STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495428	A. BUILDING _____ B. WING _____	C 04/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT RICHMOND	1503 MICHAEL ROAD RICHMOND, VA 23229

(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 04/05/22 through 04/07/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare Initial survey and Medicaid Recertification survey was conducted 04/05/22 through 04/07/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint, VA00052293- Substantiated with deficiency, was investigated during the survey. The census in this 32 certified bed facility was 28 at the time of the survey. The survey sample consisted of 15 resident reviews and 5 staff record reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		4/26/22

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

Electronically Signed | 04/20/2022

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F 584	Continued From page 1 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to provide a homelike environment for one Resident (Resident #20) in a sample size of 15 Residents. For Resident #20, the facility staff failed to ensure Resident #20 had easy access to his bathroom sink. The findings included:	F 584	1.Resident #20 has easy access to his bathroom sink. 2.A review of all resident's rooms to be conducted by the Administrator and Maintenance Director to ensure residents have easy access to their bathroom sinks. 3.Administrator/designee has educated the maintenance director to ensure the importance of all residents having easy access to their bathroom sink. The	

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F 584	Continued From page 2 On 04/05/2022 at 10:15 A.M., Resident #20 was observed seated in his wheelchair self-propelling in his room. When asked if he had any concerns about the care he receives at the facility, Resident #20 stated that his concern is that he cannot get to his sink while seated in his wheelchair. Resident #20 then stated that there was a bar in the way. This surveyor observed that the commode and sink were side by side on the left wall upon entry to the bathroom. In between the commode and the sink, there was an L-shaped bar attached to the wall, extending out the length of the commode and bolted into the floor. There was a side bar that extended into the pathway of the sink and was also bolted to the floor. On 04/06/2022 at 1:55 P.M., Resident #20 was observed seated in his wheelchair self-propelling in his room. A follow-up interview with Resident #20 was conducted. When asked how he would brush his teeth or wash up in the morning, Resident #20 stated that staff provide a pink basin for him and put it on his tray table. Resident #20 then self-propelled into the bathroom to demonstrate how he could not fit the wheelchair into the space between the side bar and the wall to access the sink. On 04/06/2022 at 2:20 P.M., Certified Nursing Assistant E (CNA E) was interviewed. CNA E verified she assisted Resident #20 this morning with set up for brushing teeth. When asked how that was done, CNA E stated that she filled a basin and placed it on the tray table and put it in front of him. When asked why Resident #20 did not use the bathroom sink, CNA E stated another Resident who shares the bathroom with Resident #20 was using the bathroom at the time.	F 584	Maintenance director has also been educated on ensuring that all empty resident designated room have bathroom sink accessibility for any new admissions or transfers. 4.The administrator/designee to conduct audits of residents/resident designated rooms having easy access to their bathroom sink. Quality monitoring to be conducted weekly X8 weeks and as needed thereafter. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 584	Continued From page 3 On 04/06/2022 at 3:35 P.M., this surveyor and Employee H, the Maintenance Director, entered Resident #20's room. Resident #20 again stated he couldn't get to his sink. The Maintenance Director measured Resident #20's wheelchair width to be 26.5 inches and the distance between the side bar and the wall in the bathroom to be 26.5 inches. Upon exiting the room, the Maintenance Director stated that it needed to be fixed and that it was "an easy fix." On 04/06/2022, Resident #20's clinical record was reviewed. Resident #20's most recent Minimum Data Set with an Assessment Reference Date of 03/14/2022 was coded as an admission assessment. The Brief Interview for Mental Status was coded as "13" out of "15" indicative of intact cognition. On 04/06/2022 at approximately 4:00 P.M., the administrator was notified of findings. On 04/07/2022 at approximately 10:15 A.M., Resident #20 was observed seated in his wheelchair self-propelling in his room. When asked about accessing the bathroom sink, Resident #20 stated he was now able to access his sink and demonstrated ability to self-propel to the bathroom sink. This surveyor observed the side bar had been removed to widen the space.	F 584		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		4/26/22

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F 658	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review, and clinical record review, the facility staff failed to follow professional standards of practice for one Resident (Resident #27) in a survey sample of 15 Residents. For Resident #27, the facility staff failed to notify the physician when a medication was not available. The findings included: On 4/5/22 and 4/6/22, a closed clinical record review was conducted for Resident #27. This review revealed: On 11/26/21 at 4:50 PM, the facility nursing staff spoke with the attending physician and obtained treatment orders which included an antibiotic and nebulizer treatments. On 1/4/22-1/10/22, Resident #27 missed 7 consecutive days of his nebulizer treatment doses, due to the medication not being available. There was no indication in the clinical chart that the physician had been notified of the unavailability to assess if alternate treatments were needed. A review was performed of the facility policy titled, "Change in Condition/Notification of Physician & Responsible Party". This policy read, "The facility will immediately inform the Resident, consult with the resident's physician, and notify responsible party/appointed guardian when there is: ...*A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 658	1.Resident #27 no longer resides at the facility and this deficient practice cannot be corrected retroactively for this resident. 2.A review of all resident orders for Inhalation treatment has been conducted by the Director of Nursing to ensure residents who have orders for nebulizer treatments have medication on hand and available. 3.The Director of Nursing/designee has educated the Nursing staff on the process of notification to the Physician when medication has been delayed and or not available from the Pharmacy. 4.The Director of Nursing/designee to conduct weekly audits of medication availability and Physician notification. Quality monitoring to be conducted weekly X8 weeks and as needed thereafter. Findings to be reported to QAPI committee monthly times two months and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 658	Continued From page 5 deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications)...A need to alter treatment significantly..." On 4/6/22, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the findings. The Director of Nursing stated the facility follows Lippincott for professional standards of practice for nursing services. Lippincott's "Manual of Nursing Practice" Eighth Edition, addresses on pages 13-14 "Examples of Ethical Dilemmas and Possible Responses". This document read, "...Nonresponse by Physician". Page 17 discusses, The "Standards of Professional Nursing Practice" and stated, "Standards of professional performance" include "Resource Utilization". Page 18 read, "Common Legal Claims for Departure from Standards of Care: Failure to communicate or document a significant change in a patient's condition to appropriate professional. Failure to administer medications properly and in a timely fashion, or to report and administer omitted doses appropriately". No further information was received/provided.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		4/19/22

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F 684	Continued From page 6	F 684		

accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews, clinical record review, and facility documentation review, the facility staff failed to provide treatment and services to one Resident (Resident #27) in a survey sample of 15 Residents.

For Resident #27, the facility staff failed to solicit assistance from the facility management and medical director for treatment orders for a Resident with pneumonia on two occasions, when the attending physician was not responsive, which resulted in a delay in treatment. Past non-compliance was achieved on 2/28/22.

The findings included:

On 4/5/22 and 4/6/22, a closed clinical record review was conducted for Resident #27. This review revealed a delay in treatment for pneumonia on two occasions. The details are as follows:

* On 11/24/21, Resident #27 exhibited abnormal bilateral lung sounds. A chest x-ray was ordered.

* On 11/25/21 at 10:35 AM, the results of the chest x-ray were received and showed a "left base infiltrate and/or small effusion". Nursing notes showed that the facility staff attempted to reach the attending physician and nurse practitioner throughout the day. However, no attempts were made to notify the medical director that the attending physician was not responding, in an effort to obtain treatment orders for

Past noncompliance: no plan of correction required.

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Resident #27's infection.

* On 11/26/21 at 4:50 PM, [two days after symptom onset], the facility nursing staff spoke with the attending physician and obtained treatment orders which included an antibiotic and nebulizer treatments.

* On 1/12/22, Resident #27 was noted to have abnormal lung sounds and increased congestion. A chest x-ray was ordered. On 1/12/22 at 10:44 PM, the chest x-ray results were received and noted "possible bilateral pneumonia". Nursing notes showed that the facility staff attempted to reach the attending physician but were not successful.

* On 1/13/22 at 6:34 AM, attempts to reach the attending physician were again unsuccessful. There was no indication that the facility nursing staff notified facility management or medical director in an effort to obtain treatment orders for Resident #27.

* On 1/13/22 at 1:15 PM, the facility staff obtained treatment orders for an antibiotic from the attending physician for Resident #27.

On 4/6/22 at 12:42 PM, an interview was conducted with LPN B. LPN B confirmed that if a Resident had a change in condition she would continue to call the provider until she got a response.

On 4/6/22 at 12:30 PM, and again at 3:17 PM, the attending physician for Resident #27 was attempted to be reached via telephone, but the calls were not successful.

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F 684	Continued From page 8	F 684		

On 4/6/22 at 3:44 PM, an interview was conducted with Employee G, an RN. She stated that she tended to get a better response from the nurse practitioner than the attending physician for Resident #27, "but neither of them were fantastic, they didn't have an on-call service and there were times they weren't reaching back out timely. It was a challenge". Employee G said if it was an excess of 24 hours, "That's when you would reach out to the Administrator, Director of Nursing and Medical Director".

On 4/6/22 at 6:11 PM, an interview was conducted with LPN D. LPN D stated that frequently she would attempt to call the attending physician and nurse practitioner and would not have an option to leave a message and would have to call multiple times to get a response. LPN D stated it was pretty common to go an entire shift without a response.

A review was performed of the facility policy titled, "Prohibition of Abuse". This policy stated, "...The facility promotes the Rights of Residents to be free from verbal, sexual, physical, and mental abuse, including involuntary seclusion, neglect, exploitation and misappropriation of property... Neglect - is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress".

A review was performed of the facility policy titled, "Attending Physician/Provider Responsibilities". This policy read, "...Ensuring Adequate Ongoing Coverage:
1. The Attending Physician/Provider will designate an alternate physician or another appropriately

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licensed practitioner to respond in an appropriate, timely manner in case the Attending Physician is unavailable. The Medical Director will respond to all residents' medical issues if facility is unable to reach Attending Physician/Provider".

On 4/6/22, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the findings.

On 4/7/22, during the review of the facility Quality Assurance (QA) Program, the facility Administrator indicated they had identified a concern with the facility staff not reaching out to the Medical Director when the attending physician was not responsive in January 2022. The facility held an ad hoc QA meeting on 1/26/22, and initiated a root cause analysis and plan of correction which was completed 2/28/22. The plan of correction included: "Primary MD (medical doctor) not responding to calls, Medical Director to be notified 30 minutes after calling primary MD without response. All Residents have the potential to be affected. The Director of Nursing or designee to educate licensed nurses to notify the Medical Director when Primary Care MD does not respond within 30 minutes. The Director of Nursing/designee to monitor the licensed nurses calling Medical Director when Primary MD does not respond monthly x 2 months. Findings to be reported to QAPI (Quality Assurance and Performance Improvement) committee monthly and updated as indicated". The education of licensed nurses was reviewed. The monthly audits were reviewed.

On 4/7/22 at 10:30 AM, an interview was conducted with LPN C, to validate the past non-compliance. LPN C said that if she was not

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F 684	Continued From page 10 able to reach the doctor or didn't get a return call within 30 minutes, she would call the medical director. LPN C confirmed she was trained on this about a month or two ago. No further information was received/provided.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide needed care and treatment for one Resident (Resident #22) in a sample size of 15 Residents. Specifically, the facility staff failed to ensure Resident #22's oxygen was humidified on 04/06/2022. The findings included: On 04/06/2022 at approximately 9:55 A.M., this surveyor observed Resident #22 approach Licensed Practical Nurse B in the hall and stated that she had been waiting over 24 hours for someone to fill her water bottle. LPN B apologized and stated she would get her water.	F 695	1.Resident #22 oxygen concentrator now contains a full humidifier bottle of distilled water as indicated. 2.A review of all resident orders for oxygen therapy has been conducted by the Director of Nursing to ensure all residents who have orders for oxygen therapy have a humidifier bottle with an adequate water supply. 3.The Director of Nursing/designee has educated the Nursing staff on the process ensuring humidification of oxygen concentrators is being monitored every shift to ensure the humidifier bottles have an adequate water supply. 4.The Director of Nursing/designee to conduct weekly visual audits of concentrators in use to ensure the	4/26/22

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F 695	Continued From page 11 Resident #22 then stated that "24 hours is too long to wait for water." At approximately 10:10 A.M., Resident #22 was observed seated in her chair in her room. Resident #22 had oxygen set at 2 liters per minute via nasal cannula (the tubing was dated 04/04/22). The humidified reservoir was empty. When asked about the empty reservoir, Resident #22 indicated that she had COPD (chronic obstructive pulmonary disease) and stated "If there's no water in there, it causes my coughing to be worse and makes my throat so dry." Resident #22 went on to explain that "About this time yesterday" she told one of the aides the bottle needed to be refilled and she said she would tell the nurse. Resident #22 stated "around dinnertime" she told a different aide and the aide said she would tell my nurse. Then a third person came around and "I told them, too." Resident #22 stated that every time she saw an aide she would tell her the bottle needed to be refilled and the aide would say she would tell the nurse. LPN B then entered the room and filled the reservoir with distilled water. Resident #22 continued and stated that "I didn't have a good night because I was coughing; my throat was so dry and I felt choked." LPN B then stated "I was in here several times yesterday and you didn't say anything to me." Resident #22 then indicated that when her oxygen is not humidified, she "finds it is hard to focus." Resident #22 then began to cry. LPN B stepped close to Resident #22 and comforted her. At approximately 10:25 A.M., Resident #22 was no longer crying when LPN B and this surveyor exited the room. LPN B then stated that when "[Resident #22] gets angry or frustrated, she will cry." When asked about the humidified reservoir, LPN B stated that she saw water in the reservoir when she came on her shift yesterday [morning of 04/05/2022].	F 695	humidifier bottles contain an adequate water supply. Quality monitoring to be conducted weekly X8 weeks and as needed thereafter. Findings to be reported to QAPI committee monthly times two months and updated as indicated. Quality monitoring schedule modified based on findings. 5. April 26, 2022.	

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F 695	Continued From page 12	F 695		

On 04/06/2022 at 10:35 A.M., Certified Nursing Assistant C (CNA C) was interviewed. CNA C verified she worked on the day shift on 04/05/2022. When asked if she had any interaction with (Resident #22), CNA C stated that she was not assigned to care for Resident #22 yesterday and didn't have any interaction with (Resident #22) yesterday.

On 04/06/2022 at 10:45 A.M., Certified Nursing Assistant D (CNA D) was interviewed. CNA D confirmed she was assigned to care for Resident #22 on 04/05/2022 and this day 04/06/2022. When asked about Resident #22 CNA D stated that "[Resident #22] is not a morning person" and "I asked her if she wanted breakfast about 10:30 [A.M.]." When asked about the water in her humidifier, CNA D stated it was a little over half full at breakfast time" yesterday. When asked if Resident #22 requested the bottle be refilled, CNA D stated that "[Resident #22] didn't say anything about her humidifier." When asked if there was water in the humidifier this morning, CNA D indicated that the machine was on but she did not take note if there was water in the humidifier reservoir.

On 04/06/2022, Resident #22's clinical record was reviewed. Resident #22's most recent Minimum Data Set with an Assessment Reference Date of 03/17/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of "15" indicative of intact cognition.

Resident #22's care plan was reviewed. A focus dated 10/08/2019 entitled, "[Resident #22] has oxygen therapy r/t [related to] COPD" included

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F 695	Continued From page 13 but was not limited to the following intervention with a revision date of 06/21/2021: "Administer O2 [oxygen] via nasal prongs/mask at 2L [2 liters per minute] continuously." Humidification of oxygen was not addressed on the care plan. On 04/06/2022 at 4:45 P.M., the administrator and Director of Nursing (DON) were notified of findings. When asked about the expectation of oxygen humidification reservoirs, the DON indicated that the nurses should be checking to make sure the reservoirs remain adequately filled. On 04/07/2022, the facility staff provided a copy of their policy entitled, "Oxygen Concentrator/Oxygen Utilization." An excerpt under the section entitled, "The facility may perform some functions to maintain adequate flow of oxygen via device to include: In [sic] oxygen device have humidifier application, ensure humidifier bottle has distill [sic] water present at appropriate level." On 04/07/2022, the Director of Nursing provided an updated copy of the care plan. Under the focus dated 10/08/2019 entitled, "[Resident #22] has oxygen therapy r/t [related to] COPD" included but was not limited to the following intervention with a revision date of 04/07/2022: "Administer O2 [oxygen] via nasal [sic] at 2L [2 liters per minute] continuously with humidification." On 04/07/2022 at approximately 1:00 P.M., the administrator stated there was no further information or documentation to submit.	F 695		
F 727	RN 8 Hrs/7 days/Wk, Full Time DON	F 727		4/26/22

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F 727 SS=E	Continued From page 14 CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, and in the course of a complaint investigation, the facility staff failed to provide Registered Nurse coverage 8 consecutive hours per day for 3 days out of 30 days in June 2021 and for 6 days out of 31 days in July 2021. The findings include: Facility staff failed to provide Registered Nurse (RN) coverage in June 2021 on 6/11, 6/21, 6/30, and in July 2021 on 7/14, 7/15, 7/16, 7/17, 7/28, and 7/31. On 4/5/22, an interview was conducted with Employee F who confirmed he was responsible for payroll records at the facility. A copy of the payroll records for all Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), to include time	F 727	1. The facility cannot retroactively correct this deficient practice. 2. A review of staffing sheets from January 1, 2022 to date revealed that the facility has had 8 hour of consecutive RN hours as indicated. 3. The Director of Nursing/designee has educated the scheduler to ensure that the facility has consecutive 8 hours of RN coverage daily. 4. The Director of Nursing/designee to conduct audits of the as worked/staffing schedule to ensure compliance of 8 hour of RN coverage daily. Quality monitoring to be conducted weekly X8 weeks and as needed thereafter. Findings to be reported to QAPI committee monthly times two months and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 727	Continued From page 15 clocked in and out, for the months of June 2021 and July 2021 was requested and provided by Employee F who verified the records were accurate and complete. On 4/6/22, a review of the payroll records revealed the following: For June 2021, there was no RN coverage on 6/11, there was partial RN coverage for 6.75 hours on 6/21, and no RN coverage on 6/30. For July 2021, there was no RN coverage for 7/14 and 7/15, there was partial RN coverage for 3.75 hours on 7/16, no RN coverage for 7/17, no RN coverage on 7/28, and partial RN coverage for 4.5 hours on 7/31. On 4/6/22, an interview was conducted with the Director of Nursing (DON) who stated, "it is facility practice for all nursing staff, including the DON, to use the timeclock when coming to work and when leaving". Review of the payroll records confirmed several timeclockings for the DON concurrently with other facility RNs. No further information was provided.	F 727		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		4/26/22

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F 755	Continued From page 16 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review, and clinical record review, the facility staff failed to administer medications due to a lack of availability on 11 occasions, to one Resident (Resident #27) in a survey sample of 15 Residents. The findings included: On 4/5/22, Surveyor B conducted a clinical record review for Resident #27. This review revealed a physician order dated 11/27/21, that read, "Xopenex Nebulization Solution 0.63 MG/3ML (Levalbuterol HCl) 1 vial inhale orally via nebulizer two times a day for Pneumonia".	F 755	1.Resident #27 no longer resides at the facility. 2.A Review of resident orders has been initiated to ensure that prescribed medications are on hand and available. 3.The Director of Nursing/designee has educated the Nursing staff on the process of notification to the Physician when medication has been delayed and or not available from the Pharmacy. Polaris Pharmacy will continue to provide twice daily medication deliveries Monday through Saturday and a once daily delivery on Sunday. Licensed Nurses have been educated on the process to	

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F 755	Continued From page 17 Review of the MAR (medication administration record) revealed that Resident #27 did not receive this medication as prescribed on 11 occasions on the following dates: 11/28/21, 1/4/22, 1/5/22, 1/6/22, 1/7/22, 1/8/22, 1/9/22, and 1/10/22. Review of the nursing notes revealed entries that noted "pending delivery" and "not available". There was no indication that the physician had been notified of the medication not being available to administer as per the physician order. On 4/6/22 and 4/7/22, interviews were conducted with LPN B, LPN C, LPN D, and Employee G, who is an RN and the facilities' infection preventionist. Each of the 4 nurses confirmed that the pharmacy makes two deliveries to the facility daily and there is a back-up pharmacy. If a medication is urgent or needed immediately, all four nurses said the pharmacy could send the prescription to a local pharmacy that could be picked up for immediate administration. On 4/6/22, the facility Administrator provided a copy of the STAT (emergency) box contents. This box is a supply of medications maintained on-hand at the facility that can be used in the event of an emergency or new order. Review of this document revealed that the Xopenex was not kept on-hand in the STAT box. Review of the facility policy titled, "Medication Pass/Administration" was reviewed. This policy read, "...If any ordered medication is not available, call the physician to get an alternate substitute to administer or get an order from the physician to administer the unavailable	F 755	remove medications from the stat box as indicated. In the event a medication is not available in the stat box or of a delay in pharmacy delivery of a medication, the Pharmacy and Physician will be contacted for possible resolution. 4. The Director of Nursing/designee to conduct audits of ensuring medication availability and Physician notification of pharmacy delays. The Director of Nursing will conduct audits of Pharmacy delivery of medication weekly x8 weeks and as needed thereafter to ensure timely delivery and/or identify any issues. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.	

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F 755	Continued From page 18 medication at a time when it is available from the pharmacy. The physician will have to make a clinical judgement if the delay in the medication will have no impact in the resident quality of care"... The facility policy titled, "Medication Ordering" was reviewed. This policy stated, "...6. If any ordered medication is not available despite been ordered/reordered, call the physician to get an alternate substitute medication available in the emergency kit. The nurse may also get an order from the physician to administer the unavailable medication at a time when available from the pharmacy. The physician will have to make a clinical judgement if the delay in the medication administration will have no impact in the resident quality of care"... On 4/6/22, during an end of day meeting, the facility Administrator and Director of Nursing were made aware that Resident #27 had a delay in receiving medications as ordered. No further information was received.	F 755		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		4/26/22

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility 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

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F 880	Continued From page 20 (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 staff interviews and facility documentation review, the facility staff failed to maintain an active facility wide Infection Prevention Control Program (IPCP) with regards to infection surveillance and tracking for one Resident (Resident #27) in a survey sample of 15 Residents, but had the potential to affect multiple Residents within the facility. The findings included: On 4/5/22, during the survey entrance conference, the facility Administrator identified Employee G as the facility Infection Preventionist. The Administrator stated that Employee G was out on vacation, but they had access to all of her information and files, as well as Employee G being available via telephone. On 4/6/22, the facility Administrator submitted the infection line listing/infection surveillance for the months of November and December 2021, and	F 880	1. Resident # 27 suffered no adverse effect related to this deficient practice. Resident's # 27 infection for Pneumonia which was treated with antibiotic in January 2022 will be retroactively included in the line listing. Also, Resident's # 27 episodes of watery stools on 12/29/21 & 12/31/2021 will be retroactively included in the infection control tracking form. 2. All resident with Healthcare Associated Infection (HAI) or epidemiological significant infections or symptoms of infection are at risk to be affected by this deficient practice. Infection Preventionist/Designee will retroactively audit clinical records of residents who were at risk of this deficient practice from November 2021- April 18, 2022. The audit will ensure all residents who were on antibiotics are included in the line listing and residents not on antibiotics but whose data contains symptoms which are	

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F 880	Continued From page 21 January 2022. These documents were reviewed and noted that only Residents with infections being treated with antibiotics, were listed. It was also noted, that Resident #27's infection for pneumonia, which was treated with an antibiotic in January 2022, was not noted on the line listing. Also, Resident #27's episodes of "watery stools" on 12/29/21 and 12/31/21, had not been recorded on any of the infection tracking documents. On 4/6/22 at 3:44 PM, a telephone interview was conducted with Employee G, the infection preventionist. Employee G stated that she tracks infections when Residents are put on an antibiotic so she can monitor and it is also a visual cue if someone has been on an antibiotic multiple times, she can evaluate if there is a colonization issue, identify trends, etc. Employee G was asked if there is any reason why someone would be on an antibiotic and not on the infection surveillance/line listing. Employee G said, "If it is an antibiotic following surgery, such as someone had cataract surgery and following that is on antibiotic eye drops, I wouldn't put them on there, or if it is treating something that is not a healthcare associated infection". Employee G was asked about a Resident having completed a course of antibiotics and then approximately two weeks later develops watery stools. Employee G said she would immediately think about "C-diff [Clostridium difficile, an infection of the large intestine (colon) caused by the bacteria Clostridium difficile. Long-term use of antibiotics reduces the normal bacterial population in the intestine and triggers the C. difficile overgrowth in the intestine] which is highly contagious". Employee G was asked if she	F 880	relevant to tracking, surveillance, contact tracing and diseases analysis are included. 3. The Administrator will educate the Infection Preventionist Control Officer (IPCO) and Nursing Leadership on the importance of maintaining an active facility wide Infection Prevention Control Program (IPCP) with regards to infection surveillance and tracking. Education will include importance of ensuring monitoring systems to identify potential infection outbreaks, symptoms, relevant tracking, contact tracing and disease analysis. The Director of Nursing/or Infection Control preventionist to provide education to the Licensed Nursing staff on ensuring that resident antibiotic medication use and symptoms displayed with or without antibiotic usage are being documented on and monitored timely. 4. The Infection Prevention Control Officer (IPCO)/ Designee will complete weekly audits of the Infection Control Line Listing Form to ensuring it reflects all residents receiving antibiotic for infection. The audit will also ensure the Line Listing contains systems monitoring to identify potential infection outbreaks, symptoms, relevant tracking, surveillance, contact tracing and disease analysis. Findings of the facility's audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance.	

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monitors systems such as this or gastro-intestinal virus symptoms such as noro-virus on a surveillance log, to identify potential infection outbreaks. Employee G said, "No, but I see where that could be beneficial now that you mention it".

Review of the facility policy titled, "Surveillance for Infections" was conducted. This policy read, "The Infection Preventionist (IP) will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions...The resident line list and staff line list should contain relevant data which will help tracking, contact tracing and disease analysis".

The facility staff submitted evidence that Employee G completed the CDC Nursing Home Infection Preventionist Training Course. In module 4 of this training the CDC stated, "The purpose of infection surveillance is to identify infections and to monitor adherence to recommended IPC (Infection Prevention and Control) practices in order to reduce infections and prevent the spread of pathogens among residents, staff, and visitors. An IPC program uses surveillance data to: Monitor trends in infections and pathogens, including detecting outbreaks. Monitor staff adherence to IPC practices. Identify performance improvement opportunities. Track progress toward priorities identified on the annual facility IPC risk assessment and inform the development of future risk assessments".

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F 880	Continued From page 23 On 4/7/22, the Administrator and Director of Nursing were made aware of the findings. On 4/7/22, the facility Administrator shared with the survey team, that she had previously discussed the surveillance and tracking of infections and symptoms with Employee G and didn't know why this wasn't being done. No further information was provided by the facility.	F 880		