soft splint. On 2/2/22 an interview with RN B was conducted and she stated that the nurses were not responsible for putting Resident # 46's splint on and taking it off. She said "Physical therapy handles her splinting." On 2/3/22 at approximately 3:00 PM the DON was interviewed and she stated that "Physical therapy's process to convey the donning and	F 657	3) The facility has developed a standard communication process in the electronic health record to ensure any resident specific splint/device recommended by the therapy teams are communicated in a written manner within the resident□s medical record. Nursing Management and Therapy teams were educated on the new process. . The DON/designee educated the MDS team and Therapist on developing and implementing an accurate and comprehensive care plan. 4) The ADON/Therapy Manager/designee will monitor 100% of new splint/device orders weekly for six weeks to ensure the device is care planned timely. The findings of this audit will be reported to the Quality Assurance and Performance Improvement committee.	

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F 657	Continued From page 9 doffing of splints is that they tell the nurse who is assigned to the Resident and then the nurse puts the orders into the computer and adds it to the care plan." When asked if they would expect to see contractures and splinting on the care plan she agreed that it should be addressed on the Comprehensive Care Plan for nursing once PT/OT has informed instructed nursing on the hours of use and proper donning and doffing of the splint. On 2/3/22 at approximately 3:30 PM the DON provided a progress note from the Employee K that read: "OT rehab has goal for pt. to tolerate 6-8 hours wearing appropriate resting R hand splint to decr. Risk of further contracture and to maintain skin integrity. Therapy is trialing different approaches such as gentle prolonged stretching, soft positioning device and built up splinting device to incr. tolerance and ROM for transition to resting hand splint as appropriate and as tolerated by pt. Pt tolerates minimal ROM and incr. tolerance / time wearing positioning device. Therapy will fit for appropriate splint as tolerated by pt. and communicate with nursing prior to establishing a care plan for wearing schedule and proper donning / doffing with skin checks.[Name redacted] OT assistant. 2/3/22 3:28 PM." On 2/3/22 at approximately 4:00 PM an interview was conducted with Employee K who stated that she wrote the progress note at 3:28 PM. She stated that Resident #46 was still working to meet her goals with splint wearing and that she could be non-compliant at times. She was asked to read Employee L's note from 1/26/22 and she	F 657		

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F 657	Continued From page 10 stated that she was not aware the Resident had met her goal with the splint. She called Employee L and placed her on speaker phone and Employee L stated that the Resident had met the goals with regards to splint wearing for skin integrity and decreasing the risk of further contractions. She stated that she had told this to the DON the previous week and the DON was supposed to Care Plan it. On 2/3/22 during the end of day meeting the DON stated she did not recall OT telling her that Resident #46 had met her goals and that nursing should now take over donning and doffing of the splint. On 2/3/22 during the end of day meeting the Administrator was made aware of the concerns an no further information was provided.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688		3/18/22

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F 688	Continued From page 11 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, the facility staff failed to implement measures to prevent further decrease range of motion for 1 Resident (#46) in a survey sample of 38 Residents. The findings included: For Resident # 46 the facility failed to implement the donning and doffing of soft splint by nursing staff. On 2/1/21 at approximately 2:30 PM an observation was made of Resident # 46 lying in bed, asleep, her right hand was visibly contracted, and a splint fastened with the Velcro strap around the bed rail at the head of the bed and not on the resident. On 2/2/22 at approximately 2:30 PM another observation was made of Resident #46 who was in bed resting eyes closed. The splint was not on the resident but instead was fastened around the rail at the head of the bed. A review of the MAR and TAR revealed no set time for donning and doffing the splint. A review of the notes written by Occupational Therapy revealed the following note written by Employee L (Occupational Therapy Assistant) "Pt will be fitted for appropriate resting hand splint for R UE [Right Upper Extremity] and tolerate for x 6-8 hours daily in order to prevent further contractures without s/s of discomfort and skin breakdown. [Name Redacted] (Occupational	F 688	1) Resident #46 is wearing the right-hand splint according to Occupational Therapies recommendations and physicians order. This is documented on the TAR. 2) The ADON and Occupational Therapist observed all residents with splints to ensure they were wearing their splint according to the occupational therapy recommendations and the physicians order. Any issues noted will be sent to occupational therapy/provider for clarification. 3) The facility has developed a standard communication process in the electronic health record to ensure any resident specific splint/device recommended by the therapy teams are communicated in a written manner within the resident□s medical record. The Director of Rehab Services/Designee will educate all RN/LPN/Therapist on preventing the decrease in range of motion and proper application of splints. 4) The ADON/Therapy Manager/designee will observe 100% of residents with splints for 6 weeks to ensure the splint is being donned ad doffed per schedule. The findings of this audit will be reported to the Quality Assurance and Performance Improvement committee.	

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F 688	Continued From page 12 Therapy Assistant) 1/26/2022 3:11 PM" (Next to the above note was the box for "Goal Completed" was checked.) A review of Resident #46's Care plan revealed that there was no mention of the right hand contracture or the use of a soft splint. On 2/2/22 an interview with RN B was conducted and she stated that the nurses were not responsible for putting Resident # 46's splint on and taking it off. She said "Physical therapy handles her splinting." On 2/3/22 at approximately 4:00 PM an interview was conducted with Employee L who stated that the Resident had met the goals with regards to splint wearing for skin integrity and decreasing the risk of further contractions. She stated that she had told this to the DON the previous week and the DON was supposed to Care Plan it. On 2/3/22 during the end of day meeting the DON stated she did not recall OT telling her that Resident #46 had met her goals and that nursing should now take over donning and doffing of the splint. On 2/3/22 during the end of day meeting the Administrator was made aware of the concerns an no further information was provided.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		3/18/22

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F 689	Continued From page 13 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility documentation review, the facility staff failed to maintain one mechanical lift in a safe operational manner, in a sample of 4 mechanical lifts observed. The facility staff failed to ensure the sling bar safety latches were present on one mechanical lift. The findings included: On 02/01/22 at 02:31 PM, Surveyor C observed the mechanical lift (Viking lift) in the storage room, plugged in and charging. The lift bar was observed to be missing the clips on both side of the bar, which the lift sling attach to. A sticker was observed on the lift that indicated an electrical safety test/inspection date of 4/28/21. Two other lifts were observed in the storage room also available for facility staff to use. All lifts within the facility were observed and the Viking lift noted above was the only one noted to not have the safety clips. On 2/2/22 at 5:16 PM, the mechanical Viking lift was observed in the storage room, plugged in and charging, available for use. The safety clips were not in place on the lift bar/they were missing. Two other mechanical lifts were observed in the storage room also available for staff use.	F 689	1) The identified mechanical lift was removed from the unit and identified as Out of Service to ensure that the device would not be used. The proper latches were ordered and will be installed upon arrival. 2) The Director of Maintenance conducted a safety check on each mechanical lift in accordance with manufacturer's instructions. No additional findings were noted. 3) Administrator/designee in-serviced in-serviced RN, LPN, CNA, TNA and Maintenance on the proper use of mechanical lifts to include but not limited to proper assessment of lift equipment prior to use and systems for removal of lift equipment using lock out tag out. 4) Administrator/designee will audit 25% of mechanical lifts weekly for six weeks then at least monthly to ensure the mechanical lifts are in safe working order and that the process is followed for Lock Out Tag Out. Any trends and/or variances will be reported to the Quality Assurance and Performance Improvement Committee.	

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F 689	Continued From page 14 On 2/3/22 at 8:58 AM, the mechanical Viking lift was observed in the storage room, plugged in and charging available for use. The safety clips were not in place on the lift bar. Other mechanical lifts were also in the storage room available for staff use. On 2/3/22 at 9:25 AM, the maintenance director showed Surveyor C the maintenance work order book at the nursing station and said he checks the book each morning to see what repairs are needed. On 2/3/22 at 9:28 AM, Surveyor C observed the maintenance work order books located at both nursing stations. Maintenance work orders dating from 8/30/21-2/3/21, were reviewed. Only one entry regarding mechanical lifts was noted, which read, "10/2/21- old lift needs new battery for scale". On 2/3/22 at 9:39 AM, the maintenance director was asked if he performs any type of repairs to the mechanical lifts, preventative maintenance or safety inspections. The maintenance director/Employee P said, "I don't work on them other than like if a screw comes out". He (the maintenance director) also confirmed he doesn't perform any inspection or preventative maintenance of the mechanical lifts. On 2/3/22 at 3:40 PM, an interview was conducted with CNA H. CNA H accompanied Surveyor C to the storage room where the mechanical lift was stored. CNA H confirmed that she currently has 6 Residents who require a mechanical lift. CNA H stated she does use the mechanical lift in question. When asked why the holes on the lift bar were there, CNA H said, "I	F 689		

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F 689	Continued From page 15 believe there is a metal clip that goes here". CNA H continued to state, "The clip is for safety, it holds the straps inside. I've never seen the clips and I've been here 2 years". On 2/3/22 at approximately 3:55 PM, an interview was conducted with CNA F. CNA F accompanied Surveyor C to the storage room where the mechanical lifts are stored. CNA F confirmed that she has one Resident currently in her assignment that she uses a mechanical lift for. CNA F confirmed that the holes on the lift bar are "For clamps that used to be here". CNA F confirmed that she hadn't seen the clips "for months". When asked what the purpose of the clips are, CNA F said, "To keep the sling in". CNA F confirmed during the interview that she uses the lift in question. During the 3 days of survey, the survey team did not observe the lift in question being utilized with any Residents. On 2/3/22 at approximately 4:05 PM, the Maintenance Director/Employee P and the Director of Nursing (DON) accompanied Surveyor C to the storage room where the lift was located. The DON acknowledged that she noted the "hooks were missing". When asked what the purpose of the hooks are, the DON said, "They hold the strap in". The DON stated they (the facility) purchased new lifts and expects staff to use the new lifts and not the one in question which is much older. When asked if she had any documentation to show that staff were told to not use the lift with the missing clips, the DON said she did not. On 2/3/22, during the interview with the DON and	F 689		

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F 689	Continued From page 16 Maintenance director, they were asked to confirm if the lift is able to be used. The maintenance director used the remote of the lift to check and the lift was operational and available for use. Surveyor C asked how staff would know not to use the lift in question. Both the DON and Maintenance director acknowledge that they do not use a lock out/tag out system for equipment that is not to be used. The DON asked the maintenance director to remove the battery so that the lift could not be used and to put a note on it to alert staff not to use that lift. On 2/3/22 at approximately 4:10 PM, the DON was asked if the facility had any incidents in the past year involving a Resident while using the mechanical lift and she said no. On 2/3/22 at 4:18 PM, the Vice President of Nursing Services (VPNS)/Employee M was observed in the mechanical lift storage room with the DON. Surveyor C entered the room. The VPNS confirmed that the clips were missing on the lift bar and the lift should not be used. The VPNS further confirmed that the mechanical lift in question has now been removed from service and they were conducting in-services with all staff at that time to advise them to no longer use the lift in question. On 2/3/22 at 5:05 PM, the Vice President of Nursing Services entered the conference room with the survey team to provide in-services of the "new mechanical lifts" the facility purchased. The in-service records had a date of 7/24/17 and 10/3/17. There was an additional in-service sheet that was dated 10/21/19, that read, "subject matter covered: mechanical lifts". The VPNS said, she was demonstrating that the training on	F 689		

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F 689	Continued From page 17 mechanical lifts is ongoing and staff had been trained to use the "new" lifts purchased. She also provided the survey team with a "skills checklist" that the staff are signed off on. This skills checklist stated, "Safety Check- visually inspect lift for external damage or excessive wear, - check that exposed fasteners are tight especially those of the sling bar, - check that sling bar safety latches are present and will freely swing closed..." During the above noted interaction with the VPNS and survey team, the VPNS was asked about the clips not being present. She said, "They are called safety clips for a reason....it's a feature that is supposed to be there. When we get our safety check they say they are to be there". A review of the facility policy titled, "Mechanical Lifts" was conducted. This policy read, "...Perform a basic safety check before use: check that the sling bar safety latches are present and will freely swing closed..." A review of the manufacturer "Instructions for Use" booklet for the mechanical lift was reviewed. The Director of Clinical Support/Employee J, confirmed this booklet was for the mechanical lift in question. This booklet read, "...Warning; this situation requires extra care and attention...Before lifting, always make sure that: o The lifting accessories are not damaged; o The lifting accessory is correctly attached to the lift; o The lifting accessory hangs vertically and can move freely; o The lifting accessory is selected appropriately, in terms of type, size, material and design, with regard to the patient's needs; o The lifting accessory is correctly and safely	F 689		

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F 689	Continued From page 18 applied to the patient in order to prevent injuries; o the latches are intact; missing or damaged latches must always be replaced..." On 2/3/22 at approximately 5:30 PM, the facility Administrator and DON were made aware of the above concerns. No further information was provided.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed for 1 resident (Resident	F 692	1) The dietary recommendation for Resident #30 was implemented on 2/2/2022.	3/18/22

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F 692	Continued From page 19 #30) in the survey sample of 36 residents, to ensure that the Registered Dietician's recommendation was submitted to the attending physician. The findings include: The facility staff failed to ensure that the dietary recommendation dated 12/14/21, to reduce Boost Oral liquid from twice daily to once daily, was submitted to the physician. Resident #30's diet wasn't changed until the 2/2/22. On 2/1/22 at approximately 1:50 P.M., an observation of Resident #30 was conducted. Resident #30 was clean, dressed appropriately, and well-groomed. On 2/1/22, a review was conducted of Resident #30's clinical record, revealing a Nutritional Assessment by a Registered Dietician dated 12/14/21. According to the report, Resident #30 had reached his optimal weight range. An excerpt read, "Recommend decrease Boost supplements to once/day with goal of maintaining current weight." Resident #30 had not yet had a significant weight gain since December, 2021. The dietary order for January, 2022, and February, 2022 were reviewed. The order had not been changed prior to the survey. The clinical record did not contain documentation that the physician had reviewed the recommendation, or changed the order. On 2/2/22 at approximately 9:15 A.M., an interview was conducted with the Director of Nursing (Employee B). When asked about the importance of insuring that the physician	F 692	2) All dietary recommendations for the last 30 days were reviewed to ensure they have been addressed by the provider and documented in the medical record. 3) The Dietitian will review their recommendations weekly to ensure the recommendation has been addressed by the provider and documented in the resident□s medical record. The Dietitian/Designee will inservice RN/LPN on the Nutritional Management Policy. 4) The Dietitian/designee will audit 100% of the dietary recommendations weekly for 6 weeks to ensure they are being addressed by the provider timely. The findings of this audit will be reported to the Quality Assurance and Performance Improvement committee.	

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F 692	Continued From page 20 reviewed the dietary recommendation, she stated, " He had a history of weight gain. We don't want him to gain weight. If he gains weight it puts him in an overweight bracket. We don't want that. The Assistant Director of Nursing (ADON Employee P) was present. The ADON stated that she did not have documentation that she'd submitted the recommendation to the physician. She further stated, "He must have given his review documentation to another nurse." The DON stated that it was the ADON's responsibility to ensure receipt and follow-up from the physician. The facility did not submit the requested policy on nutritional services. No further information was received.	F 692		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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	F 761		3/18/22

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F 761	Continued From page 21 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to properly store narcotic medications in one of two medication rooms. The findings included: On 2/3/22 at 11:58 AM, a review of the medication storage located in the Chesapeake unit medication room, was conducted with LPN B present. During this review, it was observed that the medication room was located behind the nursing station and was an open room. The room had a "pocket door" which when opened retracted into the wall. This door was observed open throughout the survey conducted 2/1/22-2/3/22. LPN B unlocked the medication refrigerator which revealed a black box attached to the fridge with a silver colored, cord/wire. The black box was noted to be unlocked and able to be opened without the use of a key/combination or other mechanism. The box contained the following medications: 1. Lorazepam/Ativan (a benzodiazepine medication), 2 mg/ml injection. Three, 1 ml, multi-dose vials were noted. 2. Lorazepam injection 2mg/ml. Ten (10), 1 ml	F 761	1) The narcotic box in the Chesapeake Unit refrigerator was immediately locked to ensure proper storage. 2) All of the narcotic storage boxes in the medication refrigerators were checked to ensure the proper storage of narcotics. 3) The DON/Designee will educate all RN/LPN on the VHS policies, Medication Disposition and Storage and Expiration of Dating of Medications, Biologicals, Syringes and Needles. 4) The DON/Designee will check for proper storage of narcotics in the medication refrigerator twice weekly for six weeks to ensure narcotics are safeguarded. The findings of this audit will be reported to the Quality Assurance and Performance Improvement committee.	

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F 761	Continued From page 22 multi-dose vial(s), all of which were unopened, was noted. LPN B confirmed that the Resident these belonged to expired about 10 days ago. 3. Lorazepam concentrate 2mg/ml. One unopened bottle containing 30 ml(s) was noted. 4. Lorazepam oral concentrate 2mg/ml. One bottle containing 30 ml(s) was noted. LPN B confirmed the above contents and counts. LPN B confirmed that the box containing these medications should have been locked to create a double lock since they are narcotic medications. LPN B indicated the double lock is for safety and to restrict access. On 2/3/22 at 12:20 PM, LPN D was interviewed. LPN D said, "Narcotics are kept under double lock and counted each shift". When asked why the double lock is necessary, LPN D said, "To prevent someone from taking it". On 2/3/22, a review of the facility policy titled, "Medication Disposition Policy" was conducted. This policy read, "Double lock can mean a locked cabinet in a locked room or a double locked cabinet...Controlled substances should be secured under double lock at all times until disposition is complete"... On 2/3/22, a review of the facility policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles" was conducted. This policy read, "...Controlled Substances Storage: Facility should ensure that Schedule II-V controlled substances are only accessible to licensed nursing, Pharmacy, and medical personnel designated by facility. After receiving controlled substances and adding to inventory, facility should ensure that Schedule	F 761		

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F 761	Continued From page 23 II-V controlled substances are immediately placed into a secured storage area (i.e., a safe, self-locked cabinet, or locked room, in all cases in accordance with applicable law). Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security". On 2/3/22 at approximately 5:30 PM, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer	F 791		3/18/22

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F 791	Continued From page 24 residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. 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 provide assistance for recommended dental services for one Resident (Resident #1) in a survey sample of 38 Residents. The findings included: On 2/1/22, in the afternoon, Resident #1 was interviewed. During the interview, Resident #1 indicated he had some dental issues. On 2/2/22, a review of the clinical record for Resident #1 was conducted. This review revealed the following: 1. A consultation dated 8/20/21. This consult	F 791	1) Resident #1 was scheduled for the recommended dental extractions on 05/03/2022. 2) All current residents who have received dental consults since September 2021 were reviewed to ensure any recommendations had been followed up on and charted in the medical record. Any variances will be corrected. 3) The DON/designee with educate 100% of the RN/LPN staff on the Dental Services policy to include timely and proper follow-up of dental recommendations. 4) The DON/designee will review 100% of	

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F 791	Continued From page 25 noted diagnosis as, "unrestorable dentition". Recommendations: "Full mouth extractions". 2. A Nurse Practitioner (NP) progress note dated 12/28/21. The NP note read, "...Pt [patient] c/o [complained of] sore anterior maxillary gums and sensation of swelling. Hx [history] of caries and missing teeth apparently awaiting a full mouth extraction, placed on amoxicillin 250 TID [three times daily] completed 12/16 with relief. F/up [follow-up] tooth pain, broken/sharp teeth irritating tongue; mouth ulcerations treated. Reporting dentist appointment planned tomorrow and extractions need to occur in Richmond..." There was no further indication noted in the clinical record of Resident #1, of him attending any further dental appointments, scheduled dental work, etc. On 2/2/22, the facility Administrator was asked to provide any further information the facility had available regarding Resident #1's dental services and the facility policy regarding dental services. On 2/3/22 at 3:22 PM, an interview was conducted with the facility Social Worker/Employee N. The Social Worker said the facilities' contracted dental provider doesn't provide extractions and Employee O, the medical secretary handled the appointments and was "working on it". On 2/3/22 at 3:25 PM, Surveyor C attempted to meet with Employee O but she had left the facility for the day. On 2/3/22 at approximately 3:30 PM, Surveyor C met with the Director of Nursing and notified her	F 791	dental consults for six weeks to ensure recommendations and follow-up are completed timely. The findings of this audit will be reported to the Quality Assurance and Performance Improvement committee.	

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F 791	Continued From page 26 that Resident #1 had seen a dentist in August 2021, and full mouth extractions were recommended. In December 2021, Resident #1 was treated for oral problems to include a course of antibiotics. She was asked to provide any additional information regarding completed/attended appointments, scheduling of appointments, etc. The facility policy regarding dental services was requested but not received prior to the end of survey. On 2/3/22 at 5:30 PM, Surveyor C met with the facility Administrator and Director of Nursing to review the above findings. No further information was provided prior to survey exit on 2/3/22 at 7:30 PM.	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		3/18/22

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F 880	Continued From page 27 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 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.	F 880		

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F 880	Continued From page 28 §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, clinical record review, and facility documentation review, the facility staff failed to adhere to soiled linen protocol for 1 resident (Resident #20) and failed to adhere to infection control guidelines in accordance with The Centers for Disease Control and Prevention (CDC) for 1 Residents (Resident #35) and in a sample size of 37 Residents. The findings included: 1. For Resident #20 the facility staff placed soiled linens on the floor of the Residents room and they remained there for a minimum of 35 minutes. On 2/1/22 at approximately 1:00 PM an observation was made of Resident #20 laying in bed watching TV. On the floor beside his bed were a pile of visibly soiled linens including a top and bottom sheet and a green bed pad. On 2/1/22 at approximately 1:35 PM a second observation was made with the linens still on the floor. At this time, RN C was in the hall and was asked about the linen being left on the floor in the Resident's room. She stated that they should not be leaving linens on the floor and she would find the CNA for that Resident.	F 880	1) The soiled linens were removed from the floor of the Resident # 20 and the floor was sanitized. There were no negative outcomes related to the staff member using improper PPE upon entering Resident # 35□s room. The involved staff members were re-educated on infection control procedures including handling of soiled linens and appropriate PPE to be worn with residents on transmission based precautions. 2) 2 The Infection Preventionist will perform 5 observations of the responsible staff member to ensure compliance with appropriate PPE usage. Rounds will be conducted by the Infection Preventionst of all resident rooms twice daily for one week to ensure rooms are free from soiled linens on the floor. 3) The Infection Preventionist / Educator will re-educate all staff on COVID-19 Infection Prevention & Control policy. The in-services will include but is not limited to the appropriate PPE to be worn when interacting with COVID positive residents as well as handling of soiled linen.	

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F 880	Continued From page 29 CNA D was in the hall and when asked if the linens should be on the floor she stated that they should not, she further stated "He is not my Resident but I will get these linens off the floor because they should never be left on the floor of a Resident's room." On the afternoon of 2/2/22 an interview was conducted with the DON who agreed that soiled linens should not be left on the floor of a Resident room when asked what is the concern with this practice, she stated its an infection control issue. On 2/3/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was made available. 2. For Resident #35 (on Droplet Precautions for confirmed COVID-19), a facility staff member, Certified Nursing Assistant B (CNA B) was observed not wearing the proper Personal Protective Equipment (PPE) when entering Resident #35's room. On 02/01/2022 at approximately 2:57 P.M., this surveyor observed 2 signs on the door of Resident #35's room. One sign was entitled, "Droplet Precautions." The other sign below it documented, "Let's protect each other; HOT PPE required when with me." There were 4 pictures on the sign indicating an N-95, face shield, gloves, and gown be worn in Resident #35's room. Resident #35's door was open. From the hall, this surveyor observed Resident #35 was in bed with the head of the bed elevated at least 45 degrees. Resident #35 had nasal cannula oxygen applied	F 880	4) The Infection Preventionist/Designee will perform PPE observations on five staff members weekly for six weeks to ensure appropriate PPE usage and conduct rounds on the nursing units daily for six weeks to ensure soiled linens are not on the floor. Any variances identified will be corrected. The Infection Preventionist /Designee will report findings to the Quality Assurance and Performance Improvement Committee.	

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F 880	Continued From page 30 and was heard to have a moist cough occasionally. Resident #35 motioned to this surveyor which indicated a request for care. This surveyor alerted a nurse nearby. The nurse approached Resident #35's room door and asked Resident #35 if she needed to be changed. The nurse then stated that she would "get help" for Resident #35. At 3:02 P.M., two staff members, CNA B and CNA C, donned gown and gloves before entering Resident #35's room. CNA C was also wearing a eye protection and an N-95. CNA B was wearing eye protection and a surgical mask, not an N-95. CNA B and CNA C then entered Resident #35's room and closed the door. At 3:07 P.M., CNA B and CNA C exited Resident #35's room. For PPE, CNA B no longer had on a gown and gloves but CNA B was still wearing eye protection and surgical mask, not an N-95. CNA B and CNA C were observed then walking down the hall and entering the clean supply room. CNA B was then observed pushing the mechanical lift out of the clean storage room and down the hall to Resident #72's room. Resident #72 was observed in bed with a visitor at the bedside. Resident #72 was not wearing a mask and there was no signage on the door to indicate Resident #72 was on precautions. CNA B and CNA C then entered Resident #72's room with the mechanical lift and shut the door. On 02/01/2022 at 3:21 P.M., CNA B was interviewed. For PPE, CNA B was wearing eye protection and a surgical mask, not an N-95. When asked about the appropriate PPE to don when entering Resident #35's room, CNA B stated PPE includes an N-95. When asked why she was not wearing an N-95 before/during/after	F 880		

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F 880	Continued From page 31 entering Resident #35's room, CNA B stated she was just trying to help assist with incontinence care and "forgot to put N-95 on." On 02/01/2022 at 4:06 P.M., CNA B approached this surveyor in the hall. CNA B stated that she now had her N-95 on. CNA B was observed to have the N-95 on over the surgical mask. The surgical mask extended out beyond the edges of the N-95, compromising the N-95 seal. When asked if she received training about PPE, CNA B stated, "Yes." When asked about the difference between an N-95 and a surgical mask, CNA B stated, "I don't know" and "N-95 protects you better but I can't remember." On 02/01/2022 and 02/02/2022, Resident #35's clinical record was reviewed. An excerpt of a nurse's note dated 01/23/2022 at 3:46 P.M. documented the following excerpt: "Tested for COVID and was positive. Droplet Precautions and isolation orders in place." On 02/01/2022 and 02/02/2022, a review of Resident #72's clinical revealed that Resident #72 had been fully vaccinated and had recently tested positive for COVID-19 (01/11/2022). On 02/02/2022, the facility staff provided their staff vaccination spreadsheet. CNA B received the first COVID-19 vaccine on 12/06/2021. CNA B cells for "Second Dose" and "Booster" were blank. In the column labeled "Vaccination Fully Completed?" it was documented, "No (needs 2nd)." On 02/02/2022, the facility staff provided a copy of their policy entitled, "COVID-19 Infection Prevention and Control." On page 4, paragraph 4,	F 880		

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F 880	Continued From page 32 it was documented, "With Residents in warm or hot zones or otherwise requiring transmission-based precautions, or for all residents on affected units (or facility-wide if cases are widespread) during outbreak: Use an N-95 or higher level respirator, eye protection, gloves, and gown." On page 4, paragraph 5 pertaining to staff not fully vaccinated, an excerpt documented, "Additional Requirements Include: Wearing a NIOSH-approved N-95 or equivalent or higher-level respirator for source control regardless of whether providing direct care to or otherwise interacting with resident." On 02/02/2022 at 4:40 P.M., the administrator and Director of Nursing (DON) were notified of findings. When asked about the expectations for appropriate PPE usage for COVID-19 positive Residents, the administrator stated that staff have been trained and the expectation is that staff would wear an N-95, eye protection, gown, and gloves in the room of Residents on isolation for COVID-19.	F 880		
F 887 SS=D	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	F 887		3/18/22

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F 887	Continued From page 33 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 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 or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (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:	F 887		

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F 887	Continued From page 34 (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, clinical record review, and facility documentation review, the facility staff failed to provide COVID-19 immunization for 1 resident, Resident #6, in a survey sample of 5 residents reviewed for COVID-19 immunization. The findings included: The facility staff failed to provide COVID-19 immunization for Resident #6. On 2/2/22, clinical record review was performed for Resident #6 and revealed no documentation of COVID-19 immunization. Resident #6 was admitted to the facility on 11/4/21. A facility Resident Vaccine Report was requested and received from the Infection Preventionist (IP). This document revealed Resident #6 had received the first dose of the Moderna vaccine on 3/29/21 prior to admission to the facility. An interview was conducted with the IP who confirmed Resident #6 was not fully vaccinated for COVID-19 at the time of admission to the facility. The IP stated the reason Resident #6 was not offered a COVID-19 vaccine was an "oversight"	F 887	1) COVID- 19 vaccination education was provided to Resident #6□s representative and consent given for vaccination. She received her 2nd vaccination on February 8, 2022 which was as soon as it was available. 2) The Infection Preventionist/designee will review all current residents for eligibility to receive additional doses of COVID -19 vaccine. All eligible residents will be educated on the risks and benefits and offered the vaccine. The vaccine will be administered to all consenting resident when it is next available and the medical record will be updated to reflect current vaccination status. 3) The Director of Clinical Support/designee will educate all RNs and LPNS on the COVID- 19 Vaccine Policy. The in-service will include but is not limited to the importance of timely vaccination. Additionally, in-service will review the process for confirming COVID-19 vaccination status upon admission and steps for notifying the Infection Preventionist of eligible resident to ensure	

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F 887	Continued From page 35 that was discovered on 1/13/22 during a booster screening process for all residents in the facility and confirmed that Resident #6 required a second Moderna COVID-19 vaccine to complete the series in order to be fully vaccinated. On 2/3/22, an interview was conducted with the IP and the Director of Clinical Support (DCS). The DCS confirmed on 11/10/21 and 12/8/21 the Moderna COVID-19 vaccine was available at the facility. Review of the facility policy entitled, "COVID-19 VACCINE", subtitle, "Purpose", read, "Maximizing COVID-19 vaccination rates in the facility will help reduce the risk residents and staff have of contracting and spreading COVID-19". The Facility Administrator and Director of Nursing were updated. No further information was provided.	F 887	timely administration of vaccine and documentation. 4) The Infection Preventionist/designee will audit 100% of current resident records weekly for six weeks to ensure COVID 19 vaccination eligibility is identified and the appropriate dose is offered and administered when available. Any variances identified will be corrected. The Infection Preventionist /Designee will report findings to the Quality Assurance and Performance Improvement committee.	