STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	C 04/27/2022

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PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(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 04/24/2022 through 04/27/2022. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	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. (D) Sewage and waste disposal.	E 015		6/7/22

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

Electronically Signed | 05/18/2022

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E 015	Continued From page 1 *[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: On 04/27/2022 at approximately 3:00 P.M., the facilities Emergency Preparedness Program was reviewed with the administrator. There was no evidence the plan included provision for sewage and waste disposal during an emergency. At approximately 5:00 P.M., the administrator acknowledged she was unable to provide evidence of the emergency sewage and disposal plan.	E 015	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	

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E 015	Continued From page 2	E 015	E015 1- The Emergency Preparedness Plan has been updated with a plan related to sewage and waste disposal 2- Current residents in the center have the potential to be affected. 3- The Administrator/Maintenance Director will be educated by the VP Of Operations/designee on the requirements for reviewing/updating the Emergency Preparedness Plan annually. 4- The VP of Operations/Designee will review the required plan related to sewage and waste disposal in the Emergency Preparedness Plan and Update as needed 5- Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis. 6- Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/24/22 through 4/27/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Seven complaints, VA00054939-Substantiated without Deficiency, VA00054699-Substantiated without Deficiency, VA00054602-Unsubstantiated,	F 000		

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F 000	Continued From page 3 VA00053952-Substantiated with Deficiency, VA00053832-Substantiated without Deficiency, VA00053182-Substantiated with Deficiency, VA00052828-Substantiated with Deficiency, were investigated during the survey. The census in this 180 certified bed facility was 153 at the time of the survey. The survey sample consisted of 58 resident record reviews.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		6/7/22

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F 565	Continued From page 4 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility documentation review, the facility staff failed to respond to Resident Council grievances. The findings included: The Resident Council President gave permission on 4-24-22 for surveyors to review the Resident Council minutes for the last 3 months prior to a meeting with the Council, planned for 4-25-22. Resident Council minutes were reviewed from January 2022 through March 2022. The minutes revealed ongoing concerns and complaints regarding: late food delivery and comes cold, quality and quantity of meals served, water and ice not being passed, call bells not answered timely, short staffing and agency staffing, and lack of care during the night shift. These concerns persisted over the course of the 3 months reviewed, and during the survey. On 4-25-22 at 11:00 A.M., a surveyor met with 5 members of the Resident Council. The Council stated that "no one from administration ever comes to Council meetings, they say they are too busy, and nothing ever gets resolved." The Residents verbalized that the same issues and complaints remain with no resolution. This is	F 565	F565 1. Resident Council grievances are now being addressed by the Administrator with follow up at the time of the grievances back to the committee. 2. Review of resident council grievances for the last three-monthly meetings have been reviewed to ensure areas of concern have been addressed. 3. The VP of operations/designee will educate the Administrator and Director of nursing on requirement to communicate their response and rationale related to concerns voiced by resident council group. In addition, education will include follow up to ensure areas of concern to not re-appear. 4. The VP of operations /designee will review resident council minutes to ensure appropriate attendance by Administrator /Director of nursing upon invitation. The administrator/designee will review resident council grievances monthly to ensure areas have been addressed. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted	

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F 565	Continued From page 5 borne out by the repetition of the same grievances in all 3 months of council minutes that were reviewed by surveyors. Throughout the survey, conducted from 4-24-22 through 4-27-22, other residents expressed the same concerns about the same issues. On 4-26-22 at 3:30 PM, an interview was conducted with a family member of one of the Residents. The daughter of the Resident stated "Nursing is a big issue here, they have a lot of agency staff, and they don't know the Residents, and don't really care. I asked one of them how they would feel if this was their mother, and the nurse replied it's not my mother." On 4-26-22, and 4-27-22, the facility Administrator was made aware of the concern that Resident Council expresses the same concerns for months with no resolution being indicated. The Administrator stated, "I have not been able to attend Council recently, however, I will go this month." The Administrator revealed that the Residents had requested that the Administrator and DON (director of nursing) attend the next scheduled meeting. No additional information was received.	F 565	on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		6/7/22

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physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 7 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, and in the course of a complaint investigation, the facility staff failed to notify the Resident Representative of a change in condition and room changes for one Resident (Resident #305) in a survey sample of 58 Residents. The findings included: 1. For Resident #305, the facility staff failed to notify the family of two room changes and didn't notify the family of a new diagnosis of COVID-19 until two days later. On 4/24/22 and 4/25/22, a closed record review was conducted. This review revealed that on 12/8/21, Resident #305 tested positive for COVID-19. Review of the census tab of the chart revealed that Resident #305 had a room change on the same day. There was an additional room change noted on the census part of the chart that took place on 12/23/21. The nursing notes revealed an entry dated 12/8/21, that didn't mention the positive COVID test, nor the room change. An entry dated 12/10/21 at 10:59 AM, read, "RP [responsible party] notified [Resident #305's name redacted] have [sic] positive covid test on 12/8/2021 and updated of facility Covid update". There was no mention of the room change. There were no other entries in the clinical record	F 580	F 580 1. Resident #305 no longer resides in center . 2. Current residents in the center have the potential to be affected 3. The DON/designee will educate Licensed nurses on the facility policy related to documentation of family notification of Covid testing result . In addition, education will include notification the Resident/Resident Representative when room changes occur. 4. The DON/designee will complete a weekly review of family notification related to Covid 19 results and documentation of resident room changes. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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to indicate the Resident and/or responsible party were notified of either of the room changes.

On 4/26/22 at 4:31 PM, the Director of Nursing (DON) was interviewed. When asked about the process of notification when a Resident tests positive for COVID-19, the DON said, "Nursing and staff will talk to the Resident and family and it is documented in the progress notes by the unit manager".

On 4/26/22 at 4:42 PM, an interview was conducted with LPN C, the unit manager and author of the progress note dated 12/10/21. LPN C confirmed that her note was a follow-up and she was unable to say when the family was actually notified of the positive COVID test for Resident #305.

On 4/27/22 at 2:22 PM, an interview was conducted with Employee J, the social worker. Employee J confirmed that he handles the Resident and family notifications regarding room changes. When asked if this is documented, he stated yes, there is a form in the misc. tab of the chart. Employee J then accessed the electronic health record for Resident #305 and confirmed 2 room changes had taken place. When asked to provide evidence that the Resident and/or family were made aware, he said, "during this time people were getting moved a lot due to COVID". The social worker was asked if he made notifications during this time period and he said, "Yes, but I can't find the paperwork for it right now".

Review of the facility policy titled, "Significant Change in Condition" with an effective date of 11/01/19, read, "...4. Responsible Party will also

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F 580	Continued From page 9 be notified of a change in condition...9. Notification of responsible party shall be documented in the progress notes including time and name of person informed". Review of the facility policy titled, "Room Changes" was performed. This policy read, "...3. The Discharge Planner will notify the patient and the roommate of the room change and the reason for the change...7. Using the Discharge Planning Progress Note, document: Room patient moved from, Room patient moved into, Date room change occurred, Confirmation that the MFA Room change notification form was completed and a copy was delivered to the patient/RP. 8. Upon completion of the MFA Room Change Notification, scan and upload the document into the patient's electronic medical record. This document should be scanned into the "Misc" tab and filed under the MFA Room Change Notification category". On 4/27/22 at 5 PM, the facility Administrator, Director of Nursing and Corporate staff, were made aware of the above findings. No further information was provided. Complaint related deficiency.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582		6/7/22

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nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due

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F 582	Continued From page 11 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) for 1 Resident (Resident #133) in a survey sample of 3 Residents reviewed for Beneficiary Notifications. For Resident #133, the facility staff failed to provide a SNF ABN notice prior to skilled care services ending. As a result of this deficient practice Resident #133 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services, known as a demand bill. The findings included: Resident #133 was discharged from a Medicare covered Part A stay on 2/13/22, he remained in the facility. Review of the clinical record revealed the facility staff/social worker issued a NOMNC (notice of Medicare non-coverage) which noted, Resident #133's RP was notified of the notice and appeal rights on 2/11/22. The clinical record revealed no evidence of an ABN being issued. The progress notes made no reference to the NOMNC or ABN. On 04/26/22 at 9:38 AM, an interview was	F 582	F 582 1. Resident #133 representative has been made aware of ABN notification not being completed prior to services ending. 2. A review of residents for the last 30 days who have been discharge from therapy services was conducted to ensure the ABN notification was issued prior to services ending. 3. The Administrator /designee will educate Discharge planning staff on requirement to issue ABN notice prior to services ending. 4. Administrator or designee will complete weekly review of residents having services end to ensure ABN has been provided prior to services ending. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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conducted with the facility Social Worker/Employee J. The Social Worker stated the NOMNC is "when we issue a last covered day to let them know when they will be liable. The ABN is when they don't plan on leaving to let know how much the rate would be and they are ok with that rate". When asked if an ABN is issued to everyone who stays in the facility, the social worker said, "Not necessarily, it is a statement of what the rate will be if they don't discharge, if they will be paying privately".

During the above interview, the social worker accessed the clinical record for Resident #133 and confirmed that the NOMNC was present but he did not see an ABN, he further confirmed that he did not have an ABN for Resident #133 that was not scanned into the electronic health record.

On 4/26/22 at 9:51 AM, the facility Administrator was made aware of the findings. She stated she could reach out to the previous business office manager to see if she had something. When asked if she would expect it to be in the clinical record since the NOMNC was, she stated that she was unsure. The Administrator stated, "When they are cut from insurance they should get both notices". The facility policy was requested.

A review of the facility policy titled, "Advance Beneficiary Notice", was conducted. It read, "The Advanced Beneficiary notice is to be used to comply with federal guidelines for notifying a beneficiary or the responsible party the care the patient is receiving will not be covered by Medicare B".

CMS identifies when the ABN is required to be

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issued in their document titled "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)" read, "Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:
" Not medically reasonable and necessary; or
" Considered custodial".

"The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services". Accessed online at:
https://www.cms.gov/search/cms?keys=ABN

The Administrator was informed on 4/25/22 at 9:51 AM, of the failure of facility staff to provide Resident #133 with a SNF ABN notice prior to skilled care services ending, which would have allowed Resident #133, to make a decision about continuation of services and have Medicare make the coverage determination.

On 4/27/22, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concern.

No further information was provided prior to survey exit.

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F 657	Continued From page 14	F 657		
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. This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to review and revise care plans for unplanned weight loss for Two Residents (Resident #105, and #110) in a survey sample of 58 Residents.	F 657	F657 1. Resident # 105 care plan has been updated to reflect weight loss interventions, Resident #110 care plan has been updated to reflect weight loss interventions, and dietary recommendations	6/7/22

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F 657	Continued From page 15 1. For Resident #105, the facility failed to specifically care plan Resident centered weight loss interventions. 2. For Resident #110, the facility staff failed to care plan weight loss interventions recommended by dietary, and failed to specifically care plan Resident centered weight loss interventions. Findings include: 1. Resident #105's most recent "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 3-24-22, was a quarterly assessment. The document revealed the Resident had minimal cognitive impairment and further documented the Resident was on a "Therapeutic Diet", and had no weight loss. The Resident was independent in eating, and required no assistance. The Resident's weight record was reviewed and revealed the following; 12-18-21 - 165.1 lbs standing 3-10-22 - 156.6 lbs standing This revealed no monthly weight taken for January and February 2022, and a greater than 5% weight loss of 8.75 lbs in less than 3 months. Review of the Resident's care plan revealed the following; Focus: created 12-20-21 "Nutrition risk on admission." Goal: created 12-20-21, revised 3-30-22, resolved 12-20-21 "Will avoid significant weight	F 657	2. A review of residents in the last 30 days with unplanned weight loss was reviewed to ensure weight loss interventions are on the care plan. 3. Staff development director or designee will educate Nursing Leadership/MDS staff on care planning unplanned weight loss interventions and/or recommendations. 4. UM or designee will complete a weekly review of residents with unplanned weight loss to ensure weight loss interventions are addressed on the care plan. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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change through next review".

No interventions were planned for this focus, and the resident's weight loss was found after the goal "resolved" date.

Focus: created 12-20-21 "Nutrition Risk related to recent hospitalization, therapeutic diet related to insulin dependent diabetes mellitus, history of hyponatremia (low sodium) respiratory failure and hypertension".

Interventions: all created 12-20-21 Labs as ordered, Provide,serve diet as ordered, monitor intake and record every meal, RD (Registered Dietician) to evaluate and make diet change recommendations as needed, weekly weights related to admission, created 4-11-22 (after weight loss) Monthly weights, "

No therapeutic Diet was ever ordered, and weekly weights were never obtained. Monthly weights were not obtained for January, and February 2022. No RD evaluation was found in the clinical record.

On 4-15-22 a doctor's order was received for "Ensure Plus once in the evening" as a supplement, and "Med plus 2.0 twice per day" as a supplement, over a month after the Resident's weight loss was known. These interventions were not documented on the Resident's care plan for nursing staff to provide.

On 4-26-22, and 4-27-22 at 5:00 PM, the Director of Nursing (DON), Regional RN, and Administrator were made aware of the issues with Resident #105's care plan.

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2. Resident #110's most recent "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 4-20-22, was a quarterly assessment. The document revealed the Resident had moderate cognitive impairment and further documented the Resident was on a "Mechanically altered Diet". The Resident required feeding, and was documented as having no weight loss.

The Resident's weight record was reviewed and revealed the following;

1-1-22 - 143.5 lbs via mechanical lift
3-11-22 - 130.0 via mechanical lift

This revealed no monthly weight obtained for February 2022, and a greater than 7.5% significant weight loss of 13.5 lbs in 2 months and 10 days.

Review of the Resident's care plan revealed the following;

Focus: dated 2-13-18, revised 3-23-21, "Nutrition risk related to advanced parkinson's disease failure to thrive, mechanically altered diet provided for ease of chewing and swallowing, and history of dysphagia."

Goal: created 3-26-21, revised 3-30-22, "Resident will avoid significant weight change through next review".

Interventions: all were created on 3-23-21, with no new additions on 3-30-22 "monitor and report signs of dysphagia (pocketing, choking, coughing,

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F 657	Continued From page 18 drooling, difficulty swallowing, refusing to eat, appears concerned during meals.", monthly weights, provide and serve supplements as ordered, provide and serve diet as ordered, monitor intake and record every meal, RD (registered dietician) to evaluate and make recommendations as needed, staff assistance with feeding." Review of physician orders revealed the following: 2-26-20 regular diet easy to chew (mechanical soft) with mildly thick liquids. 6-29-21 Ensure plus supplement one time per day. No special diet, thickened liquids, nor supplements were documented on the care plan for nursing to provide. On 4-26-22, and 4-27-22 at 5:00 PM, the Director of Nursing (DON), and Administrator were made aware of the issues with Resident #110's significant care plan.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		6/7/22

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F 686	Continued From page 19 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 necessary care and treatment as ordered by the physician to promote healing of a pressure wound for one Resident (Resident #28) in a sample size of 58 Residents. Specifically, the facility staff failed to: 1) Administer pressure wound treatments on 03/18/22, 03/19/22, 03/22/22, 03/24/22, 03/25/22, 03/28/22, 04/10/22, and 04/22/22 as ordered by the physician. 2) Apply an air mattress as ordered by the provider. The findings included: On 04/24/2022 at approximately 2:10 P.M., Resident #28 was observed in bed. Resident #28 was not on an air mattress. When asked about wounds and wound care, Resident #28 indicated that he had one wound on his right buttock and the dressing changes weren't being done consistently. On 04/24/2022 at approximately 2:20 P.M., this surveyor and Licensed Practical Nurse F (LPN F) entered Resident #28's room for an observation. LPN F assisted Resident #28 to reposition. The dressing on the right buttock was dated 04/22/22.	F 686	F 686 1. Resident # 28 ,Specialty mattress was applied 4/25/22 Medical Director was made aware of missed wound treatments 3/18/22 ,3/22/22, 3/24/22,3/25/22,3/28/22,4/10/22,4/22/22. 2. Current Residents with pressure wounds requiring a specialty mattress and pressure wound treatments have the potential to be affected. 3. DON or designee will educate all Licensed staff on need to apply specialty mattress and documentation of Pressure wound treatments as ordered. 4. DON or designee will complete weekly review of pressure wound care treatment documentation. Unit manager or designee will complete weekly review of wound care provider notes to ensure specialty mattress recommendation is reviewed and mattress placed as indicated. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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On 04/24/2022 and 04/25/2022, Resident #28's clinical record was reviewed.

An active physician's order with a revision date of 03/28/22 documented, "Right Buttock: clean with wound cleanser, apply honey fiber, cover with bordered foam every day shift for pressure ulcer." A review of the Treatment Administration Record for March 2022 and April 2022 revealed that this wound care was not signed off as administered on 03/18/22, 03/19/22, 03/22/22, 03/24/22, 03/25/22, 03/28/22, 04/10/22, and 04/22/22. There were no orders for an air mattress.

A review of the Wound Care Nurse Practitioner note dated 02/03/2022 revealed that Resident #28 was admitted with a Stage 3 pressure wound to the right buttock. Under the sub-header entitled, "Pressure Reduction/Offloading" it was documented, "Ensure compliance with turning protocol, specialty bed."

On 04/26/2022 at approximately 3:00 P.M., Resident #28 was observed in bed. Resident #28 was not on an air mattress.

On 04/26/2022 at approximately 3:15 P.M., the Wound Care Nurse Practitioner was interviewed. When asked to define "specialty bed", the Wound Care Nurse Practitioner stated that [Resident #28] was admitted with a Stage 3 wound so "I recommended an air mattress."

On 04/26/2022 at approximately 4:00 P.M., the physician's orders were reviewed. A physician's order dated 04/26/2022 documented, "Air Mattress: Monitor settings every shift for Wounds." This was 83 days after the Wound Care Nurse Practitioner recommended the air

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F 686	Continued From page 21 mattress for Resident #28. On 04/26/2022 at approximately 5:15 P.M., the administrator and Director of Nursing were notified of findings. The facility staff provided a copy of their policy entitled, "Wound Care." Under the header "Policy", it was documented, "A licensed nurse will provide wound care/dressing change(s) as ordered by physician." On 04/27/2022 by the end of survey, no further information was submitted.	F 686		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		6/7/22

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F 692	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to prevent significant weight loss for Two Residents (Resident #105, and #110) in a survey sample of 58 Residents, resulting in harm for Resident #110. Findings include: 1. For Resident #110, the facility staff failed to prevent an unplanned significant weight loss, failed to feed the resident their therapeutic diet, failed to institute weight loss interventions recommended by dietary, failed to involve the doctor in weight loss evaluation and intervention, which culminated in harm for the Resident. Resident #110 was admitted to the facility on 10-31-16. The Resident's diagnoses included; Parkinson's, seizures, anxiety, depression, low potassium, and gastro-esophageal reflux disease. The Resident's most recent "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 4-20-22, was a quarterly assessment. The document revealed the Resident had moderate cognitive impairment and further documented the Resident was on a "Mechanically altered Diet". The Resident required feeding, and was documented as having no weight loss. The Resident's weight record was reviewed and revealed the following;	F 692	F 692 1.Resident # 105 current weight obtained, weight loss has been reviewed and interventions are in place. Resident responsible party and medical director have been made aware. Resident # 110 current weight has been obtained, weight loss has been reviewed and interventions are in place. Patients responsible party and Medical Director have been made aware. 2. A review of weights for residents who required assistance with meals for the last 30 days was conducted to ensure if there is unplanned weight loss, RD has completed an evaluation, interventions placed and careplan updated. 3. Staff Development coordinator or designee will educate all Licensed staff on requirement to obtain resident weights per order. Notification to Dietitian for weight related issues, ensure weight related interventions are addressed in Resident Care plan. In addition, nursing staff will be educated on assisting residents who require assistance with meals. Residents requiring assistance will be assigned a specific staff person to assist with meals. Education will include obtaining monthly weights and documentation is the refuses to be weighed. 4.Don or designee will review weights weekly to ensure appropriate documentation, including monthly weights, RD evaluations, etc. subsequent interventions have been addressed and Care plan updates completed. In	

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F 692	Continued From page 23 1-1-22 - 143.5 lbs via mechanical lift 3-11-22 - 130.0 via mechanical lift This revealed no monthly weight obtained for February 2022, and a greater than 7.5% significant weight loss of 13.5 lbs in 2 months and 10 days. Review of the Resident's care plan revealed the following; Focus: dated 2-13-18, revised 3-23-21, "Nutrition risk related to advanced parkinson's disease failure to thrive, mechanically altered diet provided for ease of chewing and swallowing, and history of dysphagia." Goal: created 3-26-21, revised 3-30-22, "Resident will avoid significant weight change through next review". Interventions: all were created on 3-23-21, with no new additions on 3-30-22 "monitor and report signs of dysphagis (pocketing, choking, coughing, drooling, difficulty swallowing, refusing to eat, appears concerned during meals.", monthly weights, provide and serve supplements as ordered, provide and serve diet as ordered, monitor intake and record every meal, RD (registered dietician) to evaluate and make recommendations as needed, staff assistance with feeding." No special diet, thickened liquids, nor supplements were documented on the care plan for nursing to provide. Review of physician orders revealed the following:	F 692	addition, Nursing Leadership will via direct observation when rounding 5x weekly during mealtimes to ensure residents requiring assistance are being assisted in a timely manner. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6.Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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2-26-20 regular diet easy to chew (mechanical soft) with mildly thick liquids.
6-29-21 Ensure plus supplement one time per day.

From 1-1-22 through the time of significant unplanned weight loss on 3-11-22, no RD evaluation was found in the clinical record.

The progress notes were reviewed from November 2021 through April 2022 and revealed that on 3-11-22 a dietary note was documented stating that the Resident had a 7.5% significant weight loss, and was eating well with a good intake. The note went on to say that the Resident's supplement had been reduced because of good oral intake. The Resident was reweighed and the weight loss was acknowledged. The Dietary representative recommended "magic cups" with lunch and dinner to supplement the Resident, and to establish weekly weights to evaluate success. Neither recommendation was ordered, implemented, nor care planned.

Physician progress notes were reviewed and indicated no knowledge of the weight loss nor any implementation of new orders to reverse the significant unplanned weight loss.

During initial tour of the facility on 4-24-22 lunch trays were observed being delivered to resident rooms at 1:30 p.m. by 2 CNA's (certified nursing assistants) for approximately 60 residents, 8 of which needed to be fed by staff, as they were unable to eat independently. The 2 LPNs (Licensed practical nurses) on the unit were passing medications at the time.

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PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

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Resident #110 was in bed and asleep. The Resident's meal tray was on the over bed table, untouched. The drinks on the tray were thin liquids with no thickening, and no supplements were on the tray. This situation was observed for 30 minutes, as the CNAs continued to open, prepare, and pass out the trays, one resident at a time. At 2:00 p.m. one LPN was seen helping and the surveyor asked her why the lunch meal was so late, and she responded "We have bare bones staff, most of the staff are from agencies and don't know the residents needs, there are only 3 of us to get people fed 2 meals, pass meds, keep everyone clean, and do treatments, and it's impossible, it's like a pressure cooker here."

A dietary staff member was asked when seen on the hall, why all of the carts were not delivered at the same time. The response was "There are only 3 of us in the kitchen, and no way could we bring out six carts at the same time, we are running late today."

At 2:00 p.m., Resident #110's room was again observed with no change. The tray was still on the overbed table untouched, and the Resident was sleeping. The CNA on the hall was asked when the Resident would be fed, and she stated "as soon as all of the trays are passed we will feed the feeders".

At 2:30 p.m. Resident #110's room was entered and the tray was gone. The surveyor went to the cart in the hall and found the tray back in the cart untouched. A different CNA was on the hall removing trays and was asked why Resident #110 didn't eat, and she stated "I don't know she

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F 692	Continued From page 26	F 692		

was not my feeder." The second CNA could not be found.

On 4-26-22, and 4-27-22 at 5:00 PM, the Director of Nursing (DON), and Administrator were made aware of the issues with Resident #110's significant weight loss and harm. The DON, Regional RN, and Administrator were asked what their expectation was for a Resident with weight loss, and it was collectively stated that the Registered Dietician should be made aware, and the physician. Also, an assessment should be completed with new interventions care planned immediately as soon as the weight loss was identified. They stated they had nothing further to provide.

2. For Resident #105, the facility failed to prevent significant weight loss.

Resident #105 was admitted to the facility on 12-18-21. The Resident's diagnoses included; high blood pressure, diabetes, newly diagnosed lung cancer and schizophrenia.

The Resident's most recent "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 3-24-22, was a quarterly assessment. The document revealed the Resident had minimal cognitive impairment and further documented the Resident was on a "Therapeutic Diet", and had no weight loss. The Resident was independent in eating, and required no assistance.

The Resident's weight record was reviewed and revealed the following;

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12-18-21 - 165.1 lbs standing
3-10-22 - 156.6 lbs standing

This revealed no monthly weight taken for January and February 2022, and a greater than 5% weight loss of 8.75 lbs in less than 3 months.

Review of the Resident's care plan revealed the following;

Focus: created 12-20-21 "Nutrition risk on admission."

Goal: created 12-20-21, revised 3-30-22, resolved 12-20-21 "Will avoid significant weight change through next review".

No interventions were planned for this focus, and the resident's weight loss was found after the goal "resolved" date.

Focus: created 12-20-21 "Nutrition Risk related to recent hospitalization, therapeutic diet related to insulin dependent diabetes mellitus, history of hyponatremia (low sodium) respiratory failure and hypertension".

Interventions: all created 12-20-21 Labs as ordered, Provide,serve diet as ordered, monitor intake and record every meal, RD (Registered Dietician) to evaluate and make diet change recommendations as needed, weekly weights related to admission, created 4-11-22 (after weight loss) Monthly weights, "

On 4-15-22 a doctor's order was received for "Ensure Plus once in the evening" as a supplement, and "Med plus 2.0 twice per day" as

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F 692	Continued From page 28 a supplement, over a month after the Resident's weight loss was known. These interventions were not documented on the Resident's care plan for nursing staff to provide. No RD evaluation was found in the clinical record. No therapeutic Diet was ever ordered, and weekly weights were never obtained. Monthly weights were not obtained for January, and February 2022. On 4-26-22, and 4-27-22 at 5:00 PM, the Director of Nursing (DON), Regional RN, and Administrator were made aware of the issues with Resident #105's weight loss. The DON and Administrator were asked what their expectation was for a Resident with weight loss, and it was collectively stated that the Registered Dietician should be made aware, and the physician. Also, an assessment should be completed with new interventions care planned immediately as soon as the weight loss was identified. They stated they had nothing further to provide.	F 692		
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, staff interview, clinical	F 695	F 695	6/7/22

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F 695	Continued From page 29 record review, and facility documentation review, the facility staff failed to provide oxygen therapy as ordered by the physician for 1 Resident, Resident #118, in a survey sample of 58 Residents. The findings included: For Resident #118, facility staff failed to change the oxygen tubing weekly as ordered. During initial tour on 4/24/22 at approximately 1:30 PM, Resident #118 was observed with oxygen being administered via nasal cannula at 2 liters per minute as ordered by the physician. The date on the oxygen tubing was "4/4/22". Resident #118 stated, "it has been several weeks since anyone has changed my tubing". These findings were shared with the Facility Administrator and the Corporate Clinical Nurse at the End of Day Conference at approximately 5:30 PM on 4/24/22. The facility's policy for the maintenance of oxygen equipment was requested and received. Review of Resident #118's clinical record revealed a physician's order dated 1/17/2022 that read, "Oxygen tubing change weekly (11-7)...every night shift every Monday". Review of the facility's policy entitled, "Respiratory/Oxygen Equipment", effective date 11/01/19, heading "Policy", read, "Licensed staff will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per physician's order and in accordance with standards of practice" and subheading, "Oxygen Therapy via Nasal Cannula,	F 695	1. Resident #118 oxygen tubing was replaced 4/26/22. 2. Current residents with oxygen tubing change orders have potential to be affected. 3. Staff development coordinator or designee will educate all Licensed staff on policy /procedure related to oxygen tubing change. 4. The UM or designee will complete weekly review of patient□s oxygen tubing to ensure it has been changed per policy and procedure. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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F 695	Continued From page 30 Simple Mask, Venturi Mask, and Oximizer", item 6, "Nasal cannulas, Simple masks, Venturi mask, and Oximizer must be changed every week, dated, and initialed". On 4/27/22 at approximately 10:30 AM, Resident #118 was interviewed and stated, "They [nursing staff] finally changed the tubing for my oxygen yesterday". The label on the oxygen tubing was dated 4/26/22 [Wednesday]. The Facility Administrator and Director of Nursing were updated on the additional findings at the End of Day Conference on 4/27/22. No further information was provided.	F 695		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON 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 staff interview, facility documentation review, and in the course of a complaint investigation, the facility failed to ensure that an RN (Registered Nurse) was on duty 8 hours per	F 727	F727 1. Facility has reviewed the requirement related to Registered Nurse coverage. No action taken, the time frame had already	6/7/22

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F 727	Continued From page 31 day 7 days per week. The facility had no RN on duty on 3-1-22, 4-21-22, and 4-24-22. The findings included: The facility staffing was reviewed for the prior 2 months before survey, as a result of multiple complaints of inadequate staffing. Review of the as worked schedule revealed that on 3-1-22, 4-21-22, and 4-24-22, no RN was scheduled to work, and none worked on at least those three occasions. On 4-24-22 at approximately 2:30 PM, an interview was conducted with the LPN in charge, who stated, no I am in charge by default I guess, we don't have an RN today. They will be here tomorrow. On 4-26-22 at 4:45 PM, an interview with the facility Administrator was conducted. She stated that staffing had been a "struggle." She stated the facility had done a wage comparison last year and that staff were going to received a raise. She also stated a sign up bonus and referral bonus was added. The Administrator was notified of the above findings.	F 727	passed. 2. Current residents in the center have the potential to be affected. 3. Administrator or designee will educate the staff scheduler on requirement to have 8 hours of registered nurse coverage per day. 4. Administrator or designee will review weekly staffing to ensure registered nurse coverage 8 hours per day is maintained 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	
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	F 761		6/7/22

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F 761	Continued From page 32 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 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to label and store medications in accordance with currently accepted professional standards for 2 medication carts (Cart (1,2) and Cart (2,3) out of 9 medication carts. The findings included: On 04/27/2022 at 11:30 A.M., Surveyor C reviewed the contents of Med Cart (2, 3) on the West Wing with Licensed Practical Nurse J. The following medications were opened and not dated: 1. Active liquid protein - two 32 ounce bottles 2. Robitussin - one 16 ounce bottle 3. Lidocaine viscous 2% solution	F 761	F761 1. Opened Medications contained on Medication carts (2,3) west wing are now labelled and dated . Resident #259 inhalant is now in container correlating with resident□s name 2. Current residents have the potential to be affected. 3. Staff development coordinator / designee will educate all licensed staff on appropriate medication labeling and storage. 4. The UM or designee will complete weekly audits to ensure opened medications on medication carts are dated and Resident inhalants are stored in container correlating with Correct patient□s name.	

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F 761	Continued From page 33 4. Miralax 8.3 Oz 5. Senna 237 milliliters 6. Megace suspension 16 fluid ounces On 04/27/2022 at approximately 12:00 P.M., Surveyor E reviewed the contents of Med Cart (2, 3) on the West Wing with LPN F. An inhalant for Resident #259 (Mometasone 50 mcg [micrograms]/act) was housed in a medication bottle labeled with Resident #258's name on it for Humalog 100 unit/10ml [milliliters]. Upon surveyor pointing out discrepancy, LPN F stated "I don't know how that got there." According to the publication dated 06/18/2020 in "U.S. Pharmacist"(1), an article entitled "Medication Management" under the sub-header "Proper Medication Storage" an excerpt documented, "...multidose vials must be labeled to prevent them from being used beyond the expiration date." Under the sub-header entitled, "The Five Rights", an excerpt documented, "Nurses cannot confirm that a specific tablet or vial is the correct drug or that the strength and dosage are correct. However, they are accountable for reading the label ..." On 04/27/2022 at approximately 5:00 P.M., the administrator and Director of Nursing were notified of findings. (1) U.S. Pharmacist is a monthly journal dedicated to providing the nation's pharmacists with up-to-date, authoritative, peer-reviewed clinical articles relevant to contemporary pharmacy practice in a variety of settings, including community pharmacy, hospitals, managed care systems, ambulatory care clinics, home care organizations, long-term care	F 761	5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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F 761	Continued From page 34 facilities, industry, and academia.	F 761		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. 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, for 2 Residents (Resident #105, and #110) in the survey sample of 58 residents, to provide follow preferences and/or drinks for hydration. The Findings included: 1. For Resident #105, the facility staff failed follow the resident's preference for a water pitcher so that he could consume water at will. Resident #105's most recent "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 3-24-22, was a quarterly assessment. The document revealed the Resident had minimal cognitive impairment and, was independent in eating, and required no assistance. On 4-24-22 at 12:20 P.M., an interview was conducted with Resident #105. His lunch tray had not been delivered, and he stated that his food was always late. He asked if the surveyor would	F 807	F 807 1. Resident #105, currently has water pitcher at bedside. Resident #110 is being offered water, or other liquids consistent with her needs 2. Current residents have potential to be affected 3.Staff development coordinator or designee will educate all Staff to provide residents with drinks, water or other liquids consistent with resident needs and sufficient to maintain hydration. 4. UM or designee will review resident rooms weekly to ensure water pitcher is at bedside. Um or designee will complete weekly review of residents requiring feeding to ensure appropriate water, or other liquids consistent with resident needs is provided . 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis	6/7/22

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bring him a drink of water, and stated he was thirsty. His room mate was sitting in a wheel chair between the foot of the two beds, and the two were watching television together. Both Residents were found to be oriented to person, place, time and situation. Both Resident's stated that Resident #105 had recently been moved into the room stating "4-5-days ago", and agreed that Resident #105 had not been given a water pitcher, and stated it had been left in Resident #105's old room. The room mate had a water pitcher on his over bed table. Resident #105 stated "I have to ask for water every day, and they just bring me a cup full. I want my pitcher but they don't give me one."

Review of the Resident's care plan revealed the following;

Focus: created 12-20-21, revised 1-3-22. "The Resident has dehydration risk."

Goal: created 12-20-21, revised 3-30-22. "The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor."

Interventions: all created 1-03-22. Administer diuretic as ordered, encourage resident to drink fluids of choice as needed, Lab work as ordered, monitor document signs of dehydration....(signs of dehydration)."

On 4-26-22, and 4-27-22 at 5:00 PM, the Director of Nursing (DON), Regional RN, and Administrator were made aware of the issues with Resident #105's lack of water pitcher and available water. The DON and Administrator were asked what their expectation was, and it

Date of compliance 6/7/22
The Administrator and Director of Nursing are responsible for implementation of the plan of correction.

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F 807	Continued From page 36	F 807		

was collectively stated that the Resident should have a water pitcher at bedside They stated they had nothing further to provide.

2. For Resident #110, the facility staff failed to provide the ordered form of hydration in addition to water.

Resident #110's most recent "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 4-20-22, was a quarterly assessment. The document revealed the Resident had moderate cognitive impairment and further documented the Resident was on a "Mechanically altered Diet". The Resident required feeding.

Review of the Resident's care plan revealed the following;

Focus: dated 6-19-20, revised 3-30-22, "The resident has dehydration or potential fluid deficit related to diet/beverage consistency."

Goal: created 6-19-20, revised 3-30-22, "The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor."

Interventions: all were created on 6-28-18, with no new additions on 6-19-20, and 3-30-22. "Encourage the resident to drink fluids of choice (specify frequency) the resident prefers the following fluids:ginger ale, cranberry juice, tea, ensure that all beverages offered comply with diet/fluid restrictions and consistency requirements, offer fluids during various times of

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F 807	Continued From page 37	F 807		

day."

No thickened liquids, nor supplements were documented on the care plan for nursing to provide.

Review of physician orders revealed the following:

2-26-20 regular diet easy to chew (mechanical soft) with mildly thick liquids.
6-29-21 Ensure plus supplement one time per day.

During initial tour of the facility on 4-24-22 Resident #110 was in bed and asleep. The Resident's meal tray was on the over bed table, untouched, and cold. The drinks on the tray were thin liquids with no thickening, and no supplements were on the tray. This situation was observed for 30 minutes, as the CNAs continued to open, prepare, and pass out the trays, one resident at a time.

At 2:00 p.m., Resident #110's room was again observed with no change. The tray was still on the overbed table untouched, and the Resident was sleeping. The CNA on the hall was asked when the Resident would be fed, and she stated "as soon as all of the trays are passed we will feed the feeders".

At 2:30 p.m. Resident #110's room was entered and the tray was gone. The surveyor went to the cart in the hall and found the tray back in the cart untouched. A different CNA was on the hall removing trays and was asked why Resident #110 didn't eat, and she stated "I don't know she was not my feeder."

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F 807	Continued From page 38 On 4-26-22, and 4-27-22 at 5:00 PM, the Director of Nursing (DON), and Administrator were made aware of the issues with Resident #110. They stated they had nothing further to provide.	F 807		
F 812 SS=D	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 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 interviews, and facility documentation review the facility staff failed serve food in a sanitary manner for two out of six kitchen employees observed in the kitchen over the course of the survey. The findings included: On 04/24/22 at approximately 12:18 p.m. during	F 812	F 812 1. Employee #O, Employee #L have received education related to appropriate food preparation and distribution in a safe and sanitary manner . 2. Current residents have the potential to be affected 3. Dietary Regional consultant or designee will educate dietary manager on	6/7/22

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F 812	Continued From page 39 the initial dining observation observed one out three dietary staff members - Staff O was observed eating at the steam table in the kitchen. Staff O threw food into air and caught the food with his/her mouth. As well, Staff O was not wearing a facial mask at the steam table, nor was Staff O wearing a hair net. On 4/26/22 at approximately 1:30 p.m. Staff N was noted to wear face mask incorrectly while carrying out duties in the kitchen at the steam tables. Staff N's mask was worn in such a manner that the staff member's nose was not covered by the mask. An interview with Staff L at approximately 1:35 p.m., was conducted Staff L stated the staff are to wear facial mask that cover the nose and mouth in the kitchen. As well, Staff L states staff are to wear hair nets at all times while in the kitchen. In review of the facility's COVID-19 policy, dated 2/11/22, on page 28, section 11 an excerpt documented prevention include but not limited to universal source control - employee will wear a face mask while at work. Section 13, of the same policy states face covering or mask covering mouth and nose. The Administrator and Director of Nursing were notified of findings on 4/27/22 at approximately 2 p.m. and stated they had no other findings to submit.	F 812	appropriate preparation, distribution of food in a safe sanitary manner. 4. Regional dietary consultant or designee will complete weekly audits of staff to ensure food prepared and distributed in safe sanitary manner. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6 Date of Compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		6/7/22

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F 842	Continued From page 40	F 842		

(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 41 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one Resident, Resident #154, in a survey sample of 58 Residents. The findings included: For Resident #154, the facility staff failed to maintain an accurate and complete clinical record, indicating the events and actions that occurred on 2/10/22, to include CPR (cardio pulmonary resuscitation) being performed.	F 842	F 842 1. Resident #154. Medical director was made aware of failure to maintain a complete medical record related to documentation of events leading to Cardio pulmonary resuscitation being performed. 2. Current residents have the potential to be affected 3. Staff development coordinator or designee will educate all licensed staff on complete documentation related to events leading up to a resident□s change of condition requiring Cardio Pulmonary	

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F 842	Continued From page 42 On 4/24/22 and 4/25/22, a closed record review was conducted of Resident #154's clinical record. This review revealed that Resident #154 had expired at the facility. The progress notes had the following entries: 1. " 2/10/2022 at 2:27 PM, Resident pronounced deceased at 1:41 [PM] via emergency personnel. [Family members of Resident #154's names redacted] both informed via phone. Awaiting family to give funeral home arrangements. UM [unit manager] and [Nurse Practitioner's name redacted] NP aware." 2. " 2/10/2022 at 5:11 PM, Resident was picked up by [funeral home name redacted] funeral home at 5: 00 PM, [street address of funeral home redacted] Resident family aware." Review of the physician orders for Resident #154 were reviewed and revealed an order dated 1/6/22, that read, "Code Status (FULL CODE)". The entire clinical record was reviewed without any evidence of the details of Resident #154's condition, a nurse assessment, when 911 was called, what the facility staff's response was, etc. There were no details surrounding the events that occurred that day. On 4/26/22 at 8:00 AM, Surveyor F spoke with LPN D, the author of the progress note written on 2/10/22 at 2:27 PM. LPN D was asked to recall the events regarding Resident #154 on 2/10/22. LPN D stated, she had stepped out of the facility on her meal break, upon her return the Fire Department was going into the facility and when she entered she found out it was her patient. She remembered Resident #154 had complained of pain earlier that day and she had given Tylenol	F 842	resuscitation including documentation of resident assessment. 4. DON or designee will review documentation of residents with a change of condition to ensure there is documentation in the medical record of the events leading up to the change in condition including resident assessments. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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and the nurse practitioner was in the building and was going to see him". LPN D said she saw the emergency medical staff performing CPR and observed the facility nurses outside of the room. LPN D was able to recall that she saw a crash cart and equipment in the room which indicated the facility staff had initiated CPR.

On 4/26/22 at 10:05 AM, an interview was conducted with LPN C, the unit manager. LPN C was able to recall the following events regarding Resident #154. She said, "A code was called, he was unresponsive when they went in, started CPR, 911 was called, the fire department came, they continued CPR on him". When asked what she would expect to see charted in the clinical record with regards to the events that day she said, "From the time he was found unresponsive, their assessment, vital signs, when the code was called, when 911 was called, everything from the beginning to the end".

LPN C reviewed Resident #154's clinical record and was asked what she saw. LPN C said, "I see that he was pronounced and that his RP [responsible party] was informed, it says unit manager and nurse practitioner made aware. I don't see any details about the events". When asked why it is important to document such events, LPN C said, "Because if it is not documented, you can't prove it was done, the situation or what caused it". LPN C confirmed that she agreed that the clinical record for Resident #154 is incomplete.

On 4/26/22 at 2:15 PM, an interview was conducted with LPN B. LPN B was asked if she recalled Resident #154 and the events that occurred on 2/10/22. LPN B said, "I remember,

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F 842	Continued From page 44 he is the guy we did CPR on. I wasn't here but when I came back they told me". LPN B accessed Resident #154's clinical record and read the progress notes. LPN B confirmed that she saw no documentation of the events or actions taken on the day of 2/10/22. LPN B said, "I would put a note of exactly what was done, CPR, 911 called, etc." On 4/26/22 at 3:06 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked what she expects to be charted when CPR is performed in the facility. The DON said, "So after the code is called, what should happen is the charge nurse should document what steps were taken, if EMS (Emergency medical services) came in, if pronounced..." The DON reviewed Resident #154's chart and said "No, it's definitely not complete". On 4/27/22, a copy of the report from the Emergency Medical Responders was received and reviewed. This document did reveal that the facility staff were performing CPR at the time they arrived. A review of the policy titled "Significant Change of Condition" was reviewed. This policy read, "...11. Each change of condition shall be documented in the progress notes..." On 4/27/22, during an end of day meeting, the facility Administrator, DON, and corporate staff were made aware of the findings. No further information was received.	F 842		
F 883	Influenza and Pneumococcal Immunizations	F 883		6/7/22

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F 883 SS=E	Continued From page 45 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883		

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F 883	Continued From page 46 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to implement their immunization policy and ensure each Resident is offered influenza and pneumococcal immunization, for 4 Residents (Resident #10, 100, 127, and 135), in a sample of 5 Residents reviewed for immunizations. The findings included: On 4/25/22, clinical record reviews were conducted for the sampled Residents with regards to immunization for flu and pneumonia. This review revealed the following: 1. Resident #10 had been admitted to the facility on 3/18/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the flu or pneumonia vaccine status of Resident #85. Review of the misc.	F 883	F883 1. Residents #10 #100 #127 #135 Immunization status has been updated to the Electronic Medical Record . 2. Current residents have the potential to be affected 3. Staff Development coordinator or designee will educate all licensed staff on requirement to offer /document immunization status in resident Electronic Medical Record 4. Infection preventionist or designee will review 10 residents weekly to ensure documentation of the resident□s flu and pneumonia status. In addition, the review will also include documentation the resident/resident representative have been offered information related to benefits and potential side effects of immunization. 5. Results of the reviews will be	

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F 883	Continued From page 47 (miscellaneous) tab revealed no evidence of vaccine administration or offering of either. Review of the Medication Administration Records (MAR) revealed no evidence of the flu or pneumonia immunization being provided to Resident #85. 2. Resident #100 had been admitted to the facility on 3/28/22. On the immunization tab of the EHR, there was no recorded information with regards to flu immunizations. Review of the misc. tab, nursing notes and MAR(s) revealed no evidence of the flu vaccine being offered to Resident #100. 3. Resident #127 was admitted to the facility on 1/25/22. On the immunization tab of the EHR there was no information recorded with regards to flu or pneumonia immunization status. Review of the remainder of the EHR revealed no evidence of Resident #127 being asked or offered either of the immunizations. 4. Resident #135 was admitted to the facility on 11/27/2018. Review of the immunization tab of the EHR revealed "consent required" for the pneumonia immunization. Review of the remainder of the EHR revealed no further information with regards to pneumonia immunization. On 4/25/22 at 11:39 AM, an interview was conducted with LPN B. LPN B was asked where immunization records/information is found for Residents. LPN B said, under the immunization tab in the EHR. LPN B was asked to explain the admission process with regards to immunizations	F 883	presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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F 883	Continued From page 48	F 883		

for Residents. LPN B said, "When we get report I ask the nurse to tell me the immunization status. I have a list of questions to ask and then document under the immunization part of the record". LPN B accessed the EHR for Resident #127 and confirmed that she did not see any information and was not aware of her immunization status with regards to flu and pneumonia and would have to research it. LPN B went on to say that the immunizations are offered on admission and documented in the progress notes and immunization tab.

On 4/26/22 at 10:05 AM, an interview was conducted with LPN C, the unit manager for the west wing. LPN C said flu shots are offered around flu season if they don't come in with it already. Pneumonia shots are offered and this is directed through the IP (infection preventionist) person, if they have documentation they received it prior to admission, we will note that. LPN C went on to say, "If I'm doing an admission I ask when I'm doing report, usually it is documented within the admission packet and I ask the Resident and family about immunization history. I go into the immunization tab and enter when they received it as historical".

On 4/26/22 at 10:23 AM, an interview was conducted with RN B, the staff development coordinator. RN B said, "Flu shots are given during flu season and is usually done by the staff nurses, because they have a standing order. It is given by the unit nurse and documented in the EHR. Our admitting coordinator asks and gets information about vaccine status and it is added into the record by the admitting nurse". When RN B was asked why it is important to know someone's immunization status, she said,

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"Anytime we have the possibility for outbreaks, Flu season is September through April, we want to offer all employees and Residents flu shots since it is a relatively common disease the pandemic made it necessary to receive immunization status and offer it at the time of admission". RN B confirmed that immunizations are documented in the immunization section of the chart.

RN B accessed the EHR for Resident #135. RN B confirmed that for the pneumonia vaccine "consent required" was noted. RN B said, "This means she has not offered consent yet, it says to be given at time to be determined". When RN B was asked if this has been discussed with the Resident or her family, she said "no date is listed and the doctor doesn't address that issue in his notes".

Employee C, the infection preventionist then came into the office and joined RN B. Both RN B and Employee C accessed each of the Residents (Resident #10, 100, 127, and 135). Employee C confirmed the surveyor's findings and was unable to locate any information that the Residents had been offered the vaccinations.

On 4/26/22 at 3:06 PM, the facility Director of Nursing (DON), was made aware that of the 5 Residents reviewed for immunizations concerns were noted with all 5. She stated, "I am not surprised, unfortunately it is definitely a work in progress. I've been working on things ever since I came into this position and with having agency staff it is hard to get people to do the right thing".

Review of the facility policy titled, "Influenza & Pneumococcal Vaccinations" was conducted.

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F 883	Continued From page 50 This policy read, "...Vaccination against influenza will be offered to Center patients and staff annually. Vaccination against pneumonia will be offered to Center patients as indicated. 1. c... The center will check the immunization status of patients admitted during the flu season. Those who have not had a flu shot will be offered on upon admission." On 4/27/22 at 5:00 PM, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above concerns. No further information was provided.	F 883		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of	F 886		6/7/22

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asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

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F 886	Continued From page 52 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to conduct COVID-19 testing in accordance with the CDC recommendations for 15 facility staff and two Residents (Resident #11 and #104) in a survey sample of 58 Residents. The findings included: 1. The facility staff failed to conduct routine testing of facility staff who were not fully vaccinated for COVID-19. On 4/24/22, during the entrance conference, the facility staff was provided a copy of the entrance conference worksheet and asked to submit documentation related to COVID-19 testing, to include the facility's testing plan, log of the level of community transmission, and if there were any testing issues and contact with the local and state health departments with regards to testing issues. On 4/25/22, the facility submitted an employee vaccination matrix and employee testing records for 3/29/22, 3/31/22, and the month of April 2022. During the survey, the employee vaccination matrix was noted to not be accurate. Surveyor F identified 31 employees who were working during the survey, that were not listed on the staff vaccination matrix. During further review, Employee E and Employee T only had evidence of receiving one dose of a multi-dose primary vaccination for COVID-19 and 13 employees whose vaccination status was unknown. On 4/25/22 at 3:30 PM, the facility submitted the	F 886	F 886 1.Residents # 11 responsible party and medical director made aware of covid testing not being completed. Resident #104 responsible party and medical director made aware of covid testing not complete. Vaccination of employee E and T has been determined. Covid 19 testing of staff not fully vaccinated is being documented. 2.Current residents have potential to be affected. 3. Administrator or designee will educate infection preventionist on Covid 19 testing requirements. Documentation of resident testing related to Covid 19 and Documentation of Staff vaccination status. 4. Administrator or designee will complete weekly review of documentation related to staff Covid 19 testing and Resident Covid 19 testing as well as documentation of staff vaccination status. 5 Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6.Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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log of the level of community transmission. Review of this document revealed that the facility was checking this level every other week and for the time period of Jan. 14, 2022-April 24, 2022, the facility should be testing staff who are not "up to date" [current with primary COVID-19 vaccination and booster doses] should be tested twice weekly.

On 4/24/22, 4/25/22, and 4/26/22, conversations were held with the facility Administration to include but not limited to the facility Administrator, Infection Preventionist, Regional Director of Operations and the Corporate Clinical Consultant, and at no point did any of them mention or submit any evidence of any difficulty with testing or obtaining COVID-19 testing, to be considered by the survey team.

On 4/27/22 at 10:11 AM, a video conference/interview was conducted with Employee C, the infection preventionist. Employee C was asked to identify all testing dates of COVID testing in 2022. He listed the following dates for January and February: 1/20/22, 1/25/22, 2/22/22, and 2/24/22. Employee C stated, "We did no routine testing in January or February, only outbreak testing". Employee C was asked if he was sure there were not testing records kept by another party or located somewhere else and he confirmed, he was sure this was all of the testing performed in Jan and Feb.

During the above conversation, Employee C said, "in January we were using a lot of the test that had expired that they extended the time we could use them and we had to wait for VDH [Virginia Department of Health] to send more tests, no one

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had any tests. Employee C was asked if he had evidence of where he had reached out the health department and/or tried to order test kits during this period. He said, "Yes", and was asked to submit evidence of this, as well as the details of COVID testing for the two occurrences in January and the two occurrences in February. None of the items requested from Employee C were received prior to the end of the survey.

The facility was unable to submit evidence that Employee E and Employee T, and the 13 employees whose vaccination status was unknown had submitted to routine testing during January and February.

A review of the facility policy titled, "COVID-19" with an effective date of 2/11/22, was conducted. This policy read, "...The center will follow CDC guidelines...13. d. ...Patient and Employee testing conducted as required". No details were noted within the policy with regards to routine testing.

A review of the CMS (Centers for Medicare and Medicaid Services) QSO Memo 20-38-NH, with a revision date of 4/27/21, which was in effect at the time, was conducted. This memo stated, ""Unvaccinated" refers to a person who does not fit the definition of "fully vaccinated," including people whose vaccination status is not known, for the purposes of this guidance....To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary. Facilities can meet the testing requirements through the use of rapid point-of-care (POC) diagnostic testing devices or through an arrangement with an offsite

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laboratory. POC Testing is diagnostic testing that is performed at or near the site of resident care...Facilities without the ability to conduct COVID-19 POC testing should have arrangements with a laboratory to conduct tests to meet these requirements. Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48 hours) should be selected to rapidly inform infection prevention initiatives to prevent and limit transmission".

The CMS memo went on to read, "The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week. Facilities should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above...The guidance above represents the minimum testing expected. Facilities may consider other factors, such as the positivity rate in an adjacent (i.e., neighboring) county to test at a frequency that is higher than required".

On 4/27/22, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of concerns with regards to COVID testing.

No further information was submitted prior to the end of survey.

2. The facility staff failed to conduct Resident COVID testing following a known exposure for two Residents (Residents #11 and #104).

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On 4/26/22 at 4:31 PM, an interview was conducted with the Director of Nursing (DON). The DON said, "Resident testing is documented in [electronic health record name redacted]". When asked about what kind of testing is conducted in the event they have a positive COVID case identified, the DON said, "initially VDH [Virginia Department of Health] said we could do contact tracing if it was 1 person, other than that we do broad based testing".

On 4/27/22, a review was conducted of the facility submitted log of COVID infections. This listing revealed that on 1/25/22, Resident #139 tested positive for COVID-19. Review of the facility census for that day, revealed Resident #11 and Resident #104, were roommates of Resident #139.

Review of the clinical record for Resident #11 revealed he was tested for COVID-19 on 1/25/22. The next instance of him being tested for COVID-19 was 2/10/22.

Review of the clinical record for Resident #104 revealed he was tested for COVID-19 on 1/25/22. The next instance of him being tested for COVID-19 was on 2/10/22.

On 4/27/22 at 10:11 AM, an interview was conducted with Employee C, the infection preventionist. Employee C stated that for the entire year of 2022 broad based testing was performed after each identification of a new COVID case within the facility. He stated that no contact tracing was performed. Employee C confirmed that all COVID testing for Residents is documented in the electronic health record, he

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doesn't maintain a listing of which Residents were tested on occurrences of testing.

A review of the facility policy titled, "COVID-19" was conducted. This policy read, "It is the policy of the Center to establish standards of practice for prevention of Coronavirus Disease 2019 (COVID-19) and to control activities to protect employees and patients...The Center will follow CDC guidelines".

The CDC (Centers for Disease Control and Prevention) gives the following guidance regarding testing of new admissions, in their document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes: Nursing Homes & Long-Term Care Facilities. Updated Feb. 2, 2022". This guidance read, "... Asymptomatic residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure". Accessed online 4/27/22, at website https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031062858

On 4/27/22, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of concerns with regards to COVID-19 testing within the facility.

No additional information was received prior to the conclusion of the survey.

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F 887	Continued From page 58	F 887		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and	F 887		6/7/22

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F 887	Continued From page 59 (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to offer COVID vaccination(s) for Residents who were not vaccinated against COVID-19, for 2 Residents (Resident #127 & #100), in a sample of 5 Residents reviewed for immunizations. The findings included: 1. The facility staff failed to provide evidence that Resident #127 was offered, educated and provided/or declined COVID vaccination.	F 887	F 887 1.Residents #127 # 100 Have been offered covid vaccination and declined. Documentation is in place in the medical record. 2. Current residents have potential to be at affected 3. Staff development coordinator or designee will educate all Licensed staff on documentation of administration of Covid 19 vaccine, the refusal of or any medical contraindications in electronic medical record .	

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F 887	Continued From page 60 On 4/25/22, a clinical record review for Resident #127 was conducted. This review revealed the following: Resident #127 had been admitted to the facility on 1/25/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #127. All of the progress notes for Resident #127 were reviewed, which included social work, nursing and medical providers, to include from admission through the date of review. There was no indication of Resident #127 being offered or educated on the benefit of immunization for COVID. Review of the misc. (miscellaneous) tab revealed no evidence of vaccine administration or offering of the COVID vaccine. Review of the nursing admission assessment completed on 1/25/22, didn't address the immunization status of the Resident. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #127. On the misc. tab of the chart, the admission alert noted Resident #127 as "not vaccinated". Review of the listing of Resident's COVID immunization status form provided by the facility staff on 4/25/22, indicated Resident #127 was unvaccinated for COVID-19. 2. For Resident #100, the facility staff failed to offer, educate and provide COVID vaccination.	F 887	4. Infection preventionist or designee will complete a weekly audit related to documentation of administration of Covid 19 vaccine, the refusal of or any medical contraindications. in the Electronic medical record 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6.Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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On 4/25/22, a clinical record review for Resident #100 was conducted. This review revealed the following:

Resident #100 had been admitted to the facility on 3/28/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #100.

All of the progress notes for Resident #100 were reviewed, which included but were not limited to: social work, nursing and medical providers, from admission through the date of review. There was no indication of Resident #100 being offered or educated on the benefit of immunization for COVID. Review of the misc. (miscellaneous) tab revealed no evidence of vaccine administration or offering of the COVID vaccine.

Review of the nursing admission assessment completed on 3/28/22, didn't address the immunization status of the Resident. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #100.

On the misc. tab of the chart, the admission alert noted Resident #100 as "not vaccinated" and had a handwritten note that read, "Will need to quarantine 14 days". A second admission alert was noted dated 4/12/22, following a hospitalization where Resident #100 was being readmitted. This admission alert read, "Quarantine 14 days" and "not vaccinated".

Review of the listing of Resident's COVID

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immunization status form provided by the facility staff on 4/25/22, indicated Resident #100 was unvaccinated for COVID-19.

On 4/25/22 at 11:39 AM, an interview was conducted with LPN B. LPN B was asked where immunization records/information is found for Residents. LPN B said, under the immunization tab in the EHR. LPN B was asked to explain the admission process with regards to immunizations for Residents. LPN B accessed the EHR for Resident #85 and confirmed that she did not see any information under the immunization or misc. tabs regarding COVID immunization status.

On 4/26/22 at 10:05 AM, an interview was conducted with LPN C, the unit manager. LPN C stated that COVID immunizations are offered to Residents during the COVID clinics which are held twice a week, "if they want it, we give it. That is all directed through the IP (infection preventionist) person".

On 4/26/22 at 10:23 AM, an interview was conducted with RN B, the staff development coordinator. RN B stated that, "Immunizations are offered at the time of admission. We are having less people not fully vaccinated. It is placed in the chart, the information is obtained from the patient or patient's family, but we offer those to the unvaccinated at the time of need and we offer boosters too". RN B confirmed that Resident #127 is not vaccinated for COVID-19 as she can tell in chart. RN B stated that she believes consent forms are signed and kept on record, but would have to look it up to be sure.

On 4/26/22, during the interview with RN B, Employee C, the infection preventionist entered

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the room and participated in the interview. Employee C then accessed Resident #127's clinical record and stated, "She is not vaccinated for COVID-19". Employee C was asked if Resident #127 was offered the vaccine and he said, "We just did our clinic on the 15th [referring to April] and she declined". Employee C stated the process is to document this on the immunization tab that she declined. Employee C said he spoke to Resident #127's daughter and let her know she declined, but I didn't document it". Employee C confirmed that documentation of being offered the COVID vaccine should be documented in the clinical record but was not.

Employee C also confirmed that Resident #100 was offered the COVID immunization but the clinical record doesn't document this offer or refusal. Employee C was asked why it is important to document, he said "To let us know why and when they refused". Employee C said the importance of vaccination is, "To prevent hospitalizations and prevent outbreaks".

On 4/26/22 at 3:06 PM, an interview was conducted with the DON. She was asked how immunizations for Residents are handled. She said, "We get it from report in the hospital, if historical [received prior to admission] it goes in immunization tab for long-term care. That is oversaw by IP, then he communicates to nursing and if they are not immunized we get consent from the patient or RP [responsible party] to determine if they do or don't want it". The DON was asked if the consent is obtained on a form, she said, "Yes".

On 4/26/22, the facility Director of Nursing (DON) was made aware that concerns were had with

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F 887	Continued From page 64 Residents reviewed for immunizations. The DON stated, "I am not surprised". Review of the facility policy titled, "COVID-19" was reviewed. This policy read, "...5...The center should continue to encourage vaccination among new admissions..." CDC (Centers for Disease Control and Prevention) provides the following guidance to nursing facilities in their document titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes". This document read, "...New Admissions and Residents who Leave the Facility: Create a Plan for Managing New Admissions and Readmissions....In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine...COVID-19 vaccination should also be offered". Accessed online 4/27/22, at web address: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030153017 On 4/27/22 at 5 PM, during an end of day meeting the facility Administrator and Director of Nursing were made aware of concerns regarding immunizations. No further information was provided.	F 887		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and	F 888		6/7/22

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procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in

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

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

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and

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F 888	Continued From page 68 considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to 1) have an accurate system to track the immunization status of all facility employees, and 2) failed to ensure 100% of facility staff were vaccinated, the facility vaccination rate was 92.9%. 1. The facility failed to include all staff members on the vaccination tracking, therefore rendering it as incomplete. 2. The facility staff vaccination rate for COVID-19 was 92.9%. The findings included: 1. The facility failed to include all staff members on the vaccination tracking, therefore rendering it as incomplete. On 4/24/22, at approximately 11:30 AM, during an entrance conference held with the facility's corporate clinical nurse, the facility's staff vaccination matrix was requested. On 4/25/22 at 10:25 AM, the facility staff submitted a staff vaccination matrix. Review of this matrix revealed 181 facility staff members were listed. A review was then conducted by Surveyor F, using the as worked schedule for 4/24 and 4/25, as well as the facility submitted key personnel listing. This review revealed 31 employees that were working during the survey period, that were not listed on the staff	F 888	F888 1.An accurate tracking system is currently in place to track immunization status of employees. Current staff members are currently vaccinated and on vaccination tracking log. 2. Center has potential to be affected 3. Administrator or designee will educate Human Resource Manager and Infection Preventionist on requirement to verify and document all newly hired /agency staff vaccination status prior to working in center, and maintain accurate tracking log 4. Administrator or designee will review newly hired staff and new agency staff vaccination status prior to working in center. Administrator or designee will conduct weekly audits to validate accurate vaccination tracking log. 5. Results of the reviews will be presented to the QAPI Committee for review and recommendation, once the committee determines the problem no longer exits the review will be conducted on a random basis 6. Date of compliance 6/7/22 The Administrator and Director of Nursing are responsible for implementation of the plan of correction.	

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vaccination matrix.

On 4/25/22 at 2:03 PM, an interview was conducted with Employee C, the facility infection preventionist. Employee C confirmed that he is responsible for the staff vaccination tracking. Employee C was given several of the employees Surveyor F noted to not be on the staff vaccination tracking log. Employee C confirmed that he was not able to find them on the listing either and agreed that the log was incomplete/inaccurate.

On 4/25/22 at 4:06 PM, an interview was conducted with the facility Administrator. The Administrator was advised that upon the survey team's entry, the corporate clinical nurse had reported that the Administrator and Infection Preventionist oversee the COVID vaccination program within the facility. The administrator was asked to explain her role. The Administrator stated, "[IP name redacted] makes sure we have each employee's card and I check to make sure he and HR [human resources] have it. He maintains the cards and he can pull them from the VIIS [Virginia Immunization Information System] system and he prints and keeps a copy and puts them on the line listing [staff vaccination matrix]. I am just the checker".

On 4/26/22, Employee C, the infection preventionist confirmed that the staff vaccination log is used to report to NHSN (National Healthcare Safety Network) and its accuracy is important so that accurate information is reported.

Review of the facility policy titled, "COVID-19 Vaccination Policy", was reviewed. This policy

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read, "...9. Proof of full COVID-19 vaccination should be maintained for all employees in their personnel file. The center will track and securely document each staff member's vaccination status including exemptions".

On 4/25/22, the facility Administrator and Corporate Clinical Consultant were notified of the staff vaccination matrix missing multiple employees.

No further information was provided.

2. The facility staff vaccination rate for COVID-19 was 92.9%.

On 4/24/22, at approximately 11:30 AM, during an entrance conference held with the facility's corporate clinical nurse, the facility's staff vaccination matrix was requested.

On 4/25/22 at 10:25 AM, the facility staff submitted a staff vaccination matrix. Review of this matrix revealed 181 facility staff members were listed. A review was then conducted using the as worked schedule for 4/24 and 4/25, as well as the facility submitted key personnel listing. This review revealed 31 employees were noted as active employees, working during the survey period, that were not listed on the staff vaccination matrix. These 31 employees were added to the 181 employees listed on the staff vaccination matrix making the total number of staff 212.

On 4/25/22 at 4:32 PM, a video call was held with Employee C. Employee C was given the list of 31

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employees and only had evidence of COVID vaccination status for 5 of the 31 employees. Employee C confirmed that if he looks up an employee's immunizations on the VIIS system, he doesn't maintain a record or copy of this.

On 4/25/22 at approximately 5:10 PM, a video call was held with Employee C and Employee D, the Human Resources (HR) Manager. The HR manager was given the list of remaining 26 employees. The HR manager had copies of 6 employee's vaccination cards. However, for 2 of the employees (Employee E and Employee T) their card only revealed evidence of having received 1 dose of a multi-dose vaccination series. Employee E had dose 1 of Moderna on 1/14/22 and Employee T, had dose 1 of Pfizer on 2/13/22. Therefore, both were eligible for the second dose to complete their primary vaccination series for COVID-19.

On 4/26/22, the facility staff submitted vaccination cards for 7 employees that had been identified as not being on the staff vaccination matrix. Therefore, 13 employees vaccination status remained unknown, with no supporting evidence of any vaccinations.

On 4/26/22 at 3:06 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked how she knows the vaccination status of staff. She said, "My IP [infection preventionist] guy is supposed to get their information and file it and HR [human resources] deals with him with that as well".

The 13 employees whose vaccination status was unknown and the 2 employees (Employee E and Employee T) that had only 1 dose of a multi-dose

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series, were considered as not having completed the primary vaccination series for COVID-19. This made the facility have only 197 staff members who had completed the primary vaccination series. The staff vaccination rate of the facility employees was calculated to be 92.9%.

Review of the facility policy titled, "COVID-19 Vaccination Policy" was conducted. This policy read, "1. This mandatory COVID-19 vaccination policy applies to all facility staff, regardless of clinical responsibility and resident contact...3. Contracted workers (including but not limited to agency, travelers, students, and vendors) are also required to have received the full vaccine....9. Proof of full COVID-19 vaccination should be maintained for all employees in their personnel file. The center will track and securely document each staff member's vaccination status including exemptions".

On 4/27/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the findings.

No further information was submitted prior to the survey team's exit.