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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 2/16/22 through 2/23/22. One Complaint (VA00054371 -Substantiated with deficiencies) was investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 196 certified bed facility was 139 at the time of the survey. The survey sample consisted of 3 resident reviews (Residents #1 through #3).	F 000		
F 660 SS=G	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability	F 660		3/29/22

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

Electronically Signed | 03/15/2022

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and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment

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F 660	Continued From page 2 preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to develop and implement an effective discharge planning process for 2 residents (Resident #1, Resident #2) in the survey sample of 3 residents. This resulted in harm for Resident #1. The Findings included: For Resident #1, who was bed-bound, the facility failed to develop and implement a discharge plan for stretcher transportation (non-pharmacological intervention) and failed to administer pain medication. According to Resident #1, her family member, and the Transportation Driver, it resulted in unbearable positional pain, which constitutes harm. Resident #1's admitting diagnoses (1/24/22) included Chronic Neck and Back Pain related to a surgical history of cervical/lumbar spinal surgery, Arthritis, Diabetic Neuropathy, and Generalized Muscle Weakness.	F 660	1. Resident number 1 and resident number 2 was effected. Social worker followed up on the status of wheelchair delivery to home for resident number 2. 2. Resident being discharged have the potential to be affected. New admissions will have discharge planning meetings 72 hours after admission to identify discharge needs e.g. DME, services to include home evaluations. Weekly discharge meetings to be conducted to determine that a physician order is in place DME arranged and confirmed. Upon discharge the discharge plan and instruction worksheet and medication prescriptions to be reviewed, signed and copies given to the family and put in the medical record. 3. The DCS/ Designee will educate licensed staff on the Discharge Planning Process. 4. DCS/Designee to complete audits weekly X 4 weeks and then monthly X 3 months.	

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The Minimum Data Set, with an assessment reference date of 1/31/22, was reviewed. Resident #1 was coded as a 1 (indicating almost constant pain). Resident #1 was coded as having pain that makes it hard to sleep at night, and that her day-to-day activities were limited because of pain. The numeric pain intensity rating scale was 7 out of 10.

Resident #1 was coded as being able to make herself understood, and as sometimes being able to understand others. Her Brief Interview of Mental Status score was 7. According to the functional status, locomotion on and off the unit, as well as walking, were coded as 8 (did not occur). Mobility devices were coded as not being used (cane, walker, wheelchair, etc.). Resident #1 was bed-bound.

A review was conducted of the Care Plan, dated 1/25/22. An excerpt read: "The resident has chronic pain r/t Arthritis, Diabetic Neuropathy ...Anticipate the resident's need for pain relief and respond immediately to any complaint of pain ...Monitor/document for probable cause of each pain episode. Remove/limit causes where possible."

On 2/22/22, Resident #1's son was interviewed via telephone. He stated, "I went out to meet the van on 2/15/22, 12:30 P.M. It was painful to hear the pain she was in. She was wailing, whimpering, and moaning. It was agony just to hear it. The facility did not give us any discharge paperwork. No prescriptions, no paperwork. She did not get any pain medication until she was admitted to the hospital the next day."

Resident #1 was in her bedroom with her son at

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the time of the interview. She was also interviewed via telephone. Resident #1 stated, "I told them (facility staff) that I was even willing to wait another day because I didn't want to sit in a wheelchair. They shoved me in that wheelchair. Even the van driver lady (Employee P) didn't think it was right to take me in a wheelchair. It's been a long time since I was able to sit up in a chair, since 2015. I cannot lift my head. I am always hunched over. I've had several back surgeries. I have metal in my back. You can look at my back and tell. I almost didn't make it. I can't describe how bad the pain was. It was indescribable. I thought I was going to die. They didn't give me any pain medications. They made me leave on the wheelchair van."

On 2/22/22 at approximately 11:25 A.M., the transport driver (Employee P) was interviewed. She stated, "She was in a lot of pain. She told the social worker [Employee J] that she was in pain. She told me that she was in pain. I questioned the social worker and physical therapist [Employee H] if she should be in a wheelchair. [Resident #1] said that she wanted to go lay back down. I told them that she needed a stretcher. [Employee J] stated that she'd go back inside the facility and check. She came back and said that the resident could use the wheelchair. The physical therapist guy helped me put pillows around [Resident #1]. During to trip, the resident was screaming in pain saying, 'I hurt ...I hurt'. I kept checking on her. She said, 'please don't leave me in this wheelchair'. She was in pain sitting up in the wheelchair. She needed a stretcher."

On 2/18/22, the transport company owner submitted a written statement. An excerpt read,

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"[Transport company] received a request from [facility social worker/discharge planner - Employee J] for a wheelchair transport on 2/15/22 at 10:00 A.M. Upon arrival to the facility the driver inquired if the patient would be more comfortable transporting on a stretcher instead of a wheelchair. The discharge planner confirmed that it was their interdisciplinary team's clinical recommendation that the patient could transport via a wheelchair, and that a stretcher was not necessary for the trip. The discharge planner stated that the patient was discharged. She encouraged the driver to depart the facility. The driver contacted dispatch and advised the team that the offer to transport by stretcher had been declined by the facility. The driver attempted to reassure the patient and offered to stop and reposition her as needed"

On 2/16/22, at approximately 4:00 P.M. in the Assistant Director of Nursing's office (Employee G), The Director of Rehabilitation (Employee D) was interviewed, along with the Occupational Therapist (Employee H). Their sister facility Administrator (Employee L) observed the interview. The Director of Rehabilitation (Employee D) stated that the clinical record contained entries documenting that Resident #1 could only tolerate sitting in a wheelchair for up to 1 hour and that she believed that a stretcher was needed for transportation during an 85-mile trip. She submitted the following written statement: "I (Employee D) attest that to the best of my knowledge, (Resident #1) was able to comfortably tolerate a standard wheelchair for 1 hour before requesting to be returned to bed. If I had been asked, I would have recommended stretcher transportation for travel over 1 hour."

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Employee H stated, "It fluctuated where she would be in pain - it would affect her participation ...She was very frail. I have not seen her ever sitting up in a chair. She is normally laying down. I saw her when she left ... I helped put pillows around her ...She was complaining of pain. She seemed frightened. She was very small and frail."

During the interview, both the social worker (Employee K) and the Director of Social Services, (Employee J) joined the interview. Both social workers stated that they were aware that Resident #1 should have been transported in a stretcher. Employee K stated that she was present when Resident #1 was being put into a wheelchair for transportation, She further stated that Resident #1 informed her that she was in pain. She stated that she informed a nurse of the pain, and brought a few pillows to resident #1 because the driver was concerned about the suitability of the wheelchair. Both social workers stated that between the two of them, they attended all of Resident #1's discharge planning meetings, and the interdisciplinary team never discussed using a stretcher for transport. The Director of Social Services (Employee J) stated, "I informed the resident's family that the cost of transportation "was $250.00 - $475.00 depending on if you are going to use a wheelchair or a stretcher." She stated that she was aware that the resident's family had paid $475.00 to the transportation company. She did not inform the family that $475.00 was the cost for a wheelchair with oxygen transport, not stretcher transport. The social worker gave the family inaccurate information.

The Director of Social Services was interviewed again in her office on 2/17/22 at approximately

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10:30 A.M. She stated "All disciplines should be actively involved in the decision to discharge ...it is no one but my responsibility to make sure the transportation was correct." I was informed by the therapy department today (2 days after Resident #1's discharge) that the resident could go home in a wheelchair or on a stretcher. I am a Social Worker. I am not qualified to determine if a wheelchair or a stretcher should be used. I was not aware that Resident #1 was bed-bound."

On 2/17/22 a review of facility documentation was conducted. The facility Rehab Serviced Discharge Policy dated 7/27/21 was reviewed. An excerpt read, "When the discharge date is established, recommendations for the home or follow-up care are provided for the patient and/or caregivers including a home assessment, acquisition of equipment, written instruction, and how to access available community resources if needed."

A review of the physical therapy and occupational therapy notes revealed that there was no recommendation regarding the use of a wheelchair or a stretcher for transportation home upon discharge.

On 2/22/22 and 2/23/22 the Administrator (Employee A), The Clinical Consultant (Employee M), and the Director of Nursing (Employee B) were informed of the findings. No further information was received.

2) For Resident #2, the facility staff failed to ascertain her home accessibility limitations. The facility staff failed to ensure that Resident #2 had

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a wheelchair to facilitate ambulation from the car to the apartment, resulting in Resident #2 being forced to remain in her car for two hours, awaiting someone who could carry her to the apartment.

Resident #2 was admitted to the facility on 1/28/22, and discharged on 2/11/22. According to the signed physician orders dated 1/25/22, Resident #2's diagnoses included Syncope and Collapse, Unsteadiness on Feet, History of Falling, Generalized Muscle Weakness, and Other Abnormalities of Gait and Mobility. An excerpt read: "PT (Physical Therapy) Clarification: PT to treat 5 x week for 6 weeks for Therapeutic exercises. Wheelchair Training ...Pressure reducing Cushion to wheelchair."

The Physical Therapy Discharge Summary, dated 2/11/22 was reviewed. An excerpt read: "Ambulation 20 feet with contact guard." According to Resident #2's daughter, the distance from their nearest parking space to their apartment is 50 feet away, and two steps up.

A review was conducted of the Minimum Data Set dated 2/4/22. Resident #2 was coded as requiring extensive weight-bearing assistance of one person walking. The mobility device was documented as being a walker. Resident #2 was coded as "Walk 50 feet: Not attempted due to medical condition or safety concerns." Resident#2's Brief Interview of Mental Status Score was 10, indicating moderately impaired cognition.

Resident #2's Care Plan was reviewed. An excerpt read: "2/8/22. The resident is at risk for falls. Minimize the risk of sustaining a serious injury through the review date."

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On 2/22/22 at 1:15 P.M., a telephone interview was conducted with Resident #2's daughter. She stated, "I am 73 years old. My mother is 95 years old. I can't handle her. The facility was supposed to get my mother a wheelchair to take home with her. I had to bring her home without the ability for her to be mobile. As of today, they still haven't sent her a wheelchair. I wasn't informed that there was no wheelchair until I went to pick her up after she was discharged. They let me borrow a wheelchair to get her to the car, but then I had to return it. I had no way to get her from the car to the apartment. It's 50 feet away, and up two stairs." We were stuck in the parking lot for two hours until I could get someone to help us. She wasn't able to move at all. She is cold-natured. She doesn't like the cold."

On 02/22/2022 at 3:05 P.M., Employee C, physical therapist, was interviewed by Surveyor C. When asked about Resident #2's functional ability at the time of discharge, Employee C referred to Resident #2 clinical record [physical therapy notes] and stated that Resident #2 required minimal assistance for transfers. When asked what that meant, Employee C stated that it was not safe forResident #2 to transfer herself because Resident #2 was not steady to transfer herself and required minimal assistance. Employee C also stated that Resident #2 was able to stand 1-2 minutes without holding on to anything and was able to walk 20 feet with a front-wheeled walker with touch assistance (meaning someone standing by touching Resident to assist with balance).

When asked about the recommendations for assistive devices pertaining to how Resident #2

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would get from the vehicle to the home upon discharge, the physical therapist referred to the clinical record and stated that there wasn't enough documentation in Resident #2's clinical record to tell what was needed. The physical therapist then referred to the occupational therapy notes and stated if there were no stairs, a wheelchair would be recommended. When asked if Resident #2's home had stairs, Employee C indicated that the documentation didn't address if there were stairs or not. Employee C also stated that usually the therapist would note that in the documentation and add a goal to negotiate stairs without help to transition home. This surveyor and the physical therapist observed in the therapy documentation that Resident #2 lived in a first-floor apartment with her daughter and granddaughter. There was no evidence in the documentation addressing stairs or distance from the vehicle to the apartment.

On 02/22/2022 at 3:35 P.M., the Director of Rehab was interviewed by Surveyor C. When asked about Resident #2's functional status at the time of discharge, the Director of Rehab referred to Resident #2's clinical therapy notes and stated that Resident #2 was able to walk a maximum of 20 feet with a walker and contact guard. When asked what contact guard meant, the Director of Rehab stated "She would just need someone walking by her and having a hand on her back to steady her." When asked about the distance between the vehicle and the apartment, the Director of Rehab stated she didn't know and indicated if it was less than 20 feet, Resident #2 could use a walker with contact guard assistance. When asked if Resident #2 had a walker upon discharge, the Director of Rehab stated, "She should have [had one]." When asked about the

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F 660	Continued From page 11 recommendation if the distance was greater than 20 feet, the Director of Rehab stated that Resident #2 would have needed a wheelchair. When asked if there were stairs to navigate at Resident #2's home, the Director of Rehab stated that "I would hope that family would give us a head's up" whether or not there were stairs or a curb. When asked again if there were stairs, the Director of Rehab stated the "documentation didn't say explicitly there were stairs but it implies there were no stairs." The Director of Rehab then stated that a "typical set up for senior living" on the first floor "should be a straight shot" from the vehicle to the apartment. Resident #2 lived with her daughter and granddaughter in a regular apartment. On 2/22/22 and 2/23/22 the Administrator (Employee A), The Clinical Consultant (Employee M), and the Director of Nursing (Employee B) were informed of the findings. No further information was received.	F 660		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	F 661		3/29/22

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F 661	Continued From page 12 representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on family interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide a Discharge Summary for 1 resident (Resident #1) in the survey sample of 3 residents. The findings include: Resident #1's admitting diagnoses (1/24/22) included Chronic Neck and Back Pain related to a surgical history of cervical/lumbar spinal surgery, Arthritis, Diabetic Neuropathy, and Generalized Muscle Weakness. Resident #1 was discharged on 2/15/22. On 2/16/22, the facility's Discharge Planning Policy (Dated 11.30.14) was reviewed. An excerpt read, "At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: Current diagnosis, Rehabilitation potential, Summary of	F 661	1. Resident # 1 was effected. 2. Residents being discharged have the potential to be affected. The DCS/ Designee will educate Social services, Nursing, Dietary Services, Community Life, and Rehab Services on the completion Discharge Summaries. 3. Discharged residents will have a discharge summary completed by the IDT (social work, nursing, dietary, community life and rehab) prior to discharge. The IDT will review discharge summaries in the clinical morning on day of (or Friday weekend before) discharge to ensure completion. Upon discharge, the licensed nurse will review discharge summary with resident/responsible party, get it signed and give copies along with prescriptions to the family and keep a copy to be scanned	

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F 661	Continued From page 13 Prior Treatment, Physician's orders for immediate care, Community referrals as needed ...Residents discharged to home will be made aware of, understand and agree with the proposed discharge plan, discharge date and other home care needs." On 2/22/22, Resident #1's son was interviewed via telephone. He stated, "The facility did not give us any discharge paperwork. No prescriptions, no paperwork...." On 2/22/22 and 2/23/22 the Administrator (Employee A), The Clinical Consultant (Employee M), and the Director of Nursing (Employee B) were informed of the findings. No further information was received.	F 661	into the medical record. 4. DCS/Designee will audit all discharges to the community weekly X 4 weeks, then 50% weekly x 1 month then 25% monthly X 3 months. The DCS will report findings of the audits to QAPI committee to review/revise monthly x 3 months or until resolved.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide pain management services for 1 resident (Resident #1) in the survey sample of 3 residents. The Findings included: The facility failed to 1a) administer	F 697	1. Resident # 1 was discharged prior to the survey on 2/15/22. 2. Current residents have the potential to be affected. Pain assessments will be conducted on current residents to ensure residents with pain receive medications that manages their pain. Follow up with MD if pain management is not effective or if there is breakthrough pain.	3/29/22

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F 697	Continued From page 14 physician-ordered pain medication. The facility failed to 1b) ensure that stretcher transportation (non-pharmacological intervention) was available transportation upon discharge. This resulted in unbearable positional pain, which constitutes harm. Resident #1's admitting diagnoses (1/24/22) included Chronic Neck and Back Pain related to a surgical history of cervical/lumbar spinal surgery, Arthritis, Diabetic Neuropathy, and Generalized Muscle Weakness. The Minimum Data Set, with an assessment reference date of 1/31/22, was reviewed. Resident #1 was coded as a 1 (indicating almost constant pain). Resident #1 was coded as having pain that makes it hard to sleep at night, and that her day-to-day activities were limited because of pain. The numeric pain intensity rating scale was 7 out of 10. Resident #1 was coded as being able to make herself understood, and as sometimes being able to understand others. Her Brief Interview of Mental Status score was 7. According to the functional status, locomotion on and off the unit, as well as walking, were coded as 8 (did not occur). Mobility devices were coded as not being used were cane, walker, wheelchair, etc. Resident #1 was bed-bound. A review was conducted of the Care Plan, dated 1/25/22. An excerpt read: "The resident has chronic pain r/t Arthritis, Diabetic Neuropathy ...Anticipate the resident's need for pain relief and respond immediately to any complaint of pain ...Monitor/document for probable cause of each pain episode. Remove/limit causes where	F 697	3. The DCS/ Designee will educate licensed staff on Pain Management and assessing resident for pain as at the time of discharge and medicate as indicated. Resident's pain levels to be assessed prior to discharge and medicated as needed. Residents on pain management regimen will be reviewed in weekly clinical meeting to determine effectiveness of medications and interventions, and modify as indicated. 4. DCS/Designee will conduct audits to verify residents are assessed for pain and pain management regiment is effective on 15 random residents weekly X 4 weeks and then monthly X 3 months. DCS will report in QAPI monthly x months or until resolved.	

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possible."

On 2/16/22, Resident #1's clinical record was reviewed. A signed physicians order dated February 2022 read, "1. Gabapentin Capsule 100 MG [Milligrams]. Give 100 MG by mouth at bedtime for pain related to pain in unspecified joint. 2) Hydromorphone HCl Tablet 4 MG. [According to Mosby's Drug Guide for Nurses, Eighth Edition, Hydromorphone is a Controlled Substance schedule II pain medication. When taken by mouth, its duration lasts 4-5 hours]. Give 0.5 tablet by mouth every 6 hours as needed for pain related to acute pain due to trauma. 3) 1/28/22. Physical Therapy, treat 5/wk for 6 weeks for Therapeutic Exercises, Gait Training, Wheelchair Training ...Patient/caregiver education/training and discharge planning."

Resident #1 was discharged on 2/15/22. According to the transportation company records, the transport van arrived at the facility at 10:00 A.M. The resident arrived at her home at 12:30 P.M. The 85- mile trip included a few delays so that the driver could check on Resident #1's positioning and pain level.

According to the Medical Administration Record, Resident #1's last dose of Hydromorphone was administered the day before she was discharged. The medication (Hydromorphone 2 mg.) was documented as having been administered on 2/14/22 at 9:43 P.M. There was no documentation in the nurse's progress notes on 2/15/22 of a pain medication administration on the day of discharge. In addition, the Medication Audit Report for February 2022 confirms that there was no pain medication administered on 2/15/22 before Resident #1's discharge at 10:00

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A.M. On 2/17/22 at noon an interview was conducted in the conference room with the Assistant Director of Nursing (Employee G). She stated, "the Audit Report tells you what medication was given, the times, and the Resident's name. I review it during our clinical meetings daily. It tells what's missing. It documents refusals."

The surveyor requested and received a copy of the Medication Administration Record on the 1st day of the survey. On the 2nd day of the survey, the facility's Corporate Nurse (Employee M) submitted a Narcotic Count Sheet that had been altered via a line drawn partially covering the administration time of 9:00 A.M. on the day of discharge 2/15/22. The time was subsequently written in as 12:30 P.M. on 2/15/22. However, this administration was not substantiated by the Medication Audit Report. On 2/16/22, (1 day after discharge) a nurse wrote a late entry in the nurse's progress notes that the pain medication had been given (on 2/15/22) to Resident #1 in the transport van. However, Resident #1 was at her home approximately 85 miles away at 12:30 P.M.

On 2/22/22, Resident #1's son was interviewed via telephone. He stated, "I went out to meet the van on 2/15/22, 12:30 P.M. It was painful to hear the pain she was in. She was wailing, whimpering, and moaning. It was agony just to hear it. The facility did not give us any discharge paperwork. No prescriptions, no paperwork. She did not get any pain medication until she was admitted to the hospital the next day."

Resident #1 was in her bedroom with her son at the time of the interview. She was also interviewed via telephone. Resident #1 stated, "I

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told them (facility staff) that I was even willing to wait another day because I didn't want to sit in a wheelchair. They shoved me in that wheelchair. Even the van driver lady (Employee P) didn't think it was right to take me in a wheelchair. It's been a long time since I was able to sit up in a chair, since 2015. I cannot lift my head. I am always hunched over. I've had several back surgeries. I have metal in my back. You can look at my back and tell. I almost didn't make it. I can't describe how bad the pain was. It was indescribable. I thought I was going to die. They didn't give me any pain medications. They made me leave on the wheelchair van."

On 2/22/22 at approximately 11:25 A.M., the transport driver (Employee P) was interviewed. She stated, "She [Resident #1] was in a lot of pain. She told the [facility] social worker [Employee J] that she was in pain. She told me that she was in pain. I questioned the social worker and physical therapist [Employee H] if she should be in a wheelchair. [Resident #1] said that she wanted to go lay back down. I told them [facility staff] that she needed a stretcher. [Employee J] stated that she'd go back inside the facility and check. She came back and said that the resident could use the wheelchair. The physical therapist guy helped me put pillows around [Resident #1]. During to trip, the resident was screaming in pain saying, 'I hurt ...I hurt'. I kept checking on her. She said, 'please don't leave me in this wheelchair'. She was in pain sitting up in the wheelchair. She needed a stretcher."

On 2/18/22, the transport company owner submitted a written statement. An excerpt read, "[Transport company] received a request from

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[facility social worker/discharge planner - Employee J] for a wheelchair transport on 2/15/22 at 10:00 A.M. Upon arrival to the facility the driver inquired if the patient would be more comfortable transporting on a stretcher instead of a wheelchair. The discharge planner confirmed that it was their interdisciplinary team's clinical recommendation that the patient could transport via a wheelchair, and that a stretcher was not necessary for the trip. The discharge planner stated that the patient was discharged. She encouraged the driver to depart the facility. The driver contacted dispatch and advised the team that the offer to transport by stretcher had been declined by the facility. The driver attempted to reassure the patient and offered to stop and reposition her as needed.

On 2/16/22, a review was conducted of Resident #1's clinical record. Her Physical Therapy and Occupational therapy notes revealed there was no evidence of a wheelchair assessment.

On 2/16/22, at approximately 4:00 P.M. in the Assistant Director of Nursing's office (Employee G), The Director of Rehabilitation (Employee D) was interviewed, along with the Occupational Therapist (Employee H). Their sister facility Administrator (Employee L) observed the interview. The Director of Rehabilitation (Employee D) stated that the clinical record contained entries documenting that Resident #1 could only tolerate sitting in a wheelchair for up to 1 hour and that she believed that a stretcher was needed for transportation during an 85-mile trip. Employee D submitted the following written statement: "I (Employee D) attest that to the best of my knowledge, [Resident #1] was able to comfortably tolerate a standard wheelchair for 1

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hour before requesting to be returned to bed. If I had been asked, I would have recommended stretcher transportation for travel over 1 hour." Employee H stated, "It fluctuated where she would be in pain - it would affect her participation ...She was very frail. I have not seen her ever sitting up in a chair. She is normally laying down. I saw her when she left ... I helped put pillows around her ...She was complaining of pain. She seemed frightened. She was very small and frail."

During the interview, both the social worker (Employee K) and the Director of Social Services, (Employee J) joined the interview. Both social workers stated that they were aware that Resident #1 should have been transported in a stretcher. Employee K stated that she was present when Resident #1 was being put into a wheelchair for transportation, She further stated that Resident #1 informed her that she was in pain. She stated that she informed a nurse of the pain, and brought a few pillows to Resident #1 because the driver was concerned about the suitability of the wheelchair. Both social workers stated that between the two of them, they attended all of Resident #1's discharge planning meetings, and the interdisciplinary team never discussed using a stretcher for transport. The Director of Social Services (Employee J) stated, "I informed the resident's family that the cost of transportation was $250.00 - $475.00 depending on if you are going to use a wheelchair or a stretcher." She stated that she was aware that the resident's family had paid $475.00 to the transportation company. She did not inform the family that $475.00 was the cost for a wheelchair with oxygen transport, not stretcher transport. This means the social worker gave the family inaccurate information.

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F 697	Continued From page 20 The Director of Social Services was interviewed again in her office on 2/17/22 at approximately 10:30 A.M. She stated "All disciplines should be actively involved in the decision to discharge ...it is no one but my responsibility to make sure the transportation was correct." I was informed by the therapy department today [2 days after Resident #1's discharge)] that the resident could go home in a wheelchair or on a stretcher. I am a Social Worker. I am not qualified to determine if a wheelchair or a stretcher should be used. I was not aware that Resident #1 was bed-bound." On 2/17/22 a review of facility documentation was conducted. The facility Rehab Serviced Discharge Policy dated 7/27/21 was reviewed. An excerpt read, "When the discharge date is established, recommendations for the home or follow-up care are provided for the patient and/or caregivers including a home assessment, acquisition of equipment, written instruction, and how to access available community resources if needed." A review of the physical therapy and occupational therapy notes revealed that there was no recommendation regarding the use of a wheelchair or a stretcher for transportation home upon discharge. On 2/22/22 and 2/23/22 the Administrator (Employee A), The Clinical Consultant (Employee M), and the Director of Nursing (Employee B) were informed of the findings. No further information was received.	F 697		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x)	F 888		3/29/22

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F 888	Continued From page 21 §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.	F 888		

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F 888	Continued From page 22 §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all	F 888		

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documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to

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F 888	Continued From page 24 the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to develop its Policies and Procedures for "additional precautions" to mitigate the spread of COVID-19. The findings included: On 02/22/2022 at approximately 12:00 P.M., Employee E, the Infection Preventionist and staff educator, was interviewed. When asked about the additional precautions for facility staff with an exemption from the COVID-19 vaccine, Employee E stated that staff are tested twice a week. When asked about the expectation for wearing PPE for staff with an exemption, Employee E stated that the expectation is to wear eye protection and surgical mask. When asked about tracking staff vaccination status, Employee E stated that the Assistant Director of Nursing (ADON) keeps track of the staff vaccinations. On 02/22/2022 at approximately 12:15 P.M., the administrator was interviewed. When asked if there were any facility staff with exemptions from the COVID-19 vaccine, the administrator stated there were no staff with medical exemptions and three staff with religious exemptions. The administrator stated that 2 of the employees were just hired this day (02/22/2022). The administrator provided three signed and dated religious exemption documents, including Employee F	F 888	1. Our policy is being reviewed and/or modified to include additional precautions to mitigate the spread of Covid 19. 2. All current residents are at risks if the facility fails to develop its policies and procedures for additional precautions to mitigate the spread of Covid-19 3.Education will be provided by the DON and/or designee to all staff on the centers pandemic plan and policies and procedures related to the mitigation of the spread of Covid-19. 4. The DON or Designee will randomly audit a sample of 10 employees weekly x 4 weeks then monthly x 2 months on their knowledge on current updates to the Pandemic Plan and Covid-19 Policies and Procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495423	A. BUILDING _____ B. WING _____	C 02/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 888	Continued From page 25	F 888		

signed and dated 01/14/2022.

On 02/22/2022 at 2:25 P.M., Employee F was observed exiting the kitchen into the Activity room where several Residents were playing Bingo. Employee F was wearing eye protection and a surgical mask for personal protective equipment (PPE). Employee F walked over to a table where two Residents were seated and hugged another staff member that was standing nearby. As Employee F then exited the Activity room, Employee F pulled up his surgical mask over his nose. At approximately 2:26 P.M., this surveyor interviewed Employee F. Employee F verified he worked as a dietary aide for the facility. When Employee F talked, the surgical mask would sometimes fall below his nose and Employee F would readjust the surgical mask to keep his nose and mouth covered. When asked if he had an exemption to receive the COVID-19 vaccine, Employee F stated, "Yes." When asked what additional precautions were in place to mitigate the spread of COVID-19, Employee F stated that he wears a surgical mask and goggles and gets tested every Monday.

On 02/22/2022 at 2:50 P.M., the ADON was interviewed. When asked about staff education for the COVID-19 vaccine, the ADON stated that staff are educated on the risks of not getting vaccinated and possible exposure as well as the benefits of getting vaccinated. When asked about the expectation of PPE for staff members with exemptions, the ADON stated staff members with exemptions should wear an N-95 and eye protection to "limit the spread of COVID." This contradicted what Employee E, the Infection Preventionist, said in an interview on 02/22/2022 at approximately 12:00 P.M.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 888	Continued From page 26 On 02/22/2022, the facility staff provided a copy of their policy with a revision date of 12/29/2021 entitled, "Employee COVID-19 Vaccinations." In Section 4 entitled, "Exempted Employees and Reasonable Accommodation" in subparts (b),(c), and (d), it was documented, "The accommodations will include the need for additional precautions to mitigate the transmission and spread of COVID-19, in compliance with CDC, CMS, and other applicable regulatory guidance. Current guidance, which is subject to change, requires the use of Universal Source Control depending on Community transmission rates and regular testing for all unvaccinated personnel working in Care Centers. Accommodations will be updated as new guidance is published." The policy did not explicitly define "additional precautions." On 02/22/2022 at approximately 4:30 P.M., the administrator and Director of Nursing were notified of findings. On 02/23/2022, the administrator and DON confirmed they had no further information or documentation to submit.	F 888		