STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495268	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

(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 2/15/22 through 2/17/22. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems.	E 015		3/18/22

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

Electronically Signed | 03/11/2022

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E 015	Continued From page 1 (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to have policies and procedures and evidence of the provision for food and water in the event of an emergency. The Findings included: On 2/17/2022, the facility's Emergency Preparedness Plan was reviewed with the facility maintenance director (Other Employee G). The review showed that the facility's Emergency Preparedness Plan did not have policies and procedures, or signed contracts for how food and	E 015	1. Emergency Preparedness plan was updated to include the policy/procedure for the provision for food and water in the event of an emergency on 2/18/2022. A signed contract for food and water was obtained in the event of a prolonged emergency and the supply of food and water stored in-house is depleted on 2/18/2022 2. Current residents in the center have the potential to be affected but no resident have been affected.	

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E 015	Continued From page 2 water will be obtained in the event of a prolonged emergency and the supply of food and water stored in-house is depleted. The facility Administrator later joined in the review and was given a list of the items missing from the Emergency Preparedness Plan. The Administrator then reviewed the plan again with Surveyor D, and was not able to locate the policy or executed contract for such services. During the review, the Administrator stated, "An Emergency Preparedness Plan is so we will be prepared". When asked about policies and procedures with regard to obtaining food and water during activation of the facility's Emergency Preparedness Plan, the Administrator stated she knew they had a signed contract and policies and would try to find them. No further information was provided by the facility staff.	E 015	3. 100% of facility staff including contractual and agency staff will be educated by the Regional Director of Maintenance/designee on the facility□s policy/procedure for the provision for food and water in the event of an emergency by 3/18/2022. The Regional Director of Maintenance/designee of the facility will also educate the staff on contract with Healthcare Services Group/US Foods for food and water being obtained in the event of a prolonged emergency and the supply of food and water stored in-house is depleted by 3/18/2022. 4. Maintenance Director will audit emergency food and water supplies monthly for three months. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 023		3/18/22

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E 023	Continued From page 3 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have a written policy and documentation of policies and procedures the facility has developed to preserve patient information, protects confidentiality of patient information, and secures and maintains availability of records in the event of an emergency. The findings include:	E 023	1.Emergency Preparedness Policies & Procedures were updated to include Medical Record Preservation during a disaster. Included in the Policy was a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records on 3/1/2022.	

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E 023	Continued From page 4 On 2/17/2022, the facility's emergency preparedness program was reviewed with the facility maintenance director. There was no evidence of a policy and procedure to preserve patient information, protects confidentiality of patient information, and secures and maintains availability of records in the event of an emergency. The facility Administrator later joined in the review of the Emergency Preparedness program/plan and was advised of the missing policy with regards to preserve Resident information, protect confidentiality and maintain availability of records. Included in the binder in this section was an excerpt from Resident Rights. The facility Administrator stated, "Is this not sufficient?" No further information was provided by the end of the survey.	E 023	2.Current residents in the center have the potential to be affected. 3.100% of facility staff including contractual and agency staff will be educated by the Regional Director of Maintenance/designee on the facility's policy/procedure for Medical Record Preservation during a disaster to include a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records by 3/18/2022. 4.Administrator/designee will review and monitor annually. Any issues will be addressed immediately. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 024		3/18/22

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E 024	Continued From page 5 be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have policies and procedures for the use of volunteers and other staffing strategies. The findings include: On 02/17/2022, the facility's Emergency Preparedness Plan was reviewed with the facility Administrator and maintenance director. The review showed that the facility's Emergency Preparedness Plan did not have policies and	E 024	1. Emergency Preparedness Policies and Procedures were updated to include Volunteers and Staffing strategies to address surge needs during an emergency on 2/27/2022 2. Current residents in the center have the potential to be affected but no residents have been affected. 3. 100% of facility staff including contractual and agency staff will be	

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E 024	Continued From page 6 procedures for the use of volunteers and other staffing strategies. During the review the administrator stated, "We don't use volunteers". In conversation the Administrator did acknowledge that during the COVID-19 pandemic they did use volunteers with the National Guard to assist with COVID-19 testing of Residents. No further information was provided by the facility.	E 024	educated by the Regional Director of Maintenance/designee on the Emergency Preparedness Policies and Procedures related to Volunteers and Staffing strategies to address surge needs during an emergency by 3/18/2022. The education will include the updated policy and how designated health care professionals can help address needs during an emergency. 4. Administrator/designee will review and monitor annually. Any issues will be addressed immediately. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/15/2022 through 02/17/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. (VA00052321-substantiated with deficiency VA00050175-substantiated with deficiency) The census in this 66 certified bed facility was 57 at the time of the survey. The survey sample consisted of 28 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550		3/18/22

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F 550	Continued From page 7 access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility	F 550	1. Resident #46 is stable, pain has been	

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F 550	Continued From page 8	F 550		

documentation and clinical record review the facility staff failed to ensure Residents rights to a dignified existence for 1 Resident (#46) in a survey sample of 28 Residents.

The findings included

For Resident #46 the facility staff failed to answer a call bell in timely manner when Resident rang for pain and incontinence care.

On 2/16/22 at approximately 1:05 PM Surveyor C entered the room of Resident #46 and found her in bed the sheets pulled away from the corners of the bed, she was dressed in a hospital gown and she stated "I'm soaked honey and I'm hurting from my knees to my toes." When asked if she had called the nurse she stated I don't have a call bell. When asked if they had given her anything for pain she said "Yes I didn't sleep well and they gave me Tylenol earlier but it doesn't help." The call bell was draped over the headboard out of the Resident's reach. The Resident was handed the call bell and she rang it. Surveyor C stepped into the hall and observed the following:

At 1:14 PM - Resident began yelling out "Please someone help me my legs hurt so badly."
At 1:18 PM - Employee J came in and asked if she needed help she stated that she was in pain and the Employee J stated she would let her nurse know. She turned the call bell off at that time.
At 1:20 PM - Resident yelling out "Please help me I'm in pain." "Where are they at I'm hurting."
At 1:24 PM - Resident talking to self and alternating "Please God let someone come in here."
At 1:30 PM - Resident said "Please don't treat me

managed with Tylenol as needed, her call bell is within reach and incontinence care was provided on 2/16/2022.

2. All residents have the potential to be affected.

3. DON/Designee will review residents receiving pain medication to ensure that medication is effective for treating pain level. Physician will be notified for those identified not receiving pain relief.
Maintenance will check call bells to ensure clip is in place on 2/20/2022.
Nursing staff rounded to ensure residents had call bells in place on 2/20/2022.
Policy for Administration of pain medications reviewed, no revision required at this time. DON or designee will educate all RN□s and LPN□s on completing a follow up for effectiveness of prn pain medications within one hour of administration by 2/18/2022.
Policy for Accommodation of Needs reviewed, no changes required at this time.
DON/Designee will educate LPN□s, RN□s and Certified Nursing Assistants on ensuring call bell in reach prior to leaving room and addressing resident needs as requested by resident at the time of the request.

4. DON or designee will randomly audit 10 residents receiving as needed pain medications weekly x 4 weeks and then monthly x 2 months to ensure that documentation reflects effectiveness of pain medication within one hour of

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F 550	Continued From page 9 like this just because you can." At 1:35 PM - CNA came down the hall with the Lunch Trays. At 1:40 PM - The Regional Director of Clinical Services was assisting with passing trays and she spoke to the Resident and realized she needed incontinence care and she located 2 CNA's to assist with the incontinence care. At approximately 1:45 PM an interview was conducted with Employee J who stated I notified the DON when I came out of her room that she was in pain. At approximately 1:50 PM an interview was conducted with LPN E who stated "Yes the DON let me know but I already gave her pain meds at noon actually she got Tylenol at 11:58 AM so she can't have anything else." A review of the clinical record revealed that LPN C did give Tylenol at 11:58 AM however she did not recheck or evaluate the resident's pain relief until 2:30 PM and it was rated a 3 /10 at that time. On the morning of 2/17/22 the DON was asked her expectation of evaluating pain medicine for effectiveness and she stated within an hour the nurse should recheck the resident and evaluate for pain relief. At this time the DON stated "I went in and checked her at 1:00 PM and she was fine." When asked if she documented the interaction with the Resident she stated that she had not. When asked if she had addressed the incontinence she stated that she had not. On 2/17/22 at 2:29 PM the DON entered the following note "Late entry for 2/15/22 Resident had complained of pain in her legs at 11:58 AM and this writer ask [sic] her at 1:00 PM if her pain was relieved she said yes."	F 550	administration. DON or designee will randomly audit the placement of 10 call bells and interview 10 residents regarding timeliness on addressing needs on each shift weekly x 4 weeks and then monthly x 2 months to ensure call bells are in place and needs are being met. The results of the audits will be submitted to the QAPI committee for review and further recommendations.	

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F 550	Continued From page 10 Per the facility call light policy: "General Guidelines:" "6. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident." "Documentation:" "1. Document any significant requests or complaints made by the resident and how the request or complaint was addressed." On 2/17/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide reasonable accommodation to Residents who had paralysis for two (2) Residents (Resident #33 and #44) in a survey sample of 28 Residents. The facility staff failed to take into consideration the Residents' paralysis and inability to use one side, when placing the call bell so that they could call for assistance if needed.	F 558	1. Call bell buttons were positioned on resident #33 and #44 on their right side for easy access. 2. Residents residing in the facility have the potential to be affected. 100% audit was completed by DON on residents to ensure call bells were within reach and properly placed in area that was accessible to residents on 2/17/22. Residents identified with paralysis will have Care plans updated to reflect	3/18/22

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F 558	Continued From page 11 The findings included: 1. On 2/15/22 at 02:56 PM, Resident #33 was visited in his room. Resident #33 was lying in bed, left side paralysis was noted, which Resident #33 confirmed. The call bell was observed wrapped around the arm of a chair located on the left side of the bed past where the head of the bed was elevated and was out of reach. On 2/17/22 at 8:47 AM, Resident #33 was observed sitting in his wheelchair between his bed and the bed of the roommate, in the middle of the room. His hand bell that had been provided to summons staff in the event he needed assistance, was observed on the far side of the room, on the bed side table and was not within reach/accessible. Resident #33 was not able to move his wheelchair efficiently to get to the call bell due to his paralysis. A review of the clinical record for Resident #33 revealed the following diagnosis: hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. Resident #33's care plan had the following intervention, "Be sure my call light is within reach and encourage me to use it for assistance as needed", which was initiated 11/9/2021. 2. On 02/16/22 at 08:28 AM, Resident #44 was observed lying in bed, the head of the bed was elevated. Resident #44 was observed to have left side paralysis. His call bell was draped over the head of the bed and resting at the top of the mattress on the left side. Resident #44 demonstrated that he was not able to	F 558	appropriate placement of call bells. 3. Policy for Accommodation of Needs reviewed, no revision required at this time. DON/Designee will educate all RN□s, LPN□s and Certified Nursing assistants on ensuring call bell in reach prior to leaving room and that call bell is appropriately placed for residents with paralysis by 3/18/2022. Newly admitted residents will be evaluated for appropriate placement of call bell. 4. DON or designee will randomly audit the placement of 10 call bells for appropriate placement based on the residents needs on each shift weekly x 4 weeks and then monthly x2 months. The results of the audits will be submitted to the QAPI committee for review and further recommendations.	

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F 558	Continued From page 12	F 558		

access/reach the call bell.

On 2/16/22 at 4:50 PM, Resident #44 was visited in his room. Resident #44's call bell was positioned on his left side at the head of the bed. Resident #44 was not able to access the call bell without surveyor intervention to give verbal cues to its location and direct the Resident where to reach for it. Resident #44 was observed to have extreme difficulty, and it took Resident #44 approximately 6 minutes to be able to get to the call bell.

On 2/17/22 at 9:06 AM, Resident #44 was visited in his room. Resident #44 was lying in bed and his call bell was observed to be under his left shoulder. Resident #44 had no use of his left side. Resident #44 was asked to demonstrate how he would call staff if he needed assistance and was not able to do so.

A clinical record review for Resident #44 was conducted. Resident #44 was noted to have the following diagnosis: "hemiplegia and hemiparesis following other cerebrovascular disease affecting left non-dominant side". The care plan for Resident #44 included a focus area that was initiated 8/5/2020, and read, "I am at risk for falls related to impaired cognition, Left hemiplegia, and has previous history of falls". Interventions included, but were not limited to: "Resident to have all belongings with resident and staff to make sure call bell within reach".

On 02/16/22 at 08:58 AM, an interview was conducted with RN A. RN A stated call bells are used so that "If the resident needs assistance or a staff member needs assistance, it alerts us". RN A confirmed that call bells should be

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F 558	Continued From page 13 positioned so that Residents can get to them at all times. On 2/17/22 at 9:17 AM, CNA G was interviewed. CNA G stated, "Call bells are used to notify staff of emergency situations or needs". CNA G accompanied Surveyor D to Resident #44's room and confirmed that with it placed under his back on his left side he would not be able to access it to call for assistance due to his left side paralysis. A review of the facility policy titled, "Answering the Call Light", was conducted. This policy read, "...5. When the resident is in bed or confined to the chair be sure the call light is within easy reach of the resident". On 2/17/22 at 1:00 PM, the facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 558		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services;	F 576		3/18/22

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F 576	Continued From page 14 (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and local Post Master interview, the facility staff failed to uphold Residents rights to receive mail for all Residents at the facility. The findings included: For all Residents receiving mail at the facility, the facility has failed to ensure the Residents right to receive mail on Saturdays. On 2/16/22 at approximately 4:00 PM a Resident	F 576	1. On February 23, 2022, the MDS Coordinator notified the United States Postal Service located in Colonial Beach to request for mail to be delivered on the weekends as well as weekdays. On February 22, 2022, the Administrator visited the United States Postal Service located in Colonial Beach to request for mail to be delivered on the weekends as well as weekdays. 2. All residents have the potential to be	

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F 576	Continued From page 15 council meeting was held and there were 9 Residents in attendance. During the meeting, 9/9 Residents agreed that there was no mail delivery on Saturday. Resident #1 stated that he had contacted the Local Post office and they stated it was an agreement the facility started a long time ago not to deliver on Saturdays. He stated that only the facility Administration could get it re-started. On 2/16/22 an interview was conducted with the Activities Director who stated that she is the one to deliver the mail to the Residents. She stated that there was no mail delivery on Saturday. She stated that there was something that was initiated years ago by the former Administrator. She further stated "We get UPS and FED EX deliveries but not Post Office." On 2/16/22 at approximately 4:25 PM, an interview was conducted with the Administrator who stated she was not aware of the facility stopping the Saturday Mail delivery. On the morning of 2/17/22 the Local Post Master was contacted and they stated "Years ago the facility stopped mail delivery on Saturday and now they are the only ones who can have it restarted." On 2/17/21 during the end of day meeting the Administrator was made aware of the interview with the local post office and the concern with no Saturday mail delivery, no further information was provided.	F 576	affected. On Saturday February 26th, mail was delivered to the facility and was given to all residents that received mail by the Receptionist. 3. All residents were educated on weekend mail delivery on 3/3/2022 by Activities Director. Staff that are on Manager on Duty rotation will be educated on weekend mail delivery as well as ensure mail has been given to the residents. Facility staff including Receptionist, contractual staff and agency will be educated on weekend mail delivery as well as ensure mail has been given to the residents. Manager on Duty template will be updated to include ensuring the mail has been delivered as well as provided to the residents. During monthly Resident Council meetings weekend mail delivery will be reviewed to ensure delivery of mail to residents and/or any concerns. 4. Weekly audits will be conducted on weekends for four weeks to ensure mail delivery as well as provided to residents that received mail by Manager on Duty. Daily rounding by Activities Director with residents to ensure residents do not have any concerns of mail delivery. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577		3/18/22

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F 577	Continued From page 16 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility record review the facility staff failed to ensure the Residents right to examine the most recent survey results. The findings included: For all Residents and Family members the facility staff failed to provide survey results that were accessible to Residents, family members and legal representatives of Residents.	F 577	1. The Survey Results Binder that includes the most recent surveys was immediately placed on top of the Receptionist desk for accessibility and visibility on 2/16/2022. 2. All residents have the potential to be affected. 3. Location of the most recent surveys will be reviewed in monthly Resident Council Meeting. Location of most recent surveys will be	

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On 2/15/22 at approximately 10:00 AM when surveyors entered the building a sign was noted in the lobby that read:

"Survey results located at the reception desk." The reception desk was approximately 6 feet from the sitting area where the sign is located. The survey results were not visible on the desk. There was no receptionist at the desk at the time of entrance.

On 2/16/22 at approximately 8:00 AM when entrance was made by Surveyor C there was again no one at the reception desk and the survey results were not visible on the desk.

2/16/22 at approximately 4:00 PM, during the Resident Council meeting, 5 out of the 9 Resident Council members stated that they did not know where to get the survey results, and the other 4 stated they knew it was behind the receptionists desk.

On 2/17/22 at 9:25 AM an interview with the Administrator was conducted and she was asked about the sign on the table saying the Survey Results are at the reception desk, she stated yes they are. She stated that they used to be in a "Wall Pocket" and they had done renovations and it got moved and they also had a Resident who picks up things." When asked how someone would get the survey results if it is behind the reception desk. She stated that they would have to ask the receptionist.

The Administrator stated she was aware the Survey Results should be where they were easily accessible by the Residents and family members. On 2/17/22 during end of day meeting the

included in the new admission packet for all new admissions.

All Facility Staff including contractual and agency staff including Receptionist will be educated on requirement and location of the most recent surveys by 3/15/2022.

Manager on Duty template will be updated to include ensuring the most recent surveys are accessible and visible.

Staff that are on Manager on Duty rotation will be educated on requirement and location of most recent survey results by 3/15/2022.

The Survey Results Binder that includes the most recent surveys will be secured to the Receptionist desk to ensure accessibility and visibility for residents, family members and legal representatives of residents at all times. The binder is labeled for easy identification.

All residents were educated on location of the most recent surveys on 3/3/2022 by Activities Director.

4. Administrator will ensure the most recent surveys are accessible and visible five times a week for two weeks then three times a week for two weeks then once a week for two weeks.

Administrator will audit two residents twice a week to ensure they know where the most recent surveys are located for four weeks then ongoing through the monthly Resident Council Meeting by the Activities Director.

Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.

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F 577	Continued From page 18 Administrator was made aware of the concerns.	F 577		
F 607 SS=E	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 documentation review, the facility staff failed to operationalize policies and procedures on screening for 12 of 25 new employees in the Employee Records Check Sample. The findings include: 1. For Employees # 8, # 11, # 14, # 19 and # 24, the facility staff failed to ensure a criminal background check was obtained within 30 days of hire. On 2/17/2022 at 8:40 a.m., review of the employee files selected for Employee Records Check was conducted with the Human Resources Manager (Employee F) in her office. Review revealed the following:	F 607	1. Late Background Checks can not be corrected. Staff member #19 and #24 criminal background check was obtained. Any missing license verifications were obtained. 2. All residing residents have the potential to be affected. 3. New Hire checklist was revised to include obtaining a criminal background check and verification of license look up date. Education was provided to Human Resources manager on 02/17/2022 on obtaining criminal background checks within 30 days of hire and abuse prevention policy, which includes conducting criminal background checks by Administrator. Education was provided to Human Resources manager on 02/17/2022 on	3/18/22

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F 607	Continued From page 19 Employee # 8-Registered Nurse, Director of Nursing- hired 1/15/2020- Criminal Background Check on 7/8/2020 Employee # 11-Certified Nursing Assistant-hired 3/18/2020-Criminal Background Check on 7/8/2020 Employee # 14- Licensed Practical Nurse-hired 1/22/2020-Criminal Background Check on 7/8/2020 Employee # 19- Certified Nursing Assistant-hired 7/3/2019- No Criminal Background Check in employee file Employee # 24- Certified Nursing Assistant-hired 2/15/2020-No Criminal Background Check in employee file On 2/17/2022, an interview was conducted with the Human Resources Manager who stated the corporate office usually obtained all of the required information during the hiring process. The Human Resources Manager stated the Corporate office conducted Criminal Background Checks upon hire but she later learned that those did not meet the requirements. The Human Resources Manager stated she would be sure all future new hires would have Criminal Background Checks within 30 days of hire. On 2/17/2022 at 11:32 a.m., an interview was conducted with the Administrator who stated the Human Resources Manager was hired in 2019. The Administrator stated that audits were done on employee files after they were informed about Sworn Statements being signed before or on the day of hire. The Administrator stated she explained to the Human Resources Manager that criminal background checks must be obtained within 30 days of hire.	F 607	obtaining license verification for all nursing staff at the time of hire by Administrator. Human Resources Manager will audit all staff personnel files for criminal background checks to ensure all staff have a criminal background check on file by 03/18/2022. Human Resources Manager will audit all staff personnel files for license verification/license lookup to ensure license is uncumbered and valid by 3/18/2022. 4. Administrator will review all new hire personnel files weekly for 3 months to ensure criminal background checks and nursing staff license look up are obtained within the required regulatory timeframes. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process by 03/18/2022.	

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Review of the Abuse Policy entitled "Abuse Prevention Program", Revised May 2017, revealed the following:

"Policy Interpretation and Implementation
As part of the resident abuse prevention, the administration will:
2. Conduct employee background checks and will not knowingly employ or otherwise engage any who has:
a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law"

On 2/27/2022 at 3:59 p.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated Criminal Background Checks should be conducted on all new hires. The Administrator stated she had no questions about the findings.

No further information was provided.

2. The facility staff failed to verify licensure on 2 (Employees # 7 and # 8) of 3 Registered Nurses upon hire and failed to verify licensure for 3 (Employees # 6, # 14, and # 17) of 3 Licensed Practical Nurses and failed to verify certification for 3 (Employees # 11, 19, and # 20) of 12 Certified Nursing Assistants.

On 2/17/2022 at 8:40 a.m., review of the employee files selected for Employee Records Check was conducted with the Human Resources Manager (Employee F) in her office.

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Review revealed the following:

Employee # 7-Registered Nurse, Assistant Director of Nursing- hired 7/1/2021- No License Verification- no license look up date. There was a copy of a Maryland License which would expire on 8/28/2022. The Maryland License was a Compact State license that had been renewed on 6/23/2020. There was no date indicating the date of look up.

Employee # 8-Registered Nurse, Director of Nursing- hired 1/15/2020- License Verification on 12/3/2021

Employee # 11-Certified Nursing Assistant-hired 3/18/2020-License Verification on on 7/8/2020

Employee # 14- Licensed Practical Nurse-hired 1/22/2020-License Verification on 10/6/2021.

Employee # 17-Licensed Practical Nurse-hired-12/27/2019- License Verification on 1/7/2020, 2/6/2020 and 6/8/2020.

Employee # 19- Certified Nursing Assistant-hired 7/3/2019- License Verification on 2/3/2020.

Employee # 20-Certified Nursing Assistant-hired 8/25/2020-License Verification on 7/22/2021.

Employee # 8-Registered Nurse, Director of Nursing- hired 1/15/2020- License verification on 12/3/2021.

On 2/17/2022 at 10:44 a.m., an interview was conducted with the Human Resources Manager. The Human Resources Manager stated she audited the personnel files and found there were

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missing License Verification for some employees. The Human Resources Manager stated she had thrown the original license verifications away when the updated or renewed licenses were submitted. The Human Resources Manager stated she did not realize that was not the correct procedure until this surveyor requested the files along with a list of required documents on 2/16/2022.

On 2/17/2022 at 11:32 a.m., the Business Office Manager stated "Now I understand that the original Licenses cannot be thrown away when the new one is updated. I didn't know that at first."

On 2/17/2022 at 11:32 a.m., an interview was conducted with the Administrator who stated the Human Resources Manager was hired in 2019. The Administrator stated she explained to the Human Resources Manager that original licenses must be verified prior to hire or care and maintained in the personnel files. She also stated that copies of verification of renewed licenses must be maintained in the files also.

Review of the Abuse Policy entitled "Abuse Prevention Program", Revised May 2017, revealed the following:

"Policy Interpretation and Implementation
As part of the resident abuse prevention, the administration will:
2. Conduct employee background checks and will not knowingly employ or otherwise engage any who has:...
c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of abuse, neglect, exploitation, misappropriation of property."

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F 607	Continued From page 23 On 2/17/2022 at 3:59 p.m. during the end of day debriefing, the facility Administrator was again informed of the findings. The Administrator stated she had no questions about the findings. No further information was provided.	F 607		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must 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.	F 657		3/18/22

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F 657	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility and in the course of a complaint investigation, staff failed to revise a care plan for 2 Residents (#46 and #208) in a survey sample of 28 Residents. The findings included: 1. For Resident # 46 the facility failed to revise a care plan to include the need for psych services ordered in 11/8/21. Resident # 46 was admitted to the facility on 11/4/21, per her initial MDS (Minimum Data Set) she had a BIMS (Brief Interview of Mental Status) score of 9/15 indicating moderate cognitive impairment. Her most recent MDS dated 1/14/22 recorded the Resident as having a BIMS score of 7/15 indicating severe cognitive impairment. The MDS dated 1/14/22 Section E 0100 Psychosis - (Box B was checked) Delusions (misconceptions or beliefs that are firmly held contrary to reality). E 0200 Behavioral Symptoms - (Box B was checked) - Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others) - 3 -Behavior of this type occurred daily. A review of the care plan revealed the Resident was care planned for behavior of playing with feces and becoming verbally aggressive with others. A review of the physician's orders revealed that the Resident is taking Buspar for anxiety and Citalopram for depression. The Resident had an	F 657	1. Resident #46 was seen on 2/18/22 by the Nurse Psych Practitioner and no changes were made to the plan of care. Care plan was updated to reflect the provider visit. Resident #208 was a closed record review, discharged on 6/29/21. 2. Residents residing in the facility that have an order for psych services have the potential to be affected. DON/designee will review current residents medical record for psych services consult orders to ensure services were provided and ensure care plans were initiated, any discrepancy will be corrected by 3/12/22. Residents residing in the facility that have had a fall have the potential to be affected. DON/Designee will review plan of care for residents that have fallen in the last 6 months to ensure care plans are reflective of the fall by 3/16/22. Residents residing in the facility with a diagnosis of UTI have the potential to be affected. DON/Designee will review current residents that have a diagnosis of UTI to ensure care plan is reflective of UTI by 3/16/22. 3. Change in Condition policy reviewed, no revision required at this time. DON or designee will educate RN□s and LPN□s on updating plan of care with changes in condition by 3/18/2022. DON or designee will review 24-hour report during clinical meeting for residents that have new	

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F 657	Continued From page 25 active order for psych services dated 11/8/21. On 2/17/22 at approximately 1:50 PM an interview was conducted with LPN C who was asked who updates care plans, she stated that the nurses can update the care plans. When asked who is responsible for obtaining psych consults she stated that usually it is the DON or the Social Worker. On 2/17/22 at approximately 2:00 PM, the DON was interviewed and was asked about the order for psych services dated 11/8/21 a few days after her admission. The DON stated that Resident had not seen psych services as far as she knew. She further stated that the Resident was her own RP. When asked if she had any concerns about a Resident being their own RP when they have delusions, and a BIMS of 8, she stated "Well we cannot get hold of the daughter she as much as admitted she dumped her here because of her behaviors. She does not answer calls or letters." When asked about the BIMS score she stated "That is the social worker she handles that." On 2/17/22 at approximately 4:00 PM an interview was conducted with the Social Worker who stated that she did another BIMS score that morning and her BIMS is a 4 / 15 indicating Severe Cognitive Impairment. She was asked if there was a concern about a Resident having a BIMS score of 4 being her own RP. She stated that there was and that she had arranged a psych consult. When asked if she was aware that Resident #46 had an order for Psych services since 11/8/21 she stated that she was not aware. She stated they were trying to decide which competency form to use between the facility and the provider of psych services. She stated that	F 657	orders for psych services, have had a fall or a diagnosis of UTI by 3/18/2022. Care plans will be reviewed and revised at this time. 4. DON/designee will audit all residents that had a fall or a new diagnosis of a Urinary Tract Infection to ensure the resident care plan reflects the fall and/or UTI weekly for four weeks. DON/designee will audit all resident orders during daily Clinical meeting to ensure communication of Psych consultations weekly for four weeks. Social Services will ensure residents with new Psych Consultations have been conducted timely and care plan initiated. Results of the audits will be submitted to the QAPI committee for review and further recommendations.	

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psych services would be in the building on Friday and that Resident #46 will be seen at that time.

Per the facility care plan policy:
"14. The interdisciplinary team must review and update the care plan:
a. When there has been a significant change in the residents condition
b. When the desired outcome is not met
c. when the resident has been readmitted to the facility from a hospital stay and
d at least quarterly, in conjunction with the required quarterly MDS assessment."

On 2/17/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident # 208 the facility failed to review and revise the care plan to include an actual fall and UTI (urinary tract infection).

On 2/17/22 the closed clinical record was conducted and the following was noted.

Concerning UTI's, Resident #208's care plan read:
"I am at risk for UTI due to her incontinence, need for assistance with meals and fluid intake secondary to cognitive decline
Date Initiated: 09/03/2020 Canceled Date: 06/30/2021"

Progress notes read as follows:

"5/27/21 at 5:15 AM -Note Text: Continues ABT/UTI Temp 97.8 no side effects from therapy

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noted, resident HAD no s/s of pain or discomfort when voiding and no c/o lower FLANK PAIN encouraged FLUIDS THIS SHIFT ,RESIDENT REFUSED ALL FLUIDS OFFERED."

"6/22/21 at 11 PM - Upon assisting cna with repositioning of resident at approximately 9p, both writer and can noticed that resident felt warm to the touch. Vitals taken and temperature read 100.1. All other vitals stable .Resident also had clear drainage coming from her nose. No cough, congestion, or SOB present. No distress observed. Respirations even/unlabored. No facial grimacing or s/s of discomfort noted. Telehealth consulted and new orders received for CBC [Complete Blood Count], CMP [Comprehensive Metabolic Panel], UA [Urinalysis], C&S [Culture & Sensitivity] and a CXR [Chest X Ray].

6/23/21 at 8:57 PM - Note Text: New order for macrobid, [Antibiotic used for UTI] RP [name redacted] is aware.

However, the UTI care plan was not updated with new interventions when Resident #208 was diagnosed with a UTI on 6/23/2021

Concerning falls, Resident #208's care plan read: "I am at risk for falls r/t History of falls. Hypotension, Psychoactive drug use , Unaware of safety needs, Fx hip
Date Initiated: 05/02/2021 Canceled Date: 06/30/2021"

"5/5/2021 10:58 Health Status Note Resident found on floor apparently fell out of bed landing on Right hip. ROM is WNL. No facial grimacing with movement no apparent injury. Resident placed back in bed by staff. Total assist. RP and

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F 657	Continued From page 28 MD notified." However, the fall care plan was not updated with new interventions when Resident #208 fell on 5/5/2021. Per the facility care plan policy: "14. The interdisciplinary team must review and update the care plan: a. When there has been a significant change in the residents condition b. When the desired outcome is not met c. when the resident has been readmitted to the facility from a hospital stay and d at least quarterly, in conjunction with the required quarterly MDS assessment." On 2/17/22 during the end of day meeting the Administrator was made aware of the concerns not further information was provided.	F 657		
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, interview, clinical record review, and facility documentation, the facility staff failed to provide proper ADL care for dependant Residents, for 2 Residents (#46 and #41) in a survey sample of 28 Residents. The findings included: 1. For Resident #46 the facility staff failed to	F 677	1. Incontinence care was provided to resident #46 and continues to be upon request and as needed. Resident #41 received a shower and care plan was updated to reflect preference on 2/17/2022. 2. All residents residing in the facility that need assistance with incontinence care	3/18/22

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F 677	Continued From page 29 provide timely incontinence care for Resident #46. On 2/16/22 at approximately 1:05 PM Surveyor C entered the room of Resident #46 and found her in bed the sheets pulled away from the corners of the bed, she was dressed in a hospital gown and she stated "I'm soaked honey and I'm hurting from my knees to my toes." When asked if she had called the nurse she stated I don't have a call bell. The call bell was draped over the headboard out of the Resident's reach. The Resident was handed the call bell and she rang it. Surveyor C stepped into the hall and observed the following: At 1:14 PM - Resident began yelling out "Please someone help me my legs hurt so badly." At !:18 PM - Employee J came in and asked if she needed help she stated that she was in pain and the Employee J stated she would let her nurse know. She turned the call bell off at that time. At 1:20 PM - Resident yelling out "Please help me I'm in pain." "Where are they at I'm hurting." At 1:24 PM - Resident talking to self and alternating "Please God let someone come in here." At 1:30 PM - Resident said "Please don't treat me like this just because you can." At 1:35 PM - CNA came down the hall with the Lunch Trays. At 1:40 PM - The Regional Director of Clinical Services was assisting with passing trays and she spoke to the Resident and realized she needed incontinence care and she located 2 CNA's to assist with the incontinence care.	F 677	have the potential to be affected. Plan of care will be updated to reflect residents needs by 3/11/22. All residents residing in the facility have the potential to be affected. All residents will be interviewed for shower preferences and the shower schedule will be updated in Point of Care and plan of care to reflect preference by 3/11/22. 3. ADL policy reviewed; no revisions needed. DON/Designee will educate RN□s, LPN□s and C N A□s on ADL policy, providing incontinence care timely and showers per residents preference by March 15, 2022. 4. DON or designee will audit five residents a week x 4 weeks and then monthly x 2 months to ensure showers have been conducted per preference, shower is documented and careplan reflects preference. DON/designee will interview 10 residents weekly x 4 weeks then monthly x 2 months to ensure incontinence care was provided timely. Results of the audits will be submitted to the QAPI committee for review and further recommendations.	

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On the morning of 2/17/22 the DON stated "I went in and checked her at 1:00 PM and she was fine." When asked if she documented the interaction with the Resident she stated that she had not. When asked if she had addressed the incontinence she stated that she had not.

On 2/17/22 at 1:36 PM an interview was conducted with CNA B who was asked about incontinence care for Residents she stated that they try to get there as soon as possible and get them cleaned up. She stated "We usually check the Residents every 2 hours but there was a power outage this morning and we are short staffed today so everything is kind of behind. We usually have lunch at 12 and as you can see its 1:30 and I'm just passing the trays now."

Per the call light policy:

"Documentation:"
"1. Document any significant requests or complaints made by the resident and how the request or complaint was addressed."

On 2/17/22 the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #41, the facility staff failed to provide ADL (activity of daily living) assistance with showers/bath(s) once weekly as per Resident preference.

On 2/15/22 during mid-morning, Resident #41 was visited in her room. Resident #41 verbalized that she only showers once weekly per her

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preference, and she receives showers on Tuesdays on second shift.

On 2/15/22, Surveyor D asked RN A, How are showers are documented? RN A said there was a book at the desk that the CNA's use to document showers and they are also put in the electronic health record. Surveyor D reviewed the shower book at the desk and noted that there was no recorded showers for Resident #41. The Director of nursing walked up to the desk while Surveyor D was reviewing the shower book and said, "It may not be in there, they wait until the end of the week to fill out those forms many times".

Included in the shower book was a shower schedule which was requested and received. Review of the schedule revealed Resident #41 was scheduled to receive showers on Tuesday and Fridays on the second shift (3-11 PM).

On 2/16/22, Resident #41 was visited in her room and asked if she received her shower yesterday. Resident #41 said, "No, because they only had 2 CNA's [certified nursing assistants].

On 2/16/22 a review of the clinical record for Resident #41 revealed that in the past 30 days, 1/18/22-2/15/22, Resident #41 only received one (1) shower. There was documentation that she was offered a shower on 2/1/22, 2/4/22, and 2/6/22, on the third shift and had refused. There was no evidence of Resident #41 being offered a shower on the following Tuesdays: 1/18/22, 1/25/22, 2/8/22, or 2/15/22. Resident #41 was coded on the bathing ADL sheet as being totally dependent upon staff for bathing.

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Review of the care plan for Resident #41 revealed the following entry for ADL's, "Resident needs one to two person assist with bed mobility, transfer, locomotion, personal hygiene, dressing and bathing".

On 2/17/22 at 1 PM, CNA C reviewed the shower book and indicated she didn't see any indication that Resident #41 had received a shower that week. When CNA C was advised that Resident #41 said she didn't get a shower due to only having 2 CNA's, CNA C said, "That's possible. They have been working short on 2nd shift". When asked why showers are important, CNA C said, "Obviously for their hygiene and if they have wounds it is important".

On 2/17/22 at 1:06 PM, the Director of Nursing (DON) was made aware of the above findings and of Resident #41's report of not getting a shower on 2/15, due to staffing. The DON said, "probably so, occasionally that happens so we will get one today".

A review of the facility policy titled, "Bath, Shower/Tub" was conducted. This policy read, "...Documentation: 1. the date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath. 3. All assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath. 4. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken...Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath..."

A review of the facility policy titled, "Activities of

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F 677	Continued From page 33 Daily Living (ADLs), Supporting" was conducted. This policy read, "....2. Appropriate care and services will be provided for Residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care)..." On 2/17/22 at 1:00 PM, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided. Complaint related deficiency.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		3/18/22

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F 688	Continued From page 34 by: Based on observations, staff interview, facility documentation, and clinical record review, the facility staff failed to apply a hand splint to prevent the progression of contractures for one (1) Resident (Resident #27) in a survey sample of 28 Residents. The findings included: On 2/15/22 at 3:29 PM, Resident #27 sitting up in a Geri-chair (type of recliner chair) with a hand splint observed on her over bed table, not in use. Resident #27 was non-interviewable. On 2/16/22 at 8:18 AM, Resident #27 was observed lying in bed. The hand splint was noted to be on the over bed table, not in use. On 2/16/22 at 4:48 PM, Resident #27 was observed in bed, without a splint on. On 2/17/22 at 12:12 PM, Resident #27 was observed in bed, and did not have her splint on. A review of the clinical record for Resident #27 was performed. This review revealed a physician order dated 10/20/20, that read, "Pt. [patient] to wear palm guard in left hand as tolerated". Review of the care plan for Resident #27 noted the following: A focus area initiated 8/5/2020, that read, "I am at risk for pain due to impaired mobility and contractures". Interventions included, but were not limited to: "Utilize resting hand orthosis for L hand to prevent further contractures", which was initiated: 12/31/2021. On 2/17/22 at 12:13 PM, an interview was	F 688	1. Palm protector was placed on resident #27 left hand as ordered on 2/17/2022. 2. All residents residing in the facility with orders for splints have the potential to be affected. DON or designee and Rehabilitation Director will audit residents with splint orders to ensure they are appropriate, in place and care planned by 3/10/2020. 3. Resident mobility and range of motion policy reviewed; no revisions needed. DON or designee will educate RN□s, LPN□s and C N A staff on applying splints per physicians□ orders by March 15, 2022. 4. DON or designee will audit 100% residents that are ordered splints to ensure application three times a week for four weeks then once a week for two additional weeks then monthly for 2 months. Results of the audits will be submitted to the QAPI committee for review and further recommendations.	

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F 688	Continued From page 35 conducted with CNA D. CNA D confirmed she was assigned to care for Resident #27. CNA D and Surveyor D went to the room of Resident #27 and made observations of the Resident. Observations were made of the skin integrity of Resident #27's left hand, with no noted areas of concern. CNA D was asked about a splint for the left hand since she has contractures, and stated she was not aware Resident #27 had a splint. CNA D found the splint in the bed side table drawer and proceeded to apply the splint. CNA D said the splint is important to "Keep her nails from digging into her palm and keep the contracture from worsening". Review of the facility policy titled, "Assistive Devices and Equipment" was received and reviewed. This policy read, "1. Certain devices and equipment that assist with resident mobility, safety and independence are provided for residents. 2. The facility provides the resident with assistance in locating available resources to obtain assistive devices that are not provided by the facility. 3. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan. 4. Staff and volunteers are trained and demonstrate competency on the use of devices and equipment prior to assisting or supervising residents..." On 2/17/22 at approximately 1:00 PM, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 688		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		3/18/22

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F 726	Continued From page 36 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that competencies were completed for 1 of 5 sampled staff (LPN C). The Findings included:	F 726	1. LPN C corrected her practice and put eye protection on during the survey and continues to follow infection control procedures and policies. LPN C was educated on Infection Control during medication administration including	

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F 726	Continued From page 37 On 2-16-22, a review was conducted of employee records. The facility Director of Human Resources (Employee F) was interviewed. The employee training records were computer-based Relias training, and some paper copies of training which was conducted in the facility. Employee F utilized her computer to facilitate the review, and provided copies to surveyors. According to the Relias Computer System Course Completion History, and all paper copies of training in the facility, the facility failed to implement required training for LPN (C). LPN (C) was hired on 12-27-19. Review of training from 1-1-2021 through 12-31-21 showed no training for Infection Control. On 02/15/2022 LPN (C) was observed passing medications without any eye protection The Director of Human Resources was asked who was responsible for clinical staff training, and she stated that it was the nursing departments' responsibility to ensure that the required training was completed. On 2-15-22 the Administrator, and the Director of Nursing (DON) were informed of the findings. When asked about the nursing departments' responsibility to ensure that nursing staff received the required training, the DON stated, "I can't tell you about all of the required training. Staff are required to complete it online." "I can follow-up with the Completion Report printed from Relias." On 2-17-22 at 12:00 p.m., The Administrator and DON stated that all of the staff education records they had were given to the survey team. No	F 726	wearing eye protection during high Community rates on 2/15/2022. LPN C also conducted a medication pass competency on 2/15/2022 to ensure knowledge and compliance. 2. Residents residing in the facility have the potential to be affected. 3. Human Resources Director will review training each week with DON and will adjust staff schedule to ensure timely staff completion of required education. All facility staff including contractual and agency staff will be educated on Infection Control to include donning eye protection by March 18, 2022 by DON/designee. All RN□s and LPN□s will have a medication administration competency conducted during orientation by DON/Designee and yearly to ensure proper infection control during medication administration. Newly hired RN□s and LPN□s will have competencies completed prior to performing resident care to ensure infection control is maintained. All RN□s and LPN□s were educated on Infection Control during Medication Administration to include donning eye protection on 2/15/2022 by DON. Human Resources Director will audit all staff for completed Relias education (Electronic Education System) to ensure staff compliance on Infection Control education by 03/18/2022 4. DON/designee and HR Director will	

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F 726	Continued From page 38 further information was provided by the facility at the time of exit on 2-17-22 at 6:00 p.m.	F 726	audit all staff to ensure completion of Infection Control education by March 18, 2022. Medication Passes to ensure compliance with Infection Control will be conducted on three nurses for four weeks then two nurses for two additional weeks by DON/Designee. Human Resources will audit newly hired employees and current staff every other week for one month and then monthly for two months to ensure competencies on infection control are completed and annual education is completed. Results of the audits with will be presented to the QAPI committee for compliance verification and ongoing audit process.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.	F 732		3/18/22

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F 732	Continued From page 39 (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to post daily staffing information for Residents, staff, and visitors to see on one of three dates of survey. This has the potential to affect all residents. The findings included: On 2/15/22 at approximately 10:00 AM, upon the survey team's entry to the facility the daily staffing information posted in the lobby contained the date of 2/13/22. On 2/16/22, the Director of Nursing (DON) was	F 732	1. The daily staffing information was posted during the survey and has been available and visible daily thereafter. 2. Residents residing in the facility have the potential to be affected. 3. Posting of Direct Care Staffing Numbers policy reviewed, no revisions needed. DON or designee will educate charge nurses on how to update daily staffing information by March 15, 2022. The ADON or designee will post the daily staffing information for residents and visitors and update each shift as needed.	

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F 732	Continued From page 40 interviewed. The DON stated she and the Assistant Director of Nursing post the daily staffing and the ADON had failed to update the information. When asked what the purpose of posting the daily staffing is, the DON said, "I really don't know, I just know we do it and where I came from did it as well, but I really don't know why". A review of the facility policy titled, "Posting Direct Care Daily Staffing Numbers" was conducted. This policy read, "1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format". On 2/16/22, during an end of day meeting with the facility Administrator and DON, they were made aware of the above findings. No further information was provided.	F 732	4. DON or designee will audit five times a week for four weeks then three times a week for two additional weeks to ensure staffing sheets are updated. Results of the audits with will be presented to the QAPI committee for compliance verification and ongoing audit process.	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced	F 740		3/18/22

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F 740	Continued From page 41 by: Based on interview, clinical record review and facility documentation the facility staff failed to provide behavioral heath services for 1 Resident (#46) in a survey sample of 28 Residents. The findings included: For Resident #46 the facility staff failed to obtain a consult for psych services when ordered on 11/8/21. Resident # 46 was admitted to the facility on 11/4/21, per her initial MDS (Minimum Data Set) she had a BIMS (Brief Interview of Mental Status) score of 9/15 indicating moderate cognitive impairment. Her most recent MDS dated 1/14/22 recorded the Resident as having a BIMS score of 7/15 indicating severe cognitive impairment. The MDS dated 1/14/22 Section E 0100 Psychosis - (Box B was checked) Delusions (misconceptions or beliefs that are firmly held contrary to reality). E0200 Behavioral Symptoms - (Box B was checked) - Verbal behavioral symptoms directed toward others (e.g. threatening others, screaming at others, cursing at others) - 3 -Behavior of this type occurred daily. A review of the physician's orders revealed that the Resident is taking Buspar for anxiety and Citalopram for depression. The Resident had an active order for psych services dated 11/8/21. On 2/17/22 at approximately 2:00 PM the DON was interviewed and was asked about the order for psych services dated 11/8/21. The DON stated that Resident had not seen psych services as far as she knew.	F 740	1.Resident #46 was seen on 2/18/22 by the Nurse Psych Practitioner and no changes were made to the plan of care. Care plan was updated to reflect the provider visit. 2.Residents residing in the facility with orders for psych consults have the potential to be affected. DON will review residents with orders for psych services to ensure that consults were completed and plan of care updated by 3/18/2022. 3.Behavioral Health policy reviewed, no revisions needed. DON or designee will educate licensed nurses on Behavioral Health policy and notifying psych services for consult orders by 3/18/2022. Orders will be reviewed daily in the clinical meeting to ensure that psych services is notified of consults and care plan updated.. 4.Social Services will audit psych consult orders to ensure completion of consult weekly x 4 weeks and then monthly x 2 months. Results of the audits will be submitted to the QAPI committee for review and further recommendations.	

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F 740	Continued From page 42 On 2/17/22 at approximately 4:00 PM an interview was conducted with the Social Worker. When asked if she was aware that Resident #46 had an order for Psych services since 11/8/21 she stated that she was not aware. She stated they were trying to decide which competency form to use between the facility and the provider of psych services. She stated that psych services would be in the building on Friday and that Resident #46 will be seen at that time. On 2/17/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 740		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		3/18/22

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F 761	Continued From page 43 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility staff failed to store drugs appropriately in locked compartments for one of the two med carts at the facility. The findings included: 1. LPN C left several medications on the top of the cart while she went to the Resident's room to administer the medications. On 2/16/22 at approximately 8:30 AM while observing a Med Pass with LPN C, Surveyor C observed LPN C pull medications, place them in a medication cup, leave the medication cards on the top of the cart, and walking off to give the medications to a Resident. LPN D was at the nurses station and she was interviewed at that time and she was asked if it was usual practice to leave the medications on the top of the cart, she stated "Oh no those meds should not be left on the cart ever." At approximately 8:35 AM Employee J the corporate RN was asked to look at the cart and she stated "No meds should never be left unattended. She might have been nervous about being watched by a surveyor but still she shouldn't leave the meds on the cart." Per the facility Page 2 Medication Administration Policy :	F 761	1. LPN C acknowledged her deficient practice and corrected it immediately during survey on 2/16/2022. No residents have been affected by this practice. LPN was immediately in serviced on leaving medications unattended on top of med cart by DON on 2/16/2022. 2. Residents residing in the facility have the potential to be affected. Med carts were immediately audited to ensure resident medications were not left on top of the med cart unattended on 2/16/2022 by DON 3. Medication Storage policy reviewed; no revisions needed. DON or designee will educate licensed nursing staff on appropriately storing medications during medication administration by March 18, 2022. 4. DON or designee will randomly audit med carts on alternating shifts five times a week for two weeks then 4x a month for 2 months to ensure appropriate storage of drugs and biologicals. Results of the audits will be submitted to the QAPI committee for review and further recommendations.	

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F 761	Continued From page 44 "19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the resident's room , with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications and all outward sides must be in accessible to resident's or others passing by." On 2/16/22 at approximately 10:00 AM the Don was interviewed and she stated that she was aware of the incident with the LPN leaving the meds on the top of the cart and she stated the expectation is that the cart stays in view of the nurse at all times if it is not locked and if it is not in view then it is to be locked and meds are never left on top. On 2/17/22 during the end of day meeting the Administrator was made aware of the concern and no further information was provided.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's	F 803		3/18/22

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F 803	Continued From page 45 reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and facility documentation review, the facility staff failed to prepare the meal in accordance with the menu, which affected 52 of the 57 Residents, residing at the facility during survey. The findings included: On 2/15/22 at approximately 10:30 AM, a tour of the kitchen was conducted. This tour included an interview with the cook, Employee F. Employee F confirmed that he was preparing baked ziti as per the menu. On 2/15/22, the menu was reviewed which indicated the following items were to be served: Baked Ziti with meat sauce, broccoli florets, garlic breadstick, and cinnamon brown sugar blondie. The alternate meal was listed as: smothered turkey patty, Caesar salad, and mashed potatoes. On 2/15/22 at approximately 1:00 PM, the lunch	F 803	1. Dietary staff that were on duty, including Employee E the Cook, were in serviced on following menu adherence and completing how/when to complete substitution log and reporting need for changes to Food Services Director/Registered Dietician for Registered Dietician substitution on 2/15/2022 by District Manager. Substitutions were recorded on substitution log and reviewed with Registered Dietician on 2/15/2022. 2. All residents have the potential to be affected. Next meal was audited to ensure all items were inhouse. All substitutions were recorded on the substitution log and reviewed with Registered Dietician. Menu Board was updated to reflect all changes on 2/15/2022. 3. Dietary staff (Cooks and Dietary Aides) will be in serviced on following	

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F 803	Continued From page 46 meal tray line was observed by Surveyor D. Employee F, the cook, identified the items prepared as: baked ziti, broccoli florets, brownie and the alternate as a chicken patty and mashed potatoes. The preparation of trays was observed and no Residents were served a garlic break stick nor cinnamon brown sugar blondie. The chicken patty was served without being smothered. Employee F, the cook confirmed that these items had not been prepared as per the menu. On 2/15/22 at approximately 1:30 PM, Surveyor D and the Registered Dietician received and evaluated a test tray the kitchen had prepared. Review of the test tray revealed the garlic breadstick and cinnamon brown sugar blondie were not provided as per the menu. The Registered Dietician confirmed she was not made aware of, nor did she approve, any menu substitutions. Review of the Resident Council meeting minutes from the meeting held January 31, 2022, revealed Residents reported they were not getting items they were supposed to. Included in documents provided to the survey team was a document titled, "Action Plan" that was signed off on 12/30/21. This document read, "Review all orders with the district manager before submitting any order. In the event that any items that have been ordered are currently out of stock, the Manager In Training will need to call the supplier to find a substitution. If at any time there is an item missing from the menu for the daily meal, it needs to be reflected on the tray ticket and on the menu boards through the facility. You will also be required to inform your	F 803	menu adherence, completing how/when to complete substitution log and reporting need for changes to Food Services Director/Registered Dietician for Registered Dietician substitution approval by 2/16/2022 by Dietary Manager/designee. All substitutions will be recorded on substitution log and approved by Registered Dietician. Residents will be notified of menu changes via Menu board outside dining room. All new Dietary staff (Cooks and Dietary Aides) will be in serviced on following menu adherence, completing how/when to complete substitution log and reporting need for changes to Food Services Director/Registered Dietician for Registered Dietician substitution during orientation. 4. Food Services Director or designee will audit tray line 2 meals per day 5 days per week for menu adherence for 4 weeks. Food Service Director, Registered Dietician or designee will review substitution log 2x per week for 6 weeks for completion. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	

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F 803	Continued From page 47 ED (executive director) during the morning meeting and have a copy of the changes present for them to review. All changes need to be recorded on the Meal Substitution Log.." A review of the facility policy titled, "Menus" was conducted. This policy read, "...6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or special meal." On 2/16/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and in the course of a complaint investigation, the facility staff failed to provide Residents with food at an appetizing temperature for 3 Residents (Resident #21, #33, and #41) in a survey sample of 28 Residents. The findings included:	F 804	1. Dietary staff that were on duty were in serviced on following Healthcare Services Group recipes, appropriate holding temperatures for food on steamtable and actions to keep food hot during service on 2/15/2022 by District Manager Facility received new plate warmer on 2/26/2022.	3/18/22

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F 804	Continued From page 48 On 2/15/22, during Resident interviews, Residents #41, #33 and #21 reported their hot foods are served cold frequently. On 2/15/22, Surveyor D requested a test tray be prepared during the lunch meal service. On 2/15/22 at 1:58 PM, the last Resident meal tray was delivered to a Resident. Administrative Employee D, the Registered Dietician, then retrieved the test tray from the meal cart and accompanied Surveyor D to a nutrition room on the unit to review the test tray. Both Administrative Employee D and Surveyor D tasted each food item on the tray and both confirmed that the baked ziti was room temperature and was not at an appetizing temperature. On 2/15/22, following the test tray observation, Administrative Employee D stated that she expect foods to be delivered in a manner so that cold foods are cold and hot foods are hot. Review of the Resident Council meeting minutes from the meeting held January 31, 2022, revealed that Resident's reported to facility staff that their food was cold at times. Included in the documents provided to the survey team was a document titled, "Action Plan" that was signed off on 12/30/21. This document read, "...Food Quality (Temperatures). Test trays need to be performed twice a day during. [sic] Check all temperatures for food and beverages before each meal service". Review of the facility policy titled, "Meal	F 804	2. All residents have the potential to be affected 3. Dietary staff (Cooks and Dietary Aides) will be in serviced on following Healthcare Services Group recipes, appropriate holding temperatures for food on steamtable and actions to keep food hot during service by Food Services Director/designee by 2/16/2022. Dietary staff (Cooks and Dietary Aides) will be in serviced on use of plate warmer by Food Services Director/designee by 2/27/2022. All new Dietary staff (Cooks and Dietary Aides) will be educated on following Healthcare Services Group recipes, appropriate holding temperatures for food on steam table and actions to keep food hot during service on orientation by Food Services Director or designee by 3/15/2022. 4. Food Services Director or designee will do a Test Tray 3x per week to monitor for appropriate food temperature for 6 weeks. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	

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F 804	Continued From page 49 Distribution: Infection Control Considerations" was conducted. This policy read, "...3. All food items will be transported promptly for appropriate temperature maintenance". On 2/15/22, during an end of day meeting the facility Administrator was made aware of the findings. No further information was received. Complaint related deficiency.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to accommodate meal preferences for two Residents (Resident #33 and #10) in a survey sample of 28 Residents. The findings included: On 2/15/22 at approximately 10:30 AM, a tour of the kitchen was conducted. This tour included an interview with the cook, Employee F. Employee F	F 806	1. Dietary staff that were on duty were in serviced on tray accuracy and following resident preferences on 2/15/2022 by District Manager. 2. All residents have the potential to be affected. 3. All Dietary staff (Cooks and Dietary Aides) will be in serviced on following menu and reporting need for changes to	3/18/22

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F 806	Continued From page 50 confirmed that he was preparing baked ziti as per the menu. On 2/15/22, the menu was reviewed which indicated the following items were to be served: Baked Ziti with meat sauce, broccoli florets, garlic breadstick, and cinnamon brown sugar blondie. The alternate meal was listed as: smothered turkey patty, Caesar salad, and mashed potatoes. On 2/15/22, the distribution of meal trays to Residents was observed. 1. Resident #33's meal ticket was noted to read, "Baked Ziti with meat sauce, broccoli florets, garlic breadstick, cinnamon brown sugar blondie square, creamy peanut butter & jelly sandwich and fortified mashed potatoes". Resident #33 was observed to not have the garlic breadstick, a regular chocolate brownie was served instead of the cinnamon brown sugar blondie square, and he had not received a creamy peanut butter & jelly sandwich. An interview was conducted and Resident #33 said he usually gets the sandwich at lunch time. Administration Employee D, the registered dietician accompanied Surveyor D to the room of Resident #33, and confirmed Resident #33 had not received the items as noted above. On 2/15/22 during the afternoon, Employee F, the cook was asked why Resident #33 gets a peanut butter and jelly sandwich. Employee F said, "I don't know, I just know he gets it every day". Employee F confirmed that he had not prepared Resident #33's peanut butter and jelly sandwich for the noon meal.	F 806	Food Services Director/Registered Dietician for Registered Dietician substitution approval. Completed on 2/16/2022 by District Manager. All Dietary staff (Cooks and Dietary Aides) will be in serviced on tray accuracy and following resident preferences. Completed on 3/4/2022 by District Manager. All substitutions will be recorded on substitution log and approved by Registered Dietician. Residents will be notified of menu changes via Menu board outside dining room. New Dietary staff (Cooks and Dietary Aides) will be educated on following menu and reporting need for changes to Food Services Director/Registered Dietician for Registered Dietician substitution approval by Food Services Director or designee by 3/15/2022. 4. Food Services Director or designee will audit six resident trays per day 5 days per week for 6 weeks for correct meal preferences. Food Services Director, Registered Dietician or designee will review substitution log 2x per week for 6 weeks for completion for meal preferences. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	

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F 806	Continued From page 51 2. On 2/15/22, during the lunch meal, Resident #10's tray was observed. Her meal ticket indicated that she was supposed to receive a Caesar salad, which she did not receive. On 2/16/22, an interview was conducted with Resident #10 and she indicated she disliked broccoli. Review of the Resident Council meeting minutes from the meeting held January 31, 2022, revealed Residents reported they were not getting items they were supposed to. On 2/17/22, the Registered Dietician provided Surveyor D with the meal preference form for Resident #10, which indicated a dislike for broccoli. Administrative employee D, the registered dietician confirmed that Resident #10 did not receive the Caesar salad. On 2/17/22 at approximately 1:00 PM, the facility Administrator and Director of Nursing were made aware of the above findings. No additional information was provided prior to the conclusion of the survey.	F 806		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		3/18/22

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F 812	Continued From page 52 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare and distribute food in accordance with professional standards for food service safety in 4 of 4 food storage and food preparation areas. The findings included: 1. The facility staff failed to store food in a manner consistent with professional standards for food service safety with regard to, labeling and protection from contaminates. On 2/15/22 at 10:30 AM, observations were made in the facility kitchen. The facilities dietary manager was not present during the survey, therefore Surveyor D was accompanied by Administrative Employee D, the registered dietician. In the dry storage room the following items were observed to be opened and not secured in a manner to protect from environmental contaminates: a bag of dry pasta ziti noodles and a bag of elbow macaroni dry pasta. Both bags	F 812	1. All items not labeled/dated or stored correctly were immediately discarded. The Handwashing sink was replenished with paper towels and water concern was reported to maintenance on 2/15/2022. Sanitizer buckets were drained, refilled and tested to ensure sanitizer was correct on 2/15/2022 2. All residents have the potential to be affected 3. All Dietary staff (Cooks and Dietary Aides) were in serviced on labeling, dating, and storing food appropriately and use of sanitizer buckets and how to set up and test ppm. Completed on 2/16/2022 by District Manager. All Dietary staff (Cooks and Dietary Aides) were in serviced on handwashing and maintaining the handwashing facility. Completed on 3/4/2022 by District Manager. New Dietary staff (Cooks and Dietary Aides) will be in serviced on labeling, dating and storing food appropriately,	

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F 812	Continued From page 53 were open to air, not secured and had no labeling to indicate when they were opened or to be used by. There was also a container of dry cereal that had been transferred out of its original packaging into a clear container with a lid but there was no label to indicate the product's date opened or use by date. There was a rack/tray that contained 7 bowls that had no label. Administrative Employee D opened one of the bowls and indicated it was cereal. There was two bags of hamburger buns that had no labeling to indicate the date received or a date to be used by. Administrative Employee D confirmed the above noted observations. In the walk-in cooler the following items were observed: a container was noted that contained a dark colored substance that was not able to be identified by the surveyor and there was no label to indicate the contents of the container. The registered dietician indicated that it was jelly. Also observed was a container with slices of cheese that the lid was not secured, the cheese was open to air and had no date as to when it was opened or to be used by. During initial tour of the kitchen, the walk-in freezer was not able to be observed due to stock being in the floor of the walk-in cooler. Administrative Employee D, the Registered Dietician stated they had just received their truck and were in the process of putting stock away. In the stand-alone cooler there was a container that was labeled as cranberry concentrate that was open to air. The Registered dietician acknowledged all of the above noted observations and stated that it was of concern to her as well. The Dietician stated, "I	F 812	handwashing and maintaining the handwashing facility and use of sanitizer buckets and how to set up and test ppm on orientation by Food Services Director/designee. 4. Food Services Director or designee will audit labeling and dating, hand sink for all supplies, and PPM of sanitizer buckets 2x per day, 5 days per week for 4 weeks. District Manager or designee to review audits weekly for compliance for 4 weeks. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	

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F 812	Continued From page 54	F 812		

will tell the staff about it, everybody is trying to do a little to help out and I come in and check when I am here. There is a regional person coming in to help with ordering. It is very important that we label items so we know when they came in, so we aren't giving Residents soiled products".

On 02/15/22 at 1:05 PM, upon Surveyor D's return to the kitchen for further inspection, Other Employee C was introduced. Other Employee C was the former dietary manager and is currently a Regional Dietary manager in training. Additional observations were made within the facility which included the dry storage area. The ziti noodles bag was observed to be tied but contained no label. The elbow macaroni was noted to be open to air without a label. A box was noted on the shelf which contained a bag of thickener, which was open to air, the box was dated 2/1/22 as a date received but no date as to when the product was opened was noted.

On 02/15/22 at 1:09 PM, while accompanied by Other Employee C, Surveyor D observed the sliced cheese in walk-in cooler, the lid was not secured, leaving the cheese open to air and there was no dating present. A container of unidentified substance, previously identified as jelly was noted with no label, the top to the container was observed to be cracked, which permitted the contents to be subjected to environmental containments.

On 2/15/22 at 1:11 PM, the walk-in freezer was observed a case of hamburger patties was noted to be open, the bag containing the hamburger patties was open, not secured, leaving the product open to air.

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F 812	Continued From page 55	F 812		

On 02/16/22 at 08:45 AM, a follow-up visit to the kitchen was made by Surveyor D. Other Employee D, the Regional Dietary Manager was present and accompanied Surveyor D. In the stand alone cooler 27 bowls of coleslaw was noted without any labeling as to when the product was made, put in the cooler or to be used by. Other Employee D confirmed the observations and stated "We label items so we know when it was made and when it needs to be discarded".

On 02/16/22 at 08:46 AM, observations of the walk-in cooler revealed 8 individual bowls of mandarin oranges that contained no label as to when they were prepared/put in bowls or when they were to be used by. The sliced cheese was still noted to not have any label. Other Employee D confirmed the observations.

Review of the facility policy titled, "Receiving" was conducted. This policy read, "...5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation..." The policy titled, "Food Storage: Dry Goods" was received and reviewed. This policy read, "...5. All packaged and canned food items will be kept clean, dry, and properly sealed..." The facility policy titled, "Food Storage: Cold Foods" was reviewed and it read, "...5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination".

According to "ServSafe" Fourth Edition manual page 7-3 read, "When food is stored improperly and not used in a timely manner, quality and safety suffer. Poor storage practices can cause food to spoil quickly with potentially serious results. General Storage Guidelines: Label food.

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F 812	Continued From page 56	F 812		

All potentially hazardous, ready-to-eat food prepared onsite that has been held for longer than twenty-four hours must be properly labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded". Page 7-4 stated, "Discard food that has passed the manufacturer's expiration date".

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.12, pages 73-74 stated: "Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food service establishment, shall be identified with the common name of the food."

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.15, page 64 stated: "Package Integrity. FOOD packages shall be in good condition and protect the integrity of the contents so that the FOOD is not exposed to ADULTERATION or potential contaminants".

According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section "3-305.11 Food Storage..."D. A date marking system that meets the criteria...(2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded...". "Section 3-501.17 Ready-to-eat, Time/temperature control for safety food, date marking" read, "(A)...refrigerated, ready-to-eat,

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time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...".

On 2/15/22 and on 2/17/21, during end of day meetings the facility Administrator was made aware of the findings.

No further information was provided.

2. The facility staff failed to maintain handwashing facilities in the kitchen for food service staff to wash their hands prior to the handling of food.

On 2/15/22 at approximately 10:15 AM, Surveyor D presented to the kitchen. Surveyor D was accompanied by Administrative Employee D, the registered dietician. Surveyor D approached the hand washing sink and identified there was no running water at the sink. Administrative Employee D then directed Surveyor D to another hand washing sink located on the opposite side of the kitchen. Surveyor D then performed hand hygiene and determined there were no paper towels to dry her hands. Administrative Employee D had to retrieve paper towels for Surveyor D to be able to dry her hands prior to conducting the kitchen inspection.

The Registered Dietician (RD) stated that she was not aware of why there was not running water at the first sink and why the second sink was not stocked with supplies. The RD stated that all food service employees are to wash their hands prior to and between food service

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F 812	Continued From page 58	F 812		

activities.

No further information was provided.

3. The facility staff failed to maintain a sanitizer solution to sanitize food service equipment and work surfaces.

On 2/15/22 at approximately 12:50 PM, Surveyor D asked Other Employee C, the former dietary manager and regional dietary manager in training to test the sanitation buckets distributed throughout the kitchen.

Other Employee C used chemical test strips and tested 6 sanitation buckets distributed throughout the kitchen. Each of the buckets tested at 0 ppm (parts per million) of sanitizer being present. Other Employee C went to the 3 compartment sink and used the sanitizer distribution system to fill one of the sanitizer buckets and again it tested at 0 ppm. The same test strips were used to test the dish machine water and it did test appropriately. Other Employee C stated, the buckets are changed out every 2-3 hours and they use Quat Sanitizer. Other Employee C said, "Something is wrong with the sanitizer at the sink, I will make sure to put this in as a work order".

On 2/15/22 at 1:09 PM, an interview was conducted with Other Employee E, the cook. The cook confirmed that the sanitizer buckets are used to wipe down all of the kitchen/food preparation surfaces and it was critical that they be sanitized properly.

Included in the documents submitted to the

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F 812	Continued From page 59 survey team was a document titled, "Action Plan". This document read, "...Labeling and Dating: Manager in Training must perform a thorough walk thru of the kitchen using the pocket process and also needs to submit pictures of the following daily before 8:30 am. Walk-in cooler and refrigerator, reach-in refrigerator, dry storage and nourishment room. All labels need to be facing forward and easy to read for the District Manger to review". The facility policy titled "Environment" was received and reviewed. This policy read, "1. The dining services Director will ensure that the kitchen is maintained in a clean and sanitary manner...2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces..." According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-304.14, page 77 stated: "cloths in-use for wiping counters and other equipment surfaces shall be: held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114" On 2/15/22 and on 2/17/22, the facility Administrator was made aware of the findings. No further information was provided.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		3/18/22

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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:
(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

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F 880	Continued From page 61 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, facility documentation review, and clinical record review, the facility staff failed to maintain an infection control program in accordance with the Centers for Disease Control and Prevention (CDC) to prevent the spread of COVID-19 within the facility on 3 of 3 Resident halls within the facility. The findings included: 1. The facility staff failed to wear appropriate personal protective equipment (PPE) while providing care to a Resident (Resident #21) who was on quarantine for a COVID-19 exposure.	F 880	1. CNA B corrected her practice and put a N95 on during the survey on 2/15/2022 and continues to follow infection control procedures and policies. Resident #21 remains asymptomatic and is no longer on droplet precautions. LPNs C, E and F were issued eye protection during the survey on 2/15/22. Resident #33 was placed on appropriate precautions on 2/15/2022. 2. All residents residing in the facility have the potential to be affected.	

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F 880	Continued From page 62 On 2/15/22 at approximately 10:05 AM, Surveyor D observed CNA B enter the room of Resident #21. Prior to entering CNA B donned [put on] an isolation gown, face shield and gloves. CNA B was already wearing a procedure mask. There was a sign on the door that read, "Special droplet contact precautions" and indicated staff were to put on an N-95 mask, eye protection, isolation gown and gloves prior to entering the room. Upon exit, CNA B was interviewed and stated, "I apologize, and I didn't put my N-95 on". On 2/15/22 at approximately 5 PM, Resident #21 was interviewed in her room. Resident #21 indicated she had previously had COVID-19 and recovered but had recently had an exposure and indicated that was the reason staff and her spouse wear On 2/15/22, a clinical record review was conducted and revealed that Resident #21 was on "droplet precautions"/isolation for a COVID-19 exposure. A review was conducted of the facility policy titled, "Transmission Precautions for Patients and Donning and Doffing Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19" which had a revision date of September 2021. This policy read, "...PPE must be donned correctly before entering the patient care area (e.g., isolation room, cohort)...Special Droplet/Contact Precautions...3. Wear NIOSH-approved N95 or equivalent or higher-level respirator..." On 2/15/22, during an end of day meeting, the facility Administrator was made aware of the	F 880	3. Human Resources Director will assign Infection Control education to all clinical staff through the Relias training program by 3/18/2022. Policy on Infection Control and latest CMS guidance was reviewed on 2/15/2022 by DON. DON/Designee will educate all facility staff including contractual and agency staff on guidance and policy by 3/18/2022. 4. DON or designee will perform return demonstrations of donning and doffing PPE weekly on five staff members for four weeks or if in outbreak status then monthly. Human Resource Director will conduct audits on newly hired employees every other week for one month and then monthly for two months to ensure competencies on infection control are completed. Results of the audits with will be presented to the QAPI committee monthly for compliance verification and ongoing audit process.	

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findings.

No further information was provided.

2. The facility staff failed to wear eye protection when providing direct Resident care, while the facility was located in an area of high COVID-19 transmission and in an active COVID-19 outbreak as per the guidance from CDC [Centers for Disease Control and Prevention].

Prior to the survey team's entry to the facility the CDC COVID Data Tracker was reviewed and it noted the facility was located in an area with a "high" level of community transmission for COVID-19. Accessed online at: https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=Virginia&data-type=Risk&list_select_county=51193

On 2/15/22 at 10:00 AM, upon the survey team's arrival to the facility, a sign was observed on the front door, which noted that the facility was in a current COVID-19 outbreak status.

On 2/15/22 at approximately 10:05 AM, the facility Administrator confirmed that the facility was in a COVID-19 outbreak and currently had Residents on quarantine for COVID-19. Review of the Virginia Department of Health's COVID-19 data revealed the facility is located within an area with a "high level of community transmission".

On 2/15/22 from 10:05 AM, a tour of the facility was conducted of the kitchen and all Resident care/nursing halls by Surveyors C and D through 11 AM. Observations showed LPN C, LPN E, and

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LPN F going into Resident rooms and passing medications without any eye protection on.

On 02/15/22 at 1:33 PM, Other Employee B was observed on the nursing unit distributing eye goggles to staff. When asked why she was doing this she replied, "[Director of Nursing name redacted] told me to give one to everybody".

Review of the facility policy titled, "CDC Guidance- Personal Protective Equipment" with a revision date of September 2021 read, "...Eye protection should be worn during all patient care encounters when the facility's county transmission rate is substantial or high".

The CDC guidance document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic", with a revision date of Feb. 2, 2022, was reviewed. This document read, "Implement Universal Use of Personal Protective Equipment for HCP [health care personnel]...Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters..." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

On 2/17/22 at approximately 1:00 PM, the facility Administrator and Director of Nursing were made aware of the findings.

No further information was provided.

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3. The facility staff failed to wear appropriate PPE while providing care to a Resident (Resident #33) who was not fully vaccinated against COVID-19.

On 2/15/22, the facility submitted a document indicating the vaccination status of each Resident. Resident #33 was noted on this document as having received only 1 dose of the COVID-19 Pfizer multi-dose vaccine.

On 2/16/22 at approximately 9:00 AM, Resident #33 was observed in the dining room eating breakfast. Other Residents were also present and all of them were socially distanced.

On 2/16/22, a clinical record review was conducted for Resident #33. This review revealed that Resident #33 had only received one dose of a multi-dose vaccination series for COVID-19. There was a nursing note dated 2/1/22, that was entered into the clinical record by the DON (Director of Nursing) that read, "Resident has given permission for COVID 2nd vaccine but is unable to receive for 30 days after having COVID per Pharmacist [name and pharmacy name redacted]. Resident is aware and in agreement".

On 2/17/22 at 8:45 AM, CNA F and CNA B were observed entering Resident #33's room wearing only a procedure mask and eye protection.

On 2/17/22 at 8:50 AM, an interview was conducted with the DON, who is also the facility's infection preventionist. The DON confirmed that Resident #33 is not fully vaccinated for COVID-19. When asked what precautions are

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put in place for a Resident who is not fully vaccinated she indicated that if they come out of their room to common areas then everyone has to wear a mask, such as group activities. The DON was asked if any additional PPE had to be utilized when caring for Residents who are not fully vaccinated and she stated no.

On 2/17/22 at approximately 8:55 AM, the DON confirmed that the facility follows all guidance from CDC with regards to COVID-19 response and mitigation. She was shown the CDC guidance document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" which indicated that Residents who are not fully vaccinated should be cared for using full PPE. The DON stated, "We don't wear an N95 if they are not on quarantine, I didn't know".

On 2/17/22 at 10 AM, an interview was conducted with CNA D, who confirmed she was assigned to Resident #33. CNA D confirmed she had provided direct Resident care to Resident #33 which included personal hygiene and transfer to the wheelchair and had only worn a procedure mask. CNA D stated she was not aware of any additional PPE being needed/required since there was no signage on the door and not PPE located outside of the room.

On 2/17/22 at 10:08 AM, the DON approached Surveyor D and stated, "everyone has been educated [referring to the need to wear PPE when Residents are not fully vaccinated] and I have talked with him [referring to Resident #33] and let him know why".

On 2/17/22 at 10:15 AM, CNA F was observed to

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enter the room of Resident #33 wearing a KN95 and eye protection. She did not don [put on] an isolation gown or gloves prior to entry.

Review of the facility policy titled, "CDC-Guidance- New Infection in Healthcare Personnel or Resident" with a revision date of February 2022, was conducted. This policy read, "...Residents and HCP who are not up to date with all recommended COVID-19 vaccine doses: These residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher level respirator, eye protection (goggles or a face shield that covers the front and side of the face), gloves and gown. They should not participate in group activities..."

Review of the CDC guidance document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, updated Feb. 2, 2022, was conducted. This document read, "New Infection in Healthcare Personnel or Residents....Residents and HCP who are not up to date with all recommended COVID-19 vaccine doses: · These residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities...." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030997450

On 2/17/22 at 1:00 PM, the facility Administrator and Director of Nursing were made aware of the

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F 880	Continued From page 68 findings. No additional information was provided.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, facility staff interview, and facility documentation review, the facility staff failed to ensure there was a functional system for Residents to call staff for assistance, for one Resident (Resident #33) in a survey sample of 28 Residents. The findings included: On 02/15/22 at 2:56 PM, during an interview with Resident #33, the Resident reported his call bell didn't work and had not for quite some time. Surveyor D engaged the call bell and noted that it did not light the indicator outside of the room. On 2/15/222, during the late afternoon, Surveyor D met with the Maintenance Director and requested a list of all pending maintenance work orders. On 02/16/22 at 8:57 AM, Surveyor D visited Resident #33 in his room. The call bell was	F 919	1.Resident #33 was given a tap bell on 2/15/2022 and nurses educated on appropriate placement for resident to utilize bell. 2.All residents have the potential to be affected. 100% audit on all resident rooms to inspect resident call bell functionality was conducted on 2/15/2022. All identified issues were corrected on 2/15/22. 3.All Staff will be educated on proper placement for call bells or tap bells to residents and regarding residents individual needs by 3/18/2022. Staff will be re-educated on all equipment including Call Bell System to be properly operational which is to allow residents to communicate with staff directly or to a centralized staff work area by 3/18/2022.	3/18/22

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	495268	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

(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 919	Continued From page 69 pressed/engaged by the surveyor, and was noted to not be working. On 02/16/22 at 8:58 AM, an interview was conducted with RN A. RN A confirmed the call bell is engaged in the room, gives an auditory alarm, lights up out in the hall and has a notification at the desk. RN A further confirmed that call bells are used "If the resident needs assistance or a staff member needs assistance in the room as a means to alert staff". On 02/16/22 at 9:04 AM, RN A accompanied Surveyor D to the room of Resident #33. RN A engaged the call bell and confirmed it did not provide any auditory alarm, didn't light up outside of the room and didn't alarm at the nursing station. She said "This is one of our renovated rooms, I will put a work order in". RN A confirmed Resident #33 had no other means to call staff for assistance. On 02/16/22 at 9:09 AM, RN A notified the Director of Nursing (DON) of the call bell for Resident #33 not working. The DON said, she was aware of it over the weekend, a work order was in place and maintenance was waiting on parts to make the repairs. On 2/16/22 at approximately 9:12 AM, RN A provided Resident #33 with a hand bell to summons staff if assistance was needed. On 2/16/22 at 11:09 AM, the facility staff provided the survey team with the requested listing of all maintenance work orders for the month of February. Review of this document revealed the only maintenance work order for Resident #33's call bell was entered on 2/16/22.	F 919	Any nonfunctioning call bells will be reported to Administrator, Director of Nursing, Maintenance Director immediately. 4.Maintenance Director / designee will audit the call bell system in every room daily for 1 week, then 20 periodic room twice a weekly for 2 weeks, then 10 periodic rooms twice weekly for 2 months. The Administrator will be notified via phone by the weekend Manager on Duty of any call light system failure in need of repair. Results of audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	

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 919	Continued From page 70	F 919		

On 2/17/22 at 8:47 AM, Resident #33 was observed sitting in his wheelchair between his bed and the roommate's bed. The hand bell to be used to call for assistance was observed across the room, on the opposite side of his bed on the bed side table out of reach. Resident #33 had no means to summons facility staff if assistance was needed.

On 2/17/22 at 9:02 AM, an interview was conducted with the Maintenance Director with regards to Resident #33's call bell. The Maintenance Director stated, "The plate on the wall was damaged during the renovation and we are getting a new call bell system mid-March". The maintenance director further indicated that no repairs would be made to Resident #33's call bell until the call bell system is replaced in mid-March and that he was not waiting on parts to make repairs.

Review of the facility policy titled, "Answering the Call Light" was conducted. This policy read, "General Guidelines" ...4. Be sure that the call light is plugged in and functioning at all times...7. Report all defective call lights promptly".

Review of the facility policy titled, "Maintenance Service" was conducted. This policy read, "1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times..."

On 2/17/22, at approximately 1:00 PM, the facility Administrator and Director of Nursing were made aware of the above noted findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495268	A. BUILDING _____ B. WING _____	C 02/17/2022

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F 919	Continued From page 71 No further information was provided prior to the conclusion of the survey.	F 919		