STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 11/19/2021

NAME OF PROVIDER OR SUPPLIER
STANLEYTOWN HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
240 RIVERSIDE DRIVE
BASSETT, VA 24055

(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 11/16/21 through 11/19/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/16/21 through 11/19/21. One complaint VA00053101, was substantiated with deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 22 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		1/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/17/2021

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

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F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to accurately complete DDNR's for 2 of 25 residents, Residents #34 and #97. The findings included: 1. Resident #34's clinical record included the diagnoses of of diabetes, depression, and hypertension. Section C (cognitive patterns) of Resident #34's quarterly MDS (minimum data set) assessment	F 578	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	

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F 578	Continued From page 2 with an (ARD) assessment reference date of 10/01/21 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. Resident #34's clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 01/07/21 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. 11/18/2021 8:40 a.m., LPN (licensed practical nurse) #1 was interviewed and stated that the DDNR was incomplete. 11/19/21 1:30 p.m., the administrator, DON (director of nursing), and nurse consultant were made aware of the incomplete DDNR. No further information was provided regarding the incomplete DDNR prior to the exit conference. 2. Resident #97's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/25/21, was completed on 11/2/21. Resident #97 was assessed as able to make self understood and as able to understand others. Resident #97's BIMS (Brief Interview for Mental Status) summary score was a 10 out of 15 (indicating moderate cognitive impairment).	F 578	deficiencies cited have been or will be corrected by the date or dates indicated. F 578 1. Resident # 34 and 97 DDNR form was updated at the time of survey. 2. Current residents in the center were audited for accuracy of the DDNR forms and to validate resident wishes. 3. Licensed nurses will be educated by the DON/designee on the DDNR form and the process to get these in place and completed by the practitioner. 4. The DON/designee will review new admissions during clinical meeting to assure the DDNR form is in place and completed in its entirety. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	

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F 578	Continued From page 3 Resident #97's provider orders included active orders for comfort care and DNR (do not resuscitate). Resident #97's clinical documentation included a signed Virginia Department of Health DDNR Order form dated 10/21/21. This form included two (2) areas that had to be completed by a medical provider. The first area required the medical provider to certify if the individual was capable of making an informed decision related to initiating the DDNR order. The medical provider indicated Resident #97 was "incapable" of making such a decision. By indicating Resident #97 was not capable of making an informed decision about initiating the DDNR, the medical provider was required to complete the second area of the DDNR Order form. The second area required the medical provided to select one (1) of three (3) options to document how the decision to implement the DDNR Order was made due to the resident not currently being capable of making an informed decision. This second part was not completed. The incomplete DDNR Order form had been signed by a medical provider. The following information was found in a facility policy titled "Do Not Resuscitate" (with an effective date of 3/24/20): "A Virginia Department of Health Durable Do Not Resuscitate (DNR) Order form is a valid order. A licensed nurse verifies that the individual in question is the patient for whom the order is issued, and that the document is the original, or a legible copy of the DDNR form, that it has not been altered, that the form has been filled in completely, and that no signature(s) are missing. If the said DDNR form	F 578		

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F 578	Continued From page 4 is not intact or has been altered, or has not been filled out completely, it is not considered valid for withholding CPR. If there is any question about the validity of a Virginia DDNR Order form, resuscitative measures should be administered until the validity of the order is established." During a survey team meeting with the facility's Administrator, Director of Nursing (DON) and Regional Nurse Consultant (RNC) on 11/18/21 at 12:10 p.m., the failure of the facility staff to ensure Resident #97's DDNR form was correctly completed was discussed.	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review, and facility document review, the facility staff failed to implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of resident and misappropriation of resident property as evidenced by failure to pre-screen 5 of 25 new hire employees (LPN (licensed practical nurse)	F 607	F 607 1. Reference checks were obtained for LPNS #1,4,16,17 and 20. 2. A review of current agency staff scheduled to work in the center have been completed to ensure references checks are completed and placed in the personnel file.	1/3/22

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F 607	Continued From page 5 #1, LPN #4, LPN #16, LPN #17, and LPN #20). The findings included: The facility staff failed to obtain reference checks for agency LPNs #1, #4, #16, #17 and #20. A review of the employee records provided by the facility for agency LPNs #1, #4, #16, #17, and #20 revealed the following documentation: LPN #1 was employed through (name omitted) staffing agency on 10/11/21. LPN #1's employee record did not contain documentation of a reference check review. LPN #4 was employed through (name omitted) staffing agency on 9/13/21. LPN #4's employee record did not contain documentation of a reference check review. LPN #16 was employed through (name omitted) staffing agency on 10/14/21. LPN #16's employee record did not contain documentation of a reference check review. LPN #17 was employed through (name omitted) staffing agency on 9/08/21. LPN #17's employee record did not contain documentation of a reference check review. LPN #20 was employed through (name omitted) staffing agency on 11/11/21. LPN #20's employee record did not contain documentation of a reference check review. On 11/19/21 at 9:24 am, the administrator was interviewed and stated for the (name omitted) agency staff "that is all I will have for them."	F 607	3. The Human Resource Director and the scheduler will be educated by the Administrator/designee to obtain reference checks from the agencies at the time of scheduling them to work in the facility. 4. The scheduler will obtain copies of reference checks at the time the agency nurse is placed on the schedule to work. The Administrator/designee will review new agency staff files weekly to ensure reference checks have been completed prior to working their scheduled shift. 5. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	

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F 607	Continued From page 6 The facility policy entitled "Prevention/Screening/Training" stated in part "criminal background and reference checks are performed on all employees." On 11/19/21 at 1:30 pm, during a meeting with the administrator, director of nursing, and regional nurse consultant, surveyor discussed the concern of the missing reference check reviews for agency LPNs #1, #4, #16, and #17 and #20. No further information regarding these issues was presented to the survey team prior to the exit conference on 11/19/21.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) for 1 of 25 residents in the survey sample, Resident #103. For Resident #103, the facility staff coded the resident as being discharged to an acute hospital when in fact the resident had been discharged home. The findings included: Resident #103's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia without Behavioral Disturbance, Muscle Weakness, Adult Failure to	F 641	F 641 1. Resident # 103 MDS was corrected at the time of survey. 2. A review of residents discharged home in the past 30 days was reviewed to ensure the MDS was coded correctly. 3. MDS staff will be educated by the Regional DAVS/designee on accurate coding MDS for discharge disposition. 4. The Regional DAVs /designee will monitor 5 discharges weekly to ensure the MDS has been coded correctly for discharge disposition. 5. The results will be reported to the monthly to the Quality Assurance	1/3/22

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F 641	Continued From page 7 Thrive, and Bipolar Disorder. The most recent discharge MDS with an ARD (assessment reference date) of 10/09/21 assigned the resident a BIMS (brief interview for mental status) score of 7 out of 15 in section C, Cognitive Patterns. Resident #103 was coded as being discharged to an acute hospital in section A, Identification Information. A review of Resident #103's clinical record revealed a physician's order stating in part "Discharge Date: 10/09/21, Home Health Agency (name omitted) PT (physical therapy) - OT (occupational therapy) - NSG (nursing), Equipment Needs: N/A. Res (resident) may d/c (discharge) home with remaining narcotics." A nursing progress note dated 10/09/21 11:41 am stated in part, "Resident discharged home today." On 11/17/21 at 12:27 pm, the MDS RN (registered nurse) #1 was interviewed and asked if the MDS was coded for discharge to an acute hospital when the resident was discharged home. The MDS RN #1 stated "I believe it does say that." On 11/18/21 at 12:10 pm, the administrator, director of nursing, and the regional nurse consultant were notified of the inaccurate Discharge MDS assessment for Resident #103. No additional information regarding this concern was presented to the survey team prior to the exit conference on 11/19/21.	F 641	Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		1/3/22

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F 657	Continued From page 8 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must 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 staff interview and clinical record review, the facility staff failed to review and revise comprehensive care plans for 3 of 25 residents, Residents #1, #104, and #42. For Resident #1, the facility staff failed to review and revise the residents care plan when a PICC line was discontinued. For Resident #104, the care plan included the focus area for enhanced droplet precautions when Resident #104 was not on	F 657	F 657 1. Residents # 1, 104 and 42 care plans were updated at the time of survey. 2. Current residents in the center have the potential to be affected. 3. Licensed staff will be educated by the Staff Development Coordinator/designee on the facility policy for updating and revising resident care plans.	

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F 657	Continued From page 9 enhanced droplet precautions. Resident #42's care plan failed to address the resident's significant weight loss. The findings included: 1. Resident #1's diagnoses included, but were not limited to, hypertension, gastro-esophageal reflux disease, chronic atrial fibrillation, acute kidney failure, and peripheral vascular disease. Section C (cognitive patterns) of Resident #1's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/20/21 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points. Resident #1's current CCP (comprehensive care plan) included the focus area "PICC line Left arm." with a revision date of 03/19/21. On 11/18/21 at 8:11 a.m., two agency nurses were asked about the resident's CCP's and stated they were not aware where the care plans were located. The unit manager reviewed Resident #1's CCP and stated the PICC line had been discontinued and identified themselves and the MDS coordinator as the staff responsible for updating care plans. A review of Resident #1's clinical record on 11/18/21 revealed that the resident's PICC line had been discontinued in April 2021. On 11/19/21 at 1:30 p.m., the administrator, DON (director of nursing), and nurse consultant were made aware of the issue regarding the residents PICC line remaining on the CCP months after it	F 657	4. DON/ Designee will monitor 5 care plans weekly to assure that care plans have been updated and revised to reflect the resident□s current status. 5. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis 6. Completed 1/03/22	

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F 657	Continued From page 10 had been discontinued. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Resident #104's clinical record included the diagnoses of muscle weakness, end stage renal disease, dependence on renal dialysis, and gastro-esophageal reflux disease. Section C (cognitive patterns) of Resident #104's admission (readmit) MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/11/21 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. Resident #104's current care plan included the focus area "The resident is enhanced droplet r/t (related to) admit." Created date 10/19/20 revision date 11/09/20. Interventions included, "Enhanced Droplet and Contact precautions." Resident #104's clinical record did not include an order for droplet or contact precautions. On 11/18/21 at 10:26 a.m., the nurse consultant verified that Resident #104 had received their second dose of the COVID-19 vaccine on 11/02/21 and stated Resident #104 meet the criteria for being fully vaccinated, did not need to be on isolation, and that they had pulled the old care plan across from a previous admit. On 11/18/2021 at 10:45 a.m., the nurse consultant provided the policy titled "COVID-19." This policy read in part, "...New Admissions/Readmissions/Return to Center from	F 657		

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F 657	Continued From page 11 outside visits (including hemodialysis patients): Place new admission/readmission in a designated area of the Center. Quarantine is not recommended for patients who are being admitted if they are fully vaccinated..." On 11/19/21 at 1:30 p.m., the administrator, DON (director of nursing), and nurse consultant were made aware of the issue regarding the residents care plan in regards to isolation. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. Resident #42's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/2/21, was completed on 10/5/21. Resident #42 was assessed as able to understand others and as able to make themselves understood. Resident #42's Brief Interview for Mental Status (BIMS) summary score was documented as a five (5) out of 15 (this indicated severe cognitive impairment). Resident #42 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #42's diagnoses included, but were not limited to: pneumonia, thyroid disorder, osteoporosis, dementia, and lung disease. Resident #42's clinical documentation included the following weights: 9/9/21 - 105.5 lbs (pounds), 9/25/21 - 99.4 lbs, 10/3/21 - 96.2 lbs, and 11/18/21 - 89.8 lbs The difference in the 9/9/21 and 10/3/21 weight was 9.3 lbs, a greater than 8% weight loss.	F 657		

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F 657	Continued From page 12 Resident #42's care plan included the following focus area: "Nutritional Risk: recent hospitalization, dementia, COPD, PNA (pneumonia), aspiration risk. Therapeutic diet-receives nutritional supplements to provide extra kcals/protein. (history of weight) fluctuation, (resident) is on diuretic therapy." The goal for this focused area was: "The resident will maintain adequate nutritional status (as evidenced by) no significant weight change by next review." This nutritional care plan failed to address Resident #42's actual significant weight loss. The last revision to this focus area's interventions was dated 6/2/21 with "Provide and serve supplements as ordered" being the intervention added." The following information was found in a facility policy/procedure titled "Weight Monitoring and Tracking" (with an effective date of 11/1/19): "The Center has a system in place to weigh, monitor, and track patient's weights on a timely schedule. Weights are tracked and monitored by way of the interdisciplinary Weight Variance Committee...An interdisciplinary weight variance committee will meet at least monthly to discuss patients with significant weight change. Weekly weight meetings are encouraged and may be incorporated into other interdisciplinary team meetings...Significant weight changes will be identified and discussed by the interdisciplinary team using the table below" ... (information on the table indicated a 5% weight change in one (1) month and a 7.5% weight change in three (3) months were significant weight changes)." During an interview with the Director of Nursing	F 657		

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F 657	Continued From page 13 (DON) on 11/18/21 at 4:59 p.m., the DON reported no documentation was found to provide evidence of the care plan being revised to address Resident #42's aforementioned weight loss. The following information was found in a facility policy/procedure titled "Resident Assessment & Care Planning" (with an effective date of 11/1/19): "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individual care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient." During a survey team meeting with the facility's Administrator, DON, and Regional Nurse Consultant (RNC) on 11/18/21 at 5:16 p.m., the failure of the facility's staff members to review and revise Resident #42's care plan to address the resident's significant weight loss was discussed. No additional information related to this issue was provided to the survey team.	F 657		
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 staff interview, clinical record review, facility document review, and during a medication	F 658	F 658 1. Resident #37 is receiving medications	1/3/22

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F 658	Continued From page 14 pass and pour observation, the facility staff failed to provide services to meet professional standards of practice for 1 of 25 residents, Resident #37. For Resident #37, the facility staff signed that they had administered the medication Lexapro 10 mg, when it had not been administered. The findings included: Resident #37's face sheet listed diagnoses which included but not limited to depression, schizophrenia, hypertension, and insomnia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/24/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #37's comprehensive care plan was reviewed and contained a care plan, which read in part "The resident uses psychotropic medications r/t depression, suicidal ideation schizophrenia, insomnia". Interventions for this care plan included "administer meds as ordered". LPN (licensed practical nurse) #1 was observed on 11/17/21 at 8:45 am during a medication pass and pour. LPN #1 prepared and administered the medications Colace 100 mg, Lexapro 5 mg, Miralax 17 gm, Claritin 10 mg and Azelastine HCl nasal spray, 2 sprays per nostril to Resident #37. LPN #1 did not administer Lexapro 10 mg to Resident #37. Resident #37's clinical record was reviewed and contained a physician's order summary for the	F 658	as per physician orders. Employee #1 was educated immediately on the 5 R(s) of medication administration. 2. Current residents in the center have the potential to be affected. 3. Licensed staff will be educated by the Staff Development Coordinator/designee on the 5 R(s) of medication administration. 4. DON/Designee will conduct medication observations five times per week to ensure medications are given as ordered and the 5 R(s) of medication administration is being completed. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	

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F 658	Continued From page 15 month of November 2021, which read in part "Lexapro Tablet 10 mg (Escitalopram Oxalate). Give 1 tablet by mouth in the morning for Depression" and, "Lexapro Tablet 5 mg (Escitalopram Oxalate). Give 1 tablet in the morning for Depression." Resident #37's eMAR (electronic medication administration record) was reviewed and contained entries as above. Both of the entries had been initialed as being administered on 11/17/21 for the 9:00 am dose. Resident #37's medications were reconciled on 11/17/21. Upon reconciliation of medications, LPN #1 was asked if they had administered Resident #37's Lexapro 10 mg. LPN #1 stated they had misunderstood about the Lexapro, that they had pulled a 10 mg card, put it back and pulled a 5 mg card, since that was correct dose. LPN #1 was asked to confirm the order, and LPN #1 stated that Resident #37 was supposed to receive both doses. LPN #1 pulled the 10 mg dose and administered at this time (11:48 AM). LPN #1 was asked if they realized they had signed for both doses, but had actually only administered one. LPN #1 stated they did and was sorry. The DON (director of nursing) was interviewed on 11/17/21 at 12:20 pm and asked for the facility standard of practice in regards to medication administration. On 11/17/21 at 12:40 pm, DON provided the facility policy entitled "General Guidelines for Medication Administration", which read in part "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. 6. At a minimum,	F 658		

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F 658	Continued From page 16 the 5 Rights-right resident, right drug, right dose, right route, and right time-should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and medication is put away. 7. Always employ the MAR (medication administration record) during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label." The DON was asked if this was their standard of practice, and DON stated that it was. The concern of not following professional standards of practice for the administration of medications was discussed with the administrative staff (administrator, director of nursing, regional nurse consultant) during an end of day meeting on 11//17/21 at 4:15 pm. No further information was provided prior to exit.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure that residents who were unable to carry out ADL's (activities of daily living) received the	F 677	F 677 1. Residents # 62, #1 and #104 are receiving the necessary care and services for personal hygiene, including incontinence care and nail care.	1/3/22

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F 677	Continued From page 17 necessary care and services to maintain personal hygiene for 3 of 25 Residents, Residents #62, #1 and #104. The facility staff failed to provide incontinence care for Resident #62. For Resident #1 and #104, the facility staff failed to provide nail care. Resident #1 and #104's toenails were observed long and jagged. The findings included: 1. Resident #62's diagnoses included, but were not limited to, muscle weakness, diabetes, anxiety disorder, and chronic kidney disease. Section C (cognitive patterns) of Resident #62's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/09/21 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded 3/2 extensive assistance of one person for toilet use and personal hygiene. Section H (bladder and bowel) was coded to indicate the resident was frequently incontinent of urine. Resident #62's comprehensive care plan included the focus areas for ADL self-care performance deficit and bladder incontinence. Interventions included, but were not limited to, personal hygiene provide set up and assist with hygiene needs as indicated. Clean peri-area with each incontinence episode. On 11/16/21 at 2:59 p.m., Resident #62 stated "I was last changed (brief) before breakfast" and indicated they were in need of incontinence care. On 11/16/21 3:31 p.m., CNA (certified nursing assistant) #1 provided incontinence care. CNA #1	F 677	2. Current residents in the center have the potential to be affected. 3. Nursing staff will be educated by the Staff Development Coordinator/designee on providing the necessary care and services to maintain personal hygiene including incontinence and nail care. 4. DON/Unit Manager and Designee will monitor incontinence care/nail care for 10 residents weekly (who require assistance to maintain personal hygiene) via direct observations during rounding to ensure residents are receiving care. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	

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F 677	Continued From page 18 stated Resident #62 was changed after breakfast. Resident #62 again stated it was before breakfast. Resident #62's brief and pad were observed saturated with urine. On 11/18/21 at 9:05 a.m., Resident #62 stated they had not been changed since last night around 10:30 p.m. Resident #62 stated a staff came in around 3:30 a.m. and they had asked them to come back and no one ever came back. Resident #62 added that they had fallen asleep during that timeframe and they were a heavy wetter. On 11/18/21 at 9:18 a.m., CNA #2 entered the room to change Resident #62. Resident #62's pad and brief were observed saturated with urine. CNA #2 confirmed the pad and brief were saturated. The administrator, DON (director of nursing), and nurse consultant were notified of the issue of Resident #62 being left wet for an extended period of time on 11/17/21 and again on 11/19/21 at 1:30 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Resident #1's diagnoses included, but were not limited to, hypertension, gastro-esophageal reflux disease, chronic atrial fibrillation, acute kidney failure, and peripheral vascular disease. Section C (cognitive patterns) of Resident #1's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/20/21 included a BIMS (brief interview for	F 677		

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F 677	Continued From page 19 mental status) summary score of 12 out of a possible 15 points. Section G (functional status) was coded to indicate the resident required (3/2) extensive assistance of one person for personal hygiene and had limited range of motion in the upper and lower extremities. Resident #1's comprehensive care plan included the focus area of has an ADL self-care performance deficit. Interventions included, but were not limited to, personal hygiene/oral care provide set up and assist with oral/dental care and hygiene needs as indicated. On 11/17/21 at 2:35 p.m., Resident #1's toenails on right foot were observed long and jagged. Resident #1 stated they were supposed to have had them cut by the doctor but maybe the facility staff forgot. On 11/17/21 during a meeting with the administrator, DON (director of nursing), and nurse consultant, the DON stated the staff cut the resident's nails unless they are a diabetic. The nurse consultant stated they did not have a policy specific to nail care. The administrator, DON, and nurse consultant were notified of the issue of Resident #1's toenails on 11/17/21 and again on 11/19/21 at 1:30 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. Resident #104's clinical record included the diagnoses of muscle weakness, end stage renal disease, dependence on renal dialysis, gout, and	F 677		

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F 677	Continued From page 20 gastro-esophageal reflux disease. Section C (cognitive patterns) of Resident #104's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/11/21 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. Section G (functional status) was coded to indicate the resident required limited assistance (2/2) of one person for personal hygiene and used a wheelchair for mobility. Resident #104's current care plan included the focus area of has an ADL performance self-care deficit, has limited physical mobility, and pain related to gout. Interventions included, but were not limited to, personal hygiene provide set up and assist with oral/dental care and hygiene needs as indicated. On 11/17/21 at 3:00 p.m., Resident #104's toenails were observed long and jagged. Resident #104 also stated that their fingernails needed to be trimmed. On 11/17/21 during a meeting with the administrator, DON (director of nursing), and nurse consultant the DON stated the staff cut the resident's nails unless they are a diabetic. The nurse consultant stated they did not have a policy specific to nail care. On 11/19/21 at 1:30 p.m., the administrator, DON, and nurse consultant were made aware of the issue regarding the residents nails. No further information regarding this issue was provided to the survey team prior to the exit	F 677		

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F 677	Continued From page 21 conference.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review the facility staff failed to follow physician's orders for 3 of 25 residents, Resident #79, Resident #68, and Resident #10. For Resident #79 the facility staff failed to check resident's blood pressure prior administering the medication Metoprolol, per the physician's order. For Resident #68 the facility staff failed to follow physician's orders for the administration of prn (as needed) medications for constipation. For Resident #10, the facility staff failed to follow physician ordered parameters when administering blood pressure medications. The findings included: 1. Resident #79's face sheet listed diagnoses which included, but not limited to dementia, anemia, anxiety, gastroesophageal reflux disorder, insomnia, psychotic disorder, and hypertension. The most recent quarterly MDS (minimum data	F 684	F 684 1. Resident #79, #68 and # 10 are receiving medications as per physician orders. Resident #68 has been placed on a routine bowel protocol. Review of EMAR for current residents in the center for the last 30 days was completed to ensure medications were given as per MD orders with checking B/P(s) and holding medications with ordered parameters. Bowel records for current residents in the center were audited to ensure residents are having a BM q 3days and/or prn medications are administrated for residents not having a BM q3 days. 2. Licensed staff will be educated by the staff development coordinator/designee on the 5 R(s) of medication administration. In addition, the education will include monitoring BM records to ensure residents are having BM(s) q3 days. 3. DON/Designee will conduct	1/3/22

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F 684	Continued From page 22 set) with an ARD (assessment reference date) of 10/27/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15. This indicated that the resident was severely cognitively impaired. Resident #79's comprehensive care plan was reviewed and contained a care plan for, "The resident has hypertension (HTN) r/t (related to) lifestyle choices, history of Smoking, HLD (hyperlipidemia)." Interventions for this care plan included "Meds as ordered" and "Vital signs as needed." Resident #79's clinical record was reviewed on 11/18/21 and contained a signed physician's order summary for the month of November 2021, which read in part "Metoprolol Succinate ER Extended Release 24 Hour 25 MG. Give I tablet by mouth one time a day for HTN (hypertension). Hold if BP (blood pressure) is 115 or less or pulse is less than 60." Resident #79's eMAR (electronic medication administration record was reviewed and contained an entry, which read , "Metoprolol Succinate ER Extended Release 24 Hour 25 MG. Give I tablet by mouth one time a day for HTN (hypertension). Hold if BP (blood pressure) is 115 or less or pulse is less than 60." This entry did not have an area to record the resident's blood pressures. The RNC (regional nurse consultant) was interviewed on 11/18/21 at 3:40 pm regarding the resident's blood pressure. The RNC was asked if staff should be checking and recording the resident's blood pressures prior to the administration of the medication. The RNC	F 684	medication observations 5x weekly to ensure medications are given as ordered and the 5 R(s) of medication are being completed. In addition, BM records will be monitored 5x/weekly to ensure residents are having BM q3 days and administrating prn medication if indicated. 4. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 5. Completed 1/03/22	

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F 684	Continued From page 23 stated, "That would be my expectation." The RNC stated to check under vital signs tab in the electronic medical record to see if blood pressures were being record there. There were only two blood pressures recorded in this area for Resident #10 for the month of November. The concern of the facility staff not checking the resident's blood pressures prior to the administration of the medication, Metoprolol, per the physician's order was discussed with the administrative team (administrator, director of nursing, regional nurse consultant) during an end of day meeting on 11/18/21 at 5:15 pm. No further information was provided prior to exit. 2. Resident #68's face sheet listed diagnoses which included but not limited to chronic obstructive pulmonary disease, dementia, depression, anxiety, chronic kidney disease, gastroesophageal reflux disease, and constipation. Resident #68's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/22/21 assigned the resident a BIMS (brief interview for mental status) score of 10 out 15 is section C, cognitive patterns. This indicated that the resident was moderately cognitively impaired. Resident #68's comprehensive care plan was reviewed and contained a care plan for, "The resident has risk for constipation r/t (related to) decreased mobility." The goal for this care plan was, "The resident will have a normal bowel movement at least every 3rd day through the review date." Interventions for this care plan	F 684		

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F 684	Continued From page 24 include "adm (administer) meds as ordered." Resident #68's clinical record was reviewed on 11/17/21 and contained a physician's order summary for the month of November 2021, which read, "Dulcolax Milk of Magnesia Suspension (Magnesium Hydroxide). Give 30 ml by mouth every 8 hours as needed for constipation" and "Dulcolax Tablet Delayed Release (Bisacodyl). Give 10 mg by mouth every 24 hours as needed for constipation." Resident #68's eMAR (electronic medication administration record) for the month of November 2021 was reviewed and contained entries as above. The entry for Milk of Magnesia was initialed as being given on 11/06/21 at 2030 (9:30 pm), and coded with "I" meaning "ineffective". The order for Dulcolax had not been initialed for the month of November. Resident #68 was interviewed on 11/17/21 at 2:25 pm. Resident #68 stated, "I can't poop. It hurts so bad." Resident #68's bowel movement record in the electronic record was reviewed on 11/17/21. The bowel movement record indicated that Resident #68 had a bowel movement on 11/03/21 and did not have another bowel movement until 11/10/21, for a total of 6 days with no bowel movement. The DON stated they would print off the bowel movement report for Resident #68. As of 12 pm on 11/19/21, this had not been received. No further information was provided prior to exit. 3. Resident #10's clinical record included the diagnoses hypertension, congestive heart failure,	F 684		

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F 684	Continued From page 25 dementia, and anxiety. Section C (cognitive patterns) of Resident #10's significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/01/21 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. Resident #10's clinical record included orders for following hypertensive medications: Amlodipine Besylate 5 mg 1 tablet by mouth at bedtime hold if heart rate is less than 55 or SBP (systolic blood pressure), (top number) is less than 100. Start date 11/16/20. Hydralazine 100 mg 1 tablet by mouth three times a day for hypertension hold if heart rate is less than 55 of SBP less than 100. Start date 11/16/20. Metoprolol Tartrate 12.5 mg two times a day for hypertension hold if heart rate is less than 55 or SBP less than 100. Start date 11/16/20. A review of Resident #10's eMARs (electronic medication administration records) revealed that the nursing staff had documented a 15 for the medication Metoprolol Tartrate on 11/06/21 at 9:00 p.m. for a BP (blood pressure) of 115/72 and a heart rate of 58, on 11/11/21 at 9:00 p.m. for a BP of 107/60 and a heart rate of 72, and on 11/15/21 for a BP of 121/76 and a heart rate of 55. Per the preprinted code on the eMAR a 15 meant "No coverage required." On 11/17/21 at 11:53 a.m., the nurse consultant stated they were unable to find any further	F 684		

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F 684	Continued From page 26 information in regards to the blood pressure medication metoprolol being held. Further review of the eMARs revealed that the nursing staff had also held the hypertensive medications Hydralazine and Amlodipine Besylate. For the hypertensive medication Hydralazine the nursing staff had documented a 15 "No coverage required" on 11/06/21 at 9:00 p.m. for a BP of 115/72 and a heart rate of 58, on 11/11/21 at 1:00 p.m. for a BP of 103/57 and a heart rate of 69, at 9:00 p.m. for a BP of 107/60 and heart rate of 72, and on 11/15/21 at 9:00 p.m. for a BP of 121/76 and heart rate of 55. For the medication Amlodipine Besylate on 11/11/21 at 9:00 p.m, the nursing staff had documented a BP of 107/60 and a heart rate of 72. There was no documentation for a BP or heart rate on 11/06/21 or on 11/15/21 at 9:00 p.m., the medication boxes were marked with an "X." The nursing staff had documented a 15 on the eMAR for both of these dates. The administrator, DON (director of nursing), and nurse consultant were made aware that the facility staff had not followed the physician ordered parameters in regards to BP medications on 11/17/21 and again on 11/19/21 at 1:30 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		1/3/22

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F 695	Continued From page 27 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, the facility staff failed to provide respiratory services and/or care for two (2) of 25 residents, Resident #42 and Resident #158. The facility staff failed to ensure Resident #42's oxygen was provided when the resident was transported outside to the facility's gazebo for a family visit. The facility staff failed to consistently complete respiratory assessments every shift as detailed in Resident #158's COVID-19 care plan. The findings include: 1. Resident #42's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/2/21, was completed on 10/5/21. Resident #42 was assessed as able to understand others and as able to make themself understood. Resident #42's Brief Interview for Mental Status (BIMS) summary score was documented as a five (5) out of 15 (this indicated severe cognitive impairment). Resident #42's diagnoses included, but were not limited to: pneumonia, thyroid disorder, osteoporosis, dementia, and lung disease. A family member of Resident #42 (FM #1) was interviewed on 11/17/21. FM #1 reported, on	F 695	F 695 1. Resident #42 was assessed for any respiratory distress and oxygen was placed as ordered. Resident # 158 had a respiratory assessment completed and interventions for assessments were discontinue on the care plan due to resident no longer in Covid precautions. 2. Current residents in the center receiving oxygen have the potential to be affected. The care plans of resident who have recovered from COVID were reviewed to ensure the respiratory assessments every shift was removed from the plan of care. 3. Licensed staff will be educated by the Staff Development Coordinator/designee to follow MD orders and assuring residents have oxygen in place as ordered. 4. DON/Designee will monitor current residents who are receiving oxygen on daily rounds at least 5x weekly to assure that oxygen is being administrated as ordered. DON/ Designee will audit 10 care plans weekly to assure care plans have been updated/revised as needed. 5. The results will be reported to the	

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F 695	Continued From page 28 11/12/21, Resident #42 was being visited by family members. FM #1 reported that Resident #42 was brought outside the facility to the gazebo, while the family members made their way to the gazebo. When the family members arrived at the gazebo, Resident #42 was found unattended without their oxygen. On 11/17/21 at 3:20 p.m., the facility's Administrator and Regional Nurse Consultant (RNC) was informed that FM #1 reported Resident #42 was placed in the facility's gazebo without their oxygen. No documentation was found in Resident #42's clinical record related to the 11/12/21 family visit. A "SERVICE CONCERN REPORT" addressing the aforementioned concern, partially completed on 11/17/21 by the facility's Director of Nursing (DON), was provided to the survey team. The DON's investigation into this concern identified via staff interviews that Resident #42 was transported to the gazebo by a nursing student. The family visiting Resident #42 contacted the facility's receptionist requesting the resident's oxygen. The resident's oxygen was taken to the resident in the gazebo, as a result of the family's request. The following provider order was found in Resident #42's clinical record: "Oxygen Therapy - Oxygen at 3L Liters per minute via nasal cannula every shift for COPD." This order was dated 9/25/2021. Resident #42's care plan included the following focus area: "The resident has altered respiratory status/difficulty breathing (related to) COPD, chronic respiratory failure, Bronchiectasis [sic]."	F 695	monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	

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F 695	Continued From page 29 This focus area included the intervention of "OXYGEN SETTING: (oxygen) via (nasal cannula)." On 11/19/21 at 1:30 p.m., the facility's Administrator, Director of Nursing (DON), and RNC were part of a survey team meeting. During this meeting, the failure of facility staff to ensure Resident #42's oxygen was provided, as ordered, during a family visit was discussed. 2. Resident #158's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 11/5/21, was completed on 11/11/21. Resident #158 was assessed as being able to sometimes make themself understood by others and sometimes able to understand others. Resident #158's Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15 (this indicated severe cognitive impairment). Resident #158's diagnoses included, but were not limited to: high blood pressure, kidney disease, dementia, and depression. Review of Resident #158's clinical documentation on 11/18/21 failed to provide evidence of a respiratory assessment being completed every shift. On 11/18/21 at 3:35 p.m., the facility's Director of Nursing (DON) was interviewed about the missing respiratory assessments. The DON confirmed the resident assessments were not completed as care planned. The survey team was provided evidence of the completion of three (3) Respiratory Evaluations completed on 11/10/21 at 5:03 a.m.; 11/13/21 at 2:30 a.m.; and 11/14/21 at 12:39 a.m.	F 695		

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F 695	Continued From page 30 Resident #158's care plan included the focus area statement of: "The resident is Positive for COVID-19." Goals for this focus were: "The resident will be free of complications related to COVID-19 through next review...The resident will be free of symptom of respiratory distress through next review." Resident #158 was care planned with the intervention of: "Respiratory Assessment (every) shift and (as needed)." The failure of facility staff members to complete Resident #158's care planned respiratory assessments/evaluations was discussed with the facility's Administrator, Director of Nursing (DON), and RNC on 11/19/21 at 1:30 p.m.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		1/3/22

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F 755	Continued From page 31 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review and during a medication pass and pour observation the facility staff failed to ensure the medications Cymbalta 30 mg and Tylenol 325 mg were available for administration for 1 of 25 residents, Resident #8. The findings included: Resident #8's diagnoses included but were not limited to multiple sclerosis, depression, insomnia, hypertension, and quadriplegia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 09/03/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. This indicated that the resident was cognitively intact. Resident #8's comprehensive care plan was reviewed and contained a care plan for pain. Interventions for this care plan included "Medicate as ordered."	F 755	F 755 1. Resident # 8 medications were obtained and given when obtained from pharmacy. 2. Current residents in the center have the potential to be affected. 3. Licensed staff will be educated by the Staff Development Coordinator/designee on the process of what to do if medications are not available from the pharmacy. Education will also include notifications to the physician/RP. 4. DON/Designee will observe medication administration 5x weekly to ensure medications are given as ordered and that medications are available for administration. The missed medication report will be monitored 5x weekly to ensure medications are being administered as ordered. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be	

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F 755	Continued From page 32 LPN (licensed practical nurse) #2 was observed during a medication pass and pour on 11/17/21 at 8:30 am. LPN #2 prepared Resident #8's medications, but stated that they could not locate the resident's Cymbalta 30 mg or Tylenol 325 mg. LPN #2 stated they would contact the pharmacy to get the medications and let surveyor know when the medications arrived. On 11/17/21 at 11:50 am LPN #3 stated that they had gotten an order from the facility FNP (family nurse practitioner) to hold the resident's Cymbalta and Tylenol for the day. Resident #8's progress notes were reviewed and contained a note, which read in part "11/17/21 11:50. New order: Hold Cymbalta 30 MG x1 day and Tylenol 325 mg hold x 1 day ..." The facility policy entitled "Unavailable Medications" documented, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, or manufacturer's shortage of an ingredient, or may be a permanent situation due to the medication no longer being produced. The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedures: The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or	F 755	conducted on a random basis. 6. Completed 1/03/22	

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F 755	Continued From page 33 direction. 2. Obtain a new order and cancel/discontinue the order for the non-available medication. 3. Notify the pharmacy of the replacement order." The concern of the resident's medications not being available for administration was discussed with the administrative team (administrator, director of nursing, regional nurse consultant) during an end of day meeting on 11/17/21 at 4:15 pm. No further information was provided prior to exit.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		1/3/22

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F 756	Continued From page 34 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete drug regimen reviews for 4 of 25 residents and failed to follow up on a pharmacy recommendation for 1 of 25 residents. Residents #10, #34, #49 and #79. The findings included: 1. Resident #10's clinical record included the diagnoses hypertension, congestive heart failure, dementia, and anxiety. Section C (cognitive patterns) of Resident #10's significant change MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/01/21 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. On 11/18/21 at 4:16 p.m., during a review of the Resident #10's clinical record, the pharmacy drug	F 756	F 756 1. Physician for residents #10, #34, #49 and #79 was notified of missing pharmacy recommendation and no new orders. 2. An audit for Pharmacy recommendations for the last 30 days was completed to ensure recommendations were addressed by the physician. 3. DON/ Nursing Administration was educated by the Regional Director of Clinical Services/designee on the process of follow up on the recommendations and time frame to be completed. 4. DON/designee will audit pharmacy recommendations monthly to ensure they have been addressed by the physician. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 756	Continued From page 35 regimen review for July 2021 was not located. On 11/18/21 at 5:15 p.m., the missing drug regimen review was requested from the administrator, DON (director of nursing), and nurse consultant. The administrative staff stated they had recently changed their pharmacy. On 11/19/21 at 8:58 a.m., the DON stated they were unable to find a pharmacy drug regimen review for July 2021. No further information regarding the missing drug regimen review was provided to the survey team prior to the exit conference. 2. Resident #34's clinical record included the diagnoses of diabetes, depression, and hypertension. Section C (cognitive patterns) of Resident #34's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/01/21 included a BIMS (brief interview for mental status) summary score of 13 out of a possible 15 points. During a review of the Resident #34's clinical record, the pharmacy drug regimen review for July 2021 was not located. On the drug regimen review dated 08/06/21, the pharmacist had checked the box beside the statement, "See report for any noted irregularities and/or recommendations." No information in regards to this recommendation was located in the clinical record. On 11/18/21 at 5:15 p.m., the administrator, DON (director of nursing), and nurse consultant were	F 756	6. Completed 1/03/22	

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F 756	Continued From page 36 made aware of the missing information in regards to a pharmacy recommendation for August 2021 and drug regimen review for July 2021. The administrative staff stated they had recently changed their pharmacy. On 11/19/21 at 8:58 a.m., the DON stated they were unable to locate a drug regimen review for July 2021 and unable to find any information regarding the recommendation from the pharmacist for 08/06/21. No further information regarding the missing recommendation or drug regimen review was provided to the survey team prior to the exit conference. 3. Resident #49's diagnoses included but were not limited to, diabetes mellitus II, chronic kidney disease, anorexia, hypertension, hypothyroidism, insomnia, constipation, depression, dementia and anxiety. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/08/21 assigned the resident a BIMS (brief interview for mental status) score of 0 out of 15. This indicated that the resident was severely cognitively impaired. Resident #49's clinical record was reviewed on 11/18/21. The medication regimen review for the month of July 2021 was not located. On 11/18/21 the DON (director of nursing) was notified that the medication regimen review could not be located. On 11/19/21 the DON stated that the medication regimen review was not located. The concern of the facility staff not ensuring that the monthly medication regimen review was completed was discussed with the administrative	F 756		

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F 756	Continued From page 37 team (administrator, director of nursing, regional nurse consultant) on 11/18/21 at 5:15 pm. No further information was provided prior to exit. 4. Resident #79's face sheet listed diagnoses which included, but not limited to dementia, anemia, anxiety, gastroesophageal reflux disorder, insomnia, psychotic disorder, and hypertension. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/27/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15. This indicates that the resident is severely cognitively impaired. Resident #79's clinical record was reviewed on 11/18/21. A medication regimen review for the month of July 2021 was not located. On 11/18/21 the DON (director of nursing) was notified that the medication regimen review could not be located. On 11/19/21 the DON stated that the medication regimen review was not located. The concern of the facility staff not ensuring that the monthly medication regimen review was completed was discussed with the administrative team (administrator, director of nursing, regional nurse consultant) on 11/18/21 at 5:15 pm. No further information was provided prior to exit.	F 756		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F 757		1/3/22

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F 757	Continued From page 38 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 25 residents was free from unnecessary medications, Resident #49. The facility staff failed to hold the blood pressure medication, hydralizine, when it should have been held based on a blood pressure reading/pulse on 6 occassions in the month of November 2021. The findings included: Resident #49's diagnoses included but were not limited to, diabetes mellitus II, chronic kidney disease, anorexia, hypertension, hypothyroidism, insomnia, constipation, depression, dementia and anxiety.	F 757	F 757 1. Resident #49 physician was made aware of the administration of the medication and not following ordered perimeters. No new orders. 2. Current residents in the center have the potential to be affected. 3. Licensed staff will be educated by the Staff Development Coordinator/designee on following MD orders with perimeters when administering medications. 4. DON/Designee will conduct medication observations five times per week to ensure medications are given as ordered and the 5 R(s) of medication are being completed, including medications	

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F 757	Continued From page 39 The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/08/21 assigned the resident a BMS (brief interview for mental status) score of 0 out of 15. This indicated that the resident was severely cognitively impaired. Resident #49's clinical record was reviewed on 11/18/21 and contained a physician's order summary for the month of November 2021, which read, "hydrALAZINE HCl tablet 50 mg. Give 1 tablet by mouth two times a day for HTN (hypertension). Hold if SBP (systolic blood pressure) is less than 115 or pulse is less than 60." Resident #49's eMAR (electronic medication administration record) for the month of November 2021 was reviewed and contained an entry which read, "hydrALAZINE HCl tablet 50 mg. Give 1 tablet by mouth two times a day for HTN (hypertension). Hold if SBP (systolic blood pressure) is less than 115 or pulse is less than 60." This entry was initialed as administered on 11/03/21 at 9:00 am with a SBP of 107, on 11/03/21 at 8:00 pm with a SBP of 100, on 11/04/21 at 9:00 with a SBP of 100, on 11/06/21 at 8:00 pm with a SBP of 113, on 11/09/21 at 8:00 pm with a SBP of 113, and on 11/11/21 at 9:00 am with a SBP of 101 and a pulse of 58. The director of nursing (DON) was interviewed on 11/18/21 at 2:30 pm regarding Resident #49's medications. The DON stated the medication should not have been administered on the above dates/times.	F 757	with perimeters. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	

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F 757	Continued From page 40 The concern of the facility staff failing to ensure the resident was free of unnecessary medications was discussed with the administrative team (administrator, director of nursing, regional nurse consultant) on 11/18/21 at 5:15 pm. No further information was provided prior to exit.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5%. There were two errors in 26 opportunities for a medication error rate of 7.69%. The findings included: Resident #37's diagnoses included but were not limited to, depression, schizophrenia, hypertension, and insomnia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/24/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident was cognitively intact.	F 759	F 759 1. Resident #37 is receiving medications as per physician orders. 2. Current residents in the center have the potential to be affected. 3. Licensed staff will be educated by Staff Development Coordinator/designee on the five R(s) of medication administration. 4. DON/Designee will conduct medication observations five times per week to ensure medications are given as ordered and the 5 R(s) of medication are being completed. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	1/3/22

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F 759	Continued From page 41 LPN (licensed practical nurse) #1 was observed on 11/17/21 at 8:45 am during a medication pass and pour. LPN #1 prepared and administered the medications Colace 100 mg, Lexapro 5 mg, Miralax 17 gm, Claritin 10 mg and Azelastine HCl nasal spray, 2 sprays per nostril, to Resident #37. LPN #1 did not administer Lexapro 10 mg to Resident #37. Resident #37's clinical record was reviewed and contained a physician's order summary for the month of November 2021, which read, "Lexapro Tablet 10 mg (Escitalopram Oxalate). Give 1 tablet by mouth in the morning for Depression, Lexapro Tablet 5 mg (Escitalopram Oxalate). Give 1 tablet in the morning for Depression" and "Azelastine HCl solution 0.1% 1 spray in both nostrils one time a day for nasal congestion" Resident #37's medications were reconciled on 11/17/21. Upon reconciliation of medications, LPN #1 was asked if they had administered Resident #37's Lexapro 10 mg. LPN #1 stated that they had misunderstood about the Lexapro, that they had pulled a 10 mg card, then put it back and pulled a 5 mg card, since that was correct dose. LPN #1 was asked to confirm the order. LPN #1 stated that resident was supposed to receive both doses. LPN #1 pulled the 10 mg dose and administered it at this time (11:48 AM). LPN #1 was interviewed on 11/17/21/ at 12:23 pm regarding how many sprays per nostril of the Azelastine HCL nasal spray they had administered to Resident #37. LPN #1 stated "Two". LPN #1 was asked to confirm the order. LPN #1 confirmed that they should have only administered one spray per nostril per the physician's order.	F 759	6. Completed 1/03/22	

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F 759	Continued From page 42 The facility policy entitled "General Guidelines for Medication Administration", which read in part "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer. 6. At a minimum, the 5 Rights-right resident, right drug, right dose, right route, and right time-should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and medication is put away. 7. Always employ the MAR (medication administration record) during medication administration. Prior to the administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label." The concern of not ensuring a medication error rate of less than 5% was discussed with the administrative team during an end of day meeting on 11/17/21 at 4:15 pm. No further information was provided prior to exit.	F 759		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e)	F 801		1/3/22

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F 801	Continued From page 43 This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-	F 801		

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F 801	Continued From page 44 (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the dietary manager for the facility possessed the required education and/or certification. The findings include: On 11/19/21 at approximately 11:20 a.m., the facility's administrator acknowledged the facility's dietary manager did not have a certification or the education required for the position of dietary manager. The administrator explained the dietary manager was currently enrolled in an online training course and had one year to complete the course. The administrator provided a document	F 801	F 801 1. The current dietary manager is enrolled in class to obtain dietary certification. 2. Current residents in the center have the potential to be affected. 3. Regional Dietary Manager/designee for Next Level will oversee dietary department while manger is being trained at weekly. 4. The Administrator/designee will monitor the weekly report from corporate dietary manager for any concerns from the dietary department. 5. The results will be reported to the	

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F 801	Continued From page 45 which indicated the Dietary Manager Training pathway had been ordered (with the employee's name) however he/she denied knowing when that training pathway had been ordered. The only date on the document was 11/19/21, 11:14 a.m., which the administrator stated was the date/time the document was printed. The administrator provided a letter which indicated the facility's previous certified dietary manager had resigned in September 2021 with a last work day for the contracted dietary service being 10/10/2021. The administrator referred to the current dietary manager as their "interim" dietary manager for the first time during the survey and stated the facility had plans to offer the interim dietary manager a permanent position since this contracted employee had been an internal employee in dietary services for approximately four years previously. The dietary manager was interviewed on 11/19/21 at 11:45 a.m. He/She reported having enrolled in the online course two weeks ago but had not started the course because the student identification number, needed to begin the course, had not been sent. The dietary manager acknowledged having one year to complete the course. The administrator also acknowledged that although the facility's dietitian worked full-time for the contracted dietary service, the dietitian was not at the facility full-time. No further information was provided prior to the exit conference.	F 801	monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/3/22

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F 880	Continued From page 46 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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:	F 880		

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F 880	Continued From page 47 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to follow infection control policies and procedures for preventing the spread of COVID-19 on 1 of 2 units, unit 2 the observation wing, and failed to ensure screening of employees prior to work. The facility staff failed to donn PPE (personal protective equipment) before entering resident rooms that were on droplet/contact precautions,	F 880	F 880 1. Employee # 1 was immediately educated on infection control practices including PPE, hand hygiene and isolation. 2. Entrance to the facility was changed at the time of the survey to where staff will enter and exit one place in the facility. Employee #2 was immediately educated on the entrance to the facility and daily requirement for screening prior to working	

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STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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 880	Continued From page 48 failed to perform any hand hygiene prior to/after exiting these rooms; failed to doff PPE when exiting a resident's room who was on transmission-based precautions; failed to ensure proper infection control signage on Resident #33's and Resident #42's room; and failed to ensure staff were screened for symptoms of COVID-19 prior to working at the facility. The findings included: 1. On 11/16/21 upon entrance to the facility, the administrator confirmed they currently had 20 in house residents and 15 staff that were positive for COVID-19. The facility had a hot unit for positive COVID-19 residents and a warm unit for observation. On 11/16/21 at 1:33 p.m., housekeeper #1 was observed entering a resident room on the observation wing. The housekeeper had an N95 mask in place. Housekeeper #1 did not perform any hand hygiene before entering this room, did not donn any additional PPE, and did not complete any hand hygiene prior to or after exiting the room. Housekeeper #1 was observed opening the closet with their bare hands and placing an item inside. A PPE cart and two signs were observed outside of this room. One sign read in part, "Stop Contact Precautions...Perform hand hygiene using soap and water and/or alcohol-based rub before entering and before leaving room. Wear gown and gloves when entering room or cubicle..." The second sign read, "Stop Droplet Precautions...Perform hand hygiene using soap and water and/or alcohol-based hand rub before	F 880	their scheduled shift. Signage was placed on exit doors to direct staff, visitors and vendors to the main entrance to the center for proper screening. 3. Dietary Manager was immediately reeducated on the donning and doffing of PPE before entering and exiting an isolation room. In addition, the DM was educated on the infection control practices which also includes hand hygiene and isolation. 4. Residents #33 and #42 had the appropriate isolation signage posted to the outside of their doors along with the infection precaution supplies storage bins. 5. Current residents in the center have the potential to be affected. 6. Facility staff will be educated the Staff Development Coordinator on the center□s policy for infection control including donning and donning PPE, hand hygiene and isolation. In addition, staff was also educated on the required screening prior to working their scheduled shifts. Education also included only one entrance into the center for purposes of completed the required screening prior to working. 7. DON/Designee will monitor staff for proper PPE and handwashing 5x weekly to ensure proper donning and doffing of PPE and proper handwashing. In addition, isolation signage and isolation bins will be monitored 5x weekly to ensure the required signage and isolation supplies are placed at the resident□s door. SDC will monitor for correct screening process by reviewing documentation 5x weekly on Kiosk system.	

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F 880	Continued From page 49 entering and before leaving room. Wear gown and mask when entering room..." After exiting this room housekeeper #1 went up the hall, returned and at 1:36 p.m., and entered the room directly across from the previous room. The residents in this room were also on TBP (transmission-based precautions). Prior to entering the room, the housekeeper did not perform any hand hygiene and did not donn any additional PPE. The housekeeper was wearing an N95 mask. Upon entering the room housekeeper #1 opened a drawer in the resident's room with their bare hands, placed an item of clothing inside the drawer, and shut the door. The housekeeper exited the room without performing any hand hygiene. Observed outside the room was a PPE cart and two signs posted, one that read in part, "Stop Contact Precautions...Perform hand hygiene using soap and water and/or alcohol-based rub before entering and before leaving room. Wear gown and gloves when entering room or cubicle..." The second sign read, "Stop Droplet Precautions...Perform hand hygiene using soap and water and/or alcohol-based hand rub before entering and before leaving room. Wear gown and mask when entering room..." On 11/17/21 at 1:40 p.m., Housekeeper #1 stated they did not put PPE on to enter resident rooms they just "ran in and then ran back out." On 11/17/21 at 1:51 p.m., the administrator and nurse consultant were notified that housekeeper #1 entered two isolation rooms without performing hand hygiene or donning PPE and placed clothing items in a closet and drawer.	F 880	8. Complete 1/03/22	

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F 880	Continued From page 50 On 11/17/2021 during a meeting with the administrator, DON (director of nursing), and nurse consultant, the administrator stated housekeeping had been in-serviced on the proper use of PPE. The policy titled Transmission Based Precautions (effective date 02/06/20) was provided on 11/18/21. This policy read in part, "...Droplet precautions In addition to standard precautions, use droplet precautions, for a patient known or suspected to be infected with microorganisms transmitted by droplets...Contact precautions...Perform hand hygiene before entering room and after removing PPE upon room exit...Wear gloves when entering room and whenever touching the patient's intact skin, surfaces or articles in close proximity...After glove removal and hand hygiene, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient's room to avoid transfer of microorganisms to other patients or environments..." On 11/19/21 at 9:32 a.m., the infection preventionist stated that the housekeeper should not have entered rooms without any PPE in place. The facility provided the survey team with a copies of negative COVID-19 test for housekeeper #1 for 11/03/21, 11/06/21, 11/10/21, 11/12/21, and 11/15/21. The facility also provided information that housekeeper #1 was fully vaccinated. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 880		

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F 880	Continued From page 51 2. The facility policy titled "COVID-19" (effective date 09/30/21) documented, "It is the policy of the Center to establish standards of practice for prevention of Coronavirus Disease 2019 (COVID-19) and to control activities to protect employees and patients...Surveillance-Employees Screen Center employees prior to beginning shift..." On 11/18/21 at 3:47 p.m., CNA (certified nursing assistant) #2 was asked if they were screened for COVID-19 symptoms prior to entering and/or beginning work at the facility. CNA #2 stated they were not screened daily and they came in the side door by therapy. CNA #2 stated they were tested twice a week for COVID-19. On 11/18/21 at 3:50 p.m., CNA #3 stated they were screened daily and tested twice a week for COVID-19. The administrative staff were asked for evidence of screenings for both of these employees. On 11/19/21 at 8:13 a.m., the nurse consultant stated they were unable to find in their kiosk where CNA #2 had signed in for the last few weeks. The nurse consultant stated that CNA #2 shared with them yesterday that they had been coming in the side door entrance and sometimes they got their temperature and sometimes they did not. The nurse consultant stated they have locked the side doors. In regards to CNA #3, the nurse consultant stated they were unable to locate sign in logs for this employee and stated this employee also stated they were using the side entrance.	F 880		

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F 880	Continued From page 52 A kiosk for screening was observed in the front lobby; however, there was not a kiosk for employees to use at the side entrance. A white notebook labeled vendors and a thermometer was observed on a table at the side entrance. The facility provided negative COVID-19 tests for both of these employees dated 11/12/21 and a negative test for CNA #3 dated 11/18/21. The facility also provided an "EMPLOYEE CORRECTIVE ACTION" for CNA #2, "Employee failed to sign in on kiosk at start of shift on 11/18/21. You must sign in at the start of any shift." On 11/19/21 at 9:32 a.m., the IP (infection preventionist) was interviewed. The IP stated they were not aware staff were coming in the side door and the staff should either screen at the kiosk or use the book for documentation. On 11/19/21 at 1:30 p.m., the issues regarding staff screening was again reviewed with the administrator, DON (director of nursing), and nurse consultant. No further information was provided to the surveyor team prior to the exit conference. 3. On 11/17/21 at 2:13 pm, the past two weeks of daily screenings for COVID-19 signs and symptoms for staff member (SM) #1 were requested. On 11/18/21 at 1:34 pm, the administrator stated that SM #1's last day of employment was 11/01/21. On 11/18/21 at 9:55 am during a meeting with the Infection Preventionist, administrator, and Regional Nurse Consultant (RNC), were asked	F 880		

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F 880	Continued From page 53 how staff were screened prior to each shift. The administrator stated the staff have a sign-in book with screening questions and a temperature check. On 11/18/21 at 5:15 pm, the administrator, DON (director of nursing), and the RNC were asked for daily screening for the last two weeks of SM #1's employment. On 11/19/21 at 10:43 am, the administrator provided daily screenings for SM #1 for 10/07/21 and 10/08/21 only. On 11/19/21 at 11:10 am, the HR (human resource) Manager was asked for the dates SM #1 worked in the facility after 10/08/21. The HR Manager stated SM #1 worked in the facility on 10/09/21, 10/10/21, 10/14/21, 10/19/21, 10/23/21, 10/24/21, 10/26/21, and 10/28/21. Surveyor requested and received the facility policy entitled "COVID-19" which states in part: 6. Surveillance - Employees a. Screen Center employees prior to beginning shift to include: Positive travel history to locations with sustained community transmission of COVID-19 within the past 14 days. Signs or symptoms of COVID-19 (fever (temperature greater than 99.5 degrees F or 37.5 degrees C), chills, sore throat, cough, nasal congestion, congestion, runny nose, fatigue, myalgia, body aches, shortness of breath, difficulty breathing, headache, nausea, vomiting, diarrhea, or new loss of taste or smell). Has had high risk/prolonged contact with someone who is suspected or positive for COVID-19. On 11/19/21 at 1:30 pm the administrator, DON, and RNC were notified of the missing daily screenings for SM #1.	F 880		

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F 880	Continued From page 54 No additional information regarding this concern was presented to the survey team prior to the exit conference on 11/19/21. 4. On 11/17/2021 at 1:25 p.m., while observing staff serve lunch trays on Unit 2's observation unit (outside of the COVID unit), the dietary manager was observed donning a gown to take a lunch tray into a resident room. The manager was wearing goggles and a mask. There was a PPE cart and two signs that read "Stop Contact Precautions" and "Stop Droplet Precautions" at the entrance of the resident room. When the dietary manager left the room, they did not doff the gown before coming into the hall. Another kitchen staff handed the dietary manager a Styrofoam container which the manager took back into the same room, still wearing the same gown. The dietary manager again left the room without removing the gown, donned gloves and scooped ice from a container on top of a food cart, put the ice in a cup and returned to same room. The dietary manager left the room again and removed the gown in the hall and walked towards the nurse's station with the gown balled up. When the dietary manager returned from the nurse's station, they no longer had the gown. The dietary manager was interviewed and acknowledged being trained to remove the gown before leaving the room, but indicated the trash can within the room was not the type of trash can for PPE so they took the gown "up there" pointing to the nurse station. The dietary manager acknowledged coming in and out of the room without donning/doffing PPE per policy. The Stop Contact Precautions sign read, "Visitors must report to Nursing Station before entering. Perform hand hygiene using soap and water	F 880		

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F 880	Continued From page 55 and/or alcohol-based rub before entering and before leaving room. Wear gown and gloves when entering room or cubicle. Bag linen to prevent contamination of self, environment or outside bag. Discard infectious trash to prevent contamination of self, environment or outside bag." The Stop Droplet Precautions sign read the same as above. On 11/17/2021 at 1:51 p.m. the administrator and regional nurse consultant were informed of the infection control observation described above. The facility's policy titled, "Transmission Based Precautions (TBPs)" with an effective date of 02/06/20 was provided on 11/18/2021. For contact precautions the policy read in part, "b. Gloves and Handwashing i. Perform hand hygiene before entering room and after removing PPE upon room exit. ii. Wear gloves when entering room and whenever touching the patient's intact skin, surfaces or articles in close proximity. c. Gown. In addition to standard precautions, wear a gown (a clean non-sterile, water-resistant gown is adequate) when entering the room. Remove the gown before leaving the patient's environment... Disposable gowns are placed in regular trash unless contaminated with infectious material..." For Droplet Precautions the policy read in part, "In addition to standard precautions, use droplet precautions, for a patient know or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets, larger than 5 micros in size that can be generated during coughing, sneezing, talking or the performance of	F 880		

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F 880	Continued From page 56 procedures.)... b. Masks. In addition to standard precautions, wear a mask when working within 3 feet of the patient." No further information was provided prior to the exit conference. 5. Resident #33 and Resident #42 were observed in their room (Unit 2) on the afternoon of 11/16/21 at approximately 3:30 p.m. There were no signs outside the residents' room indicating what personal protective equipment (PPE) needed to be used for infection precaution. There was no storage bin placed outside the residents' room to hold any needed infection precaution PPE and supplies. On 11/16/21 at 4:55 p.m., Resident #33's and Resident #42's room was observed to have a "Droplet Precautions" sign and a "Contact Precautions" sign posted outside the room; there was an infection precaution supply storage bin noted to have been placed outside the room. On 11/16/21 at 4:57 p.m., the facility's Infection Preventionist (IP) and Licensed Practical Nurse (LPN) #21 was interviewed about the placement of infection precaution signs and infection precaution supplies storage bin outside of Resident #33's and Resident #42's room. The IP reported they noticed the missing items and placed them outside of the residents' room on 11/16/21 at approximately 4:30 p.m. On 11/16/21 at 5:48 p.m., LPN #21 reported Resident #33 was placed on infection control precautions on 11/13/21 due to COVID-19 exposure. On 11/19/21 at 12:25 p.m., the facility Regional	F 880		

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F 880	Continued From page 57 Nurse Consultant (RNC) reported Resident #42 was exposed to COVID-19 on 11/15/21. The RNC reported the IP confirmed the isolation signs and supply storage bin were noted, on the afternoon of 11/16/21, to not be placed outside of Resident #33's and Resident #42's room; the signs and storage bin were placed when they were noted to be missing. The following information was found in a facility policy/procedure titled "Transmission Based Precautions (TBPs)" (with an effective date of 2/6/20): "A combination of droplet and contact precautions may be utilized for diseases that have multiple routes of transmission. When used, they are used in addition to standard precautions. There are also empiric precautions for when an infection is suspected but not yet diagnosed. Place the type of precaution needed into the TELS system and notify Central Supply staff for a storage container with the appropriate supplies." The failure of facility staff members to ensure Resident #33's and Resident #42's room was correctly identified as requiring individuals entering the room to follow Contact Infection Control Precautions and Droplet Infection Control Precautions was discussed for a final time with the facility's Administrator, Director of Nursing (DON), and RNC on 11/19/21 at 1:30 p.m.	F 880		
F 886 SS=D	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,	F 886		1/3/22

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F 886	Continued From page 58 for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (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	F 886		

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F 886	Continued From page 59 individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to conduct routine COVID-19 testing for 1 of 3 sampled employees (Staff Member #2) and 2 agency nurses. The findings included: 1. On 11/17/21, the administrator provided a signed document stating "We have remained in high community transmission rate since 10/01/21." A review of SM #2's COVID-19 testing since 10/01/21, included documentation of testing performed on 10/04/21, 10/14/21, 10/21/21, 10/28/21, 11/08/21, and 11/12/21 each with negative results. A copy of SM #2's COVID-19 Vaccination Record Card documented they received their first dose of	F 886	F 886 1. Employee # 2 will not be scheduled to work until the second vaccine is obtained. Agency nurse #1 no longer works at the facility. Agency nurse #2 presented the facility with her vaccine card indicating she was fully vaccinated. 2. Current residents in the center have the potential to be affected. SDC will audit current staff records to assure that all current staff members are vaccinated, and vaccine cards are in the employee files including agency staff. 3. The Human Resource Director and the scheduler will be educated by the Administrator/designee to obtain vaccination status from the agencies at the time of scheduling them to work in the facility. In addition, the education will include maintaining an ongoing list on	

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F 886	Continued From page 60 the (name omitted) COVID-19 vaccine on 9/17/21 but had not received the second dose. The facility policy entitled, "COVID-19 Testing" documented: 1. Routine testing of employees...b. Unvaccinated employees are to be routinely tested based on the center's county level of community transmission." On 11/18/21 at 5:15 pm, the administrator, director of nursing, and the regional nurse consultant were notified of the missing routine COVID-19 testing for SM #2. The following morning on 11/19/21, the administrator provided documentation of additional COVID-19 testing for SM #2 for 10/07/21, 11/04/21, and 11/18/21 each with negative results. Following review of the additional test results, SM #2 still had four missing COVID-19 test results. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/19/21. 2. On 11/18/21 at approximately 10:55 a.m., agency nurse #1 and #2 were asked about testing for COVID-19 and stated they were tested outside of the facility on 11/17/21. The results of these tests were not provided. On 11/18/21 at 12:10 p.m., the administrator, DON (director of nursing) and nurse consultant were asked for evidence of COVID-19 testing and vaccination status for the two agency nurses currently working in the building. On 11/18/21 at 2:20 p.m., the administrator stated they did not have a tracking system in place for vaccines for agency employees, that they were testing employees twice a week, and they did not	F 886	employee□s vaccination status including agency staff so testing guidelines are adhered to. 4. DON/Designee will monitor new employee records at least weekly to assure vaccine status. Staff at the time of hire will be educated on the risk and benefits of Covid vaccine. The vaccine cards will be placed in the employee files. SDC will audit current staff records to assure that all current staff members are vaccinated. Scheduler will monitor vaccination cards at the time of offering a shift to work with the agency services. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Completed 1/03/22	

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F 886	Continued From page 61 have a COVID-19 outbreak related to agency staff. On 11/18/21 at 2:22 p.m., the staff development coordinator stated agency staff should be tested for COVID-19 prior to being allowed to work in the facility. On 11/18/21 at 2:30 p.m., the administrator stated they would work the agency staff into the scheduled testing routine. It would be good for them to be tested but not required. On 11/19/21 at 9:32 a.m., the IP (infection preventionist) stated they should know the vaccination status and COVID-19 status of agency employees prior to allowing them to work in the building. On 11/19/21 at 10:13 a.m., the IP stated they swabbed the agency nurses late yesterday. The facility provided evidence of negative COVID-19 testing for both these employees dated 11/18/21. These tests were completed after the survey team requested information regarding testing for agency employees. On 11/19/21 at 10:17 a.m., human resource employee #1 stated they did not complete anything in regards to agency staff. The facility did not provide any evidence to the survey team indicating the agency nurses were fully vaccinated. The facility provided the policy titled, "COVID-19 Testing" which read in part, "...Outbreak testing will occur immediately, and be conducted by two options: Contact tracing/focused testing approach...Broad-based testing approach, in which the center tests all	F 886		

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F 886	Continued From page 62 employees and patients when a new case is identified, regardless of vaccination status...Testing-Others: Unvaccinated consultants, contractors, volunteers, students, transportation staff and anyone else who 'provide services under arrangement and volunteers' should be tested. These individuals must be tested using the timeframe that corresponds to the centers testing frequency. If the individual has been tested from another source, the center must obtain documentation of the results, including the date and the test results, and keep a copy of the result on file. If the individual has not been previously tested the center can perform a POC (antigen) test, if available and document the results..." No further information regarding this issue was provided to the survey team prior to the exit conference.	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	F 887		1/3/22

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F 887	Continued From page 63 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: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;	F 887		

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F 887	Continued From page 64 (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 document review, the facility staff failed to properly prevent COVID-19 by failing to provide evidence of education regarding the benefits and potential risks associated with the COVID-19 vaccine and declination of the vaccine for 5 of 5 sampled residents (#1, #4, #17, #29, and #67) and 2 agency nurses. The findings included: 1. For Resident #1, the facility staff failed to provide evidence of education regarding the benefits and potential risks associated with the COVID-19 vaccine and declination of the vaccine. Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Chronic Atrial Fibrillation, Acute Kidney Failure, Peripheral Vascular Disease, Chronic Diastolic (Congestive) Heart Failure, and Muscle Weakness. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 8/20/21 assigned the resident a BIMS (brief interview for mental status) score of 12 out of 15 in section C, Cognitive Patterns. A review of Resident #1's clinical record revealed documentation located under the Immunization section of the electronic health record stating	F 887	F 887 1. Residents # 1, 4, 17, 29, and 67 were reviewed for Covid vaccination status and education was provided for risk and benefits of vaccine. One agency nurse will no longer work in this facility and one agency nurse presented her vaccine card. 2. Current residents were audited for vaccine status and education of the vaccine and was given if no proof of education. 3. Leadership staff was educated by the Regional Director of Clinical Services/designee on the process for documenting the education (risks and benefits of obtaining or not obtaining the COVID vaccine) provided to residents/RP(s) and staff if they decline the vaccine. 4. The DON/designee will audit new admission records to determine vaccination status and unvaccinated, to ensure there is documentation in the medical record and/or personnel file of the education provided. 5. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 887	Continued From page 65 "consent refused" for the SARS-COV-2 (COVID-19) (Dose 1) and (Dose 2), neither entry included the date of refusal. On 11/17/21 at 4:56 pm, surveyor requested from the administrator evidence of Resident #1 receiving education regarding the COVID-19 vaccine and declination by the resident or resident representative. On 11/18/21 at 5:15 pm during a meeting with the administrator, director of nursing, and the regional nurse consultant, surveyor discussed the concern of Resident #1's clinical record not including evidence of education provided to the resident and/or resident representative regarding the COVID-19 vaccine and declination of the vaccine. Surveyor requested any additional documentation regarding this issue. Surveyor requested and received the facility policy entitled, "COVID-19 Vaccinations" which states in part: 3. Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: a. Provide the Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers" to patient and/or responsible party and educate regarding benefits and potential side effects. Maintain a copy in the patient's record. c. If contraindicated or refused, document in patient's immunization record, including that the patient and/or responsible party was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine. No further information regarding this issue was presented to the survey team prior to the exit	F 887	6. Completed 1/03/22	

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F 887	Continued From page 66 conference on 11/19/21. 2. For Resident #4, the facility staff failed to provide evidence of education regarding the benefits and potential risks associated with the COVID-19 vaccine and declination of the vaccine. Resident #4's diagnosis list indicated diagnoses, which included, but not limited to Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage 3, Type 2 Diabetes without Complications, Chronic Diastolic (Congestive) Heart Failure, and Morbid Obesity. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 8/27/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. A review of Resident #4's clinical record revealed documentation located under the Immunization section of the electronic health record stating "consent refused" for the SARS-COV-2 (COVID-19) (Dose 1) and (Dose 2), neither entry included the date of refusal. On 11/17/21 at 4:56 pm, surveyor requested from the administrator evidence of Resident #4 receiving education regarding the COVID-19 vaccine and declination by the resident or resident representative. On 11/18/21 at 5:15 pm during a meeting with the administrator, director of nursing, and the regional nurse consultant, surveyor discussed the concern of Resident #4's clinical record not including evidence of education provided to the resident and/or resident representative regarding the	F 887		

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F 887	Continued From page 67 COVID-19 vaccine and declination of the vaccine. Surveyor requested any additional documentation regarding this issue. Surveyor requested and received the facility policy entitled, "COVID-19 Vaccinations" which states in part: 3. Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: a. Provide the Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers" to patient and/or responsible party and educate regarding benefits and potential side effects. Maintain a copy in the patient's record. c. If contraindicated or refused, document in patient's immunization record, including that the patient and/or responsible party was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/19/21. 3. For Resident #17, the facility staff failed to provide evidence of education regarding the benefits and potential risks associated with the COVID-19 vaccine and declination of the vaccine. Resident #17's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Mood Affective Disorder, Mixed Irritable Bowel Syndrome, Diverticulosis of Intestine, Gastro-Esophageal Reflux Disease, and Essential Primary Hypertension. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of	F 887		

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F 887	Continued From page 68 9/10/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns. A review of Resident #17's clinical record revealed documentation located under the Immunization section of the electronic health record stating "consent refused" for the SARS-COV-2 (COVID-19) (Dose 1) and (Dose 2), neither entry included the date of refusal. Resident #17's clinical record included results of a PCR COVID-19 lab test dated 11/13/21 indicating the resident was positive for COVID-19. On 11/17/21 at 4:56 pm, surveyor requested from the administrator evidence of Resident #17 receiving education regarding the COVID-19 vaccine and declination by the resident or resident representative. On 11/18/21 at 5:15 pm during a meeting with the administrator, director of nursing, and the regional nurse consultant, surveyor discussed the concern of Resident #17's clinical record not including evidence of education provided to the resident and/or resident representative regarding the COVID-19 vaccine and declination of the vaccine. Surveyor requested any additional documentation regarding this issue. Surveyor requested and received the facility policy entitled, "COVID-19 Vaccinations" which states in part: 3. Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: a. Provide the Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers"	F 887		

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F 887	Continued From page 69 to patient and/or responsible party and educate regarding benefits and potential side effects. Maintain a copy in the patient's record. c. If contraindicated or refused, document in patient's immunization record, including that the patient and/or responsible party was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/19/21. 4. For Resident #29, the facility staff failed to provide evidence of education regarding the benefits and potential risks associated with the COVID-19 vaccine and declination of the vaccine. Resident #29's diagnosis list indicated diagnoses, which included, but not limited to Chronic Atrial Fibrillation, Chronic Diastolic Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Unspecified Dementia with Behavioral Disturbance, Essential Primary Hypertension, and Hemiplegia and Hemiparesis following Cerebral Infarction. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 9/24/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. A review of Resident #29's clinical record revealed documentation located under the Immunization section of the electronic health record stating "consent refused" for the SARS-COV-2 (COVID-19) (Dose 1) and (Dose 2), neither entry included the date of refusal.	F 887		

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F 887	Continued From page 70 On 11/17/21 at 4:56 pm, surveyor requested from the administrator evidence of Resident #29 receiving education regarding the COVID-19 vaccine and declination by the resident or resident representative. On 11/18/21 at 5:15 pm during a meeting with the administrator, director of nursing, and the regional nurse consultant, surveyor discussed the concern of Resident #29's clinical record not including evidence of education provided to the resident and/or resident representative regarding the COVID-19 vaccine and declination of the vaccine. Surveyor requested any additional documentation regarding this issue. Surveyor requested and received the facility policy entitled, "COVID-19 Vaccinations" which states in part: 3. Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: a. Provide the Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers" to patient and/or responsible party and educate regarding benefits and potential side effects. Maintain a copy in the patient's record. c. If contraindicated or refused, document in patient's immunization record, including that the patient and/or responsible party was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/19/21. 5. For Resident #67, the facility staff failed to	F 887		

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F 887	Continued From page 71 provide evidence of education regarding the benefits and potential risks associated with the COVID-19 vaccine and declination of the vaccine. Resident #67's diagnosis list indicated diagnoses, which included, but not limited to Seizures, Acute Kidney Failure, Generalized Muscle Weakness, Essential Primary Hypertension, Gastro-Esophageal Reflux Disease, Fibromyalgia, and Atrioventricular Block First Degree. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/06/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns. A review of Resident #67's clinical record revealed documentation located under the Immunization section of the electronic health record stating "consent refused" for the SARS-COV-2 (COVID-19) (Dose 1) and (Dose 2), neither entry included the date of refusal. On 11/17/21 at 4:56 pm, surveyor requested from the administrator evidence of Resident #67 receiving education regarding the COVID-19 vaccine and declination by the resident or resident representative. On 11/18/21 at 5:15 pm during a meeting with the administrator, director of nursing, and the regional nurse consultant, surveyor discussed the concern of Resident #67's clinical record not including evidence of education provided to the resident and/or resident representative regarding the COVID-19 vaccine and declination of the vaccine. Surveyor requested any additional documentation	F 887		

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F 887	Continued From page 72 regarding this issue. Surveyor requested and received the facility policy entitled, "COVID-19 Vaccinations" which states in part: 3. Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for patients: a. Provide the Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers" to patient and/or responsible party and educate regarding benefits and potential side effects. Maintain a copy in the patient's record. c. If contraindicated or refused, document in patient's immunization record, including that the patient and/or responsible party was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine. No further information regarding this issue was presented to the survey team prior to the exit conference on 11/19/21. 2. The facility failed to identify the vaccination status of two agency nurses currently working in the facility. As part of the survey process, the survey team requested of the facility the vaccination status of all residents and employees of the facility. When the list was provided to the surveyor it did not include two agency staff (nurses) currently working in the building. 11/18/21 12:10 p.m., the survey team requested information from the administrator, DON (director of nursing) and nurse consultant regarding evidence of testing and vaccination status in regards to COVID-19 for two agency nurses currently working in the building.	F 887		

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F 887	Continued From page 73 11/18/21 2:20 p.m., the administrator stated they did not have a tracking system in place in regards to vaccines for agency employee, that they were testing employees twice a week, and they did not have a COVID-19 outbreak related to agency staff. 11/19/21 9:32 a.m., the IP (infection preventionist) stated they should know the vaccination status and COVID-19 status of agency employees prior to allowing them to work in the building. 11/19/21 10:13 a.m., the IP stated they swabbed the agency nurses late yesterday. The facility provided evidence of negative COVID-19 testing for both these employees dated 11/18/21. These tests were completed after the survey team requested information regarding testing for agency employees. 11/19/21 10:17 a.m., human resource employee #1 stated they did not complete anything in regards to agency staff." The facility policy titled, "COVID-19 Vaccinations" with an effective date of 11/02/21 read in part, "...Vaccination against COVID-19 will be offered to all Center patients and employees, as indicated..." Prior to the exit conference the facility did not provide any evidence to the survey team indicating the agency nurses were fully vaccinated or that the vaccine had been offered and declined. No further information regarding this issue was provided to the survey team prior to the exit	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495216		C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

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F 887	Continued From page 74 conference.	F 887		