STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495144	A. BUILDING _____ B. WING _____	C 04/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETERSBURG HEALTHCARE CENTER	287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805

(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 04/12/22 through 04/15/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/12/22 through 04/15/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints, (VA00053078- Substantiated with deficiency, VA00052689- Substantiated with deficiency, and VA00052454- Substantiated with deficiency), were investigated during the survey. The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 40 resident reviews and 11 staff record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		5/27/22

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

Electronically Signed | 05/09/2022

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F 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews the facility failed to promote dignity with dining by failing to provide residents with proper silverware by serving the residents in the facility with disposable, plastic spoons daily. Finding Included:	F 550	E-00000 This plan of correction is prepared and executed because it is required by the provisions of state and federal law not because Petersburg Healthcare Center admits or denies the validity of the allegations and citations listed on the	

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F 550	Continued From page 2 1. The facility failed to promote dignity with dining by failing to provide residents with proper silverware by serving the residents in the facility with disposable, plastic spoons daily During the initial pool portion of the survey process on the afternoon of 04/12/22 and through the morning of 04/13/22 several alert and oriented residents were interviewed/screened. Some of the residents were observed with their meal trays during the interviews and it was noted that they had regular forks and knives but could only get plastic spoons with their meals. Some of the residents complained the plastic wares could be difficult for residents with impaired grip and/or hand function/coordination issues. When asked, the residents stated they had made the facility aware that they preferred regular silverware. During a group meeting on 04/14/22 at 2:00 PM, the residents also stated that they had run out of spoons in the facility, and they had been getting plastic spoons on their trays since plastic wares were initiated for COVID containment. Those restriction had been lifted but the facility remained out of standard spoons for residents to use. In an interview with the Dietary Manager (DM) on 04/14/22 at 12:30 PM, the DM stated he thought majority of the facility spoons had been accidentally thrown away when the residents were using disposable wares (plastic containers and silverware) during the COVID-19 restrictions. The DM stated he had been out of dinnerware spoons for a few months because they had been on back order. He was asked to produce the work order or invoice for the spoons, but "could not find it." On 04/15/22 the DM advised the surveyor that he had spoons for residents to use. The facility	F 550	pages of this Statement of Deficiencies. CommuniCare, Petersburg Healthcare Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. F-TAG 550 1. The Administrator went out and purchased spoons for the residents. 2. Current residents that reside in the facility were reviewed to identify those that have the potential to be affected. 3. The Administrator or designee will complete re-education of the dietary staff related to inventory controls for silverware within the dining room 4. Administrator and/or designee will audit dining staff practices regarding dignity/appropriate silverware on the resident trays 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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F 550	Continued From page 3 paid for him to get some locally while waiting for his order to be filled. The Administrator confirmed he had approved the expense for new silverware for the resident's use and the DM had purchased spoons on 04/14/22 at 5:00 PM during the end of day meeting with the team.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		5/27/22

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F 561	Continued From page 4 facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to facilitate resident self-determination for one resident (Resident #93) in a survey sample size of 40 residents. The findings included; 1a) For Resident #93, the facility failed to allow the Resident use of condom catheters. Resident #93's most recent MDS (minimum data set) assessment was dated 4-5-22. The document coded the Resident as always incontinent of bowel and bladder, fully intact with cognition, and was totally dependant on Staff for all activities of daily living to include toileting and hygiene. The Resident used a motorized wheel chair which he was able to maneuver himself without assistance as observed by the surveyor. On 4-13-22 At approximately 9:00 AM Resident 93 was observed and interviewed in his room. Resident #93 was dressed only in a shirt and an incontinence brief. The incontinence brief was soaked heavily with urine and the Resident stated "look in that cabinet, it is full of condom catheters that I need to use, and have used for years. I want to use them, that would keep me dry and clean, I don't like stinking, and they won't let me use them." The surveyor inspected the cabinet and found it stacked with boxes of hundreds of condom catheters. The Resident stated "they won't let me use them because they	F 561	1. Resident # 93 received a physician's order on 04/13/2022 resident permitted to use a condom catheter. Resident aware of risks for using condom catheter. Resident made aware of the order and condom catheter placed on Resident # 93 on 04/13/2022. Care plan updated for condom catheter. The facility received a physician order on 04/13/2022 for Resident # 93 to leave the facility without supervision. Resident # 93 made aware of the order to leave the facility without supervision. Resident is aware of safety concerns. Resident agreed to have a safety flag place on the back of the motorized wheelchair when leaving the facility. Care Plan updated to reflect LOA without supervision. 2. All other like residents with potential to be affected were interviewed and physician orders and care plans were updated as needed. 3. Education provided to 100% of all the facility staff on resident's rights for self-determination by DON or Designee 4. DON or designee will audit resident medical records for orders for condom catheters 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. DON or designee will audit resident medical records for new orders for leave	

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F 561	Continued From page 5 don't want me to be able to go out of the facility, and with the condom catheters I would not get wet, so I could have more freedom." The Resident's care plan was reviewed and revealed the Resident as incontinent of bowel and bladder, with interventions of the following only; Barrier cream after incontinence care. Assist with ADL's ....hygiene and toileting. On 4-13-22 the DON was asked why the Resident had not been allowed his preference for condom catheters, and she stated they were afraid it would break down the Resident's skin. On 4-13-22 at the end of day debrief, the DON notified the surveyor that they had received an order for the Resident to use the condom catheters. On that day the condom catheters were placed on the Resident's care plan. On 4-14-22 during the end of day meeting the Administrator and DON were made aware of the concerns and no further information was provided. Complaint Deficiency. 1b). Resident #93 was not permitted to go out of the facility by himself. Resident #93's most recent MDS (minimum data set) assessment was dated 4-5-22. The document coded the Resident as always incontinent of bowel and bladder, fully intact with cognition, and was totally dependant on Staff for	F 561	of absence without supervision 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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F 561	Continued From page 6 all activities of daily living to include toileting and hygiene. The Resident used a motorized wheel chair which he was able to maneuver himself without assistance as observed by the surveyor. On 4-13-22 At approximately 9:00 AM Resident 93 was observed and interviewed in his room. Resident #93 was dressed only in a shirt and an incontinence brief. The resident stated, "they won't let me use them because they don't want me to be able to go out of the facility, and with the condom catheters I would not get wet, so I could have more freedom On 4-13-22 the DON was asked why the Resident was not allowed to go out with family and friends, she stated "the doctor feels it is not safe." On 4-14-22, there was an order for the Resident going out in his motorized wheel chair was also added to the care plan as ordered. On 4-14-22 during the end of day meeting the Administrator and DON were made aware of the concerns and no further information was provided.	F 561		
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 physician intervention;	F 580		5/27/22

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F 580	Continued From page 7	F 580		

(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 room changes between its different locations

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F 580	Continued From page 8 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to notify the responsible representative of a change in condition for one Resident (Resident #103) in a sample size of 40 Residents. For Resident #103, the facility staff failed to: a) Notify the Physician and the Responsible Representative in a timely fashion for significant weight loss on 09/03/2020. b) Notify the Responsible Representative for Resident #103's right eye infection on 09/17/2020. The findings included: On 04/12/2022 and 04/13/2022, Resident #103's clinical record was reviewed. According to the Weight Flowsheet, Resident #103 weighed 138 pounds on 08/01/2020 and weighed 125 pounds on 09/03/2022 which was a 9.42% weight loss in one month. The progress notes for August and September 2020 were reviewed. A nurse's note dated 09/03/2020 at 9:52 A.M. documented, "Note Text: Ate 25% or less x 1 day. Alternate meals and snacks offered and accepted. Nursing staff will continue to monitor." There was no evidence the Physician or the Responsible Representative was notified of Resident #103's significant weight loss. A progress note dated 09/17/2020 at 8:26 P.M., documented, "Note Text: NP [Nurse Practitioner]	F 580	1. Resident # 103 discharged from facility 2. Audit all resident's records for undesired significant weight loss and notification of change of condition to the physician and responsible party Audit all resident's records for eye infection and notification of change of condition to the physician and responsible party. 3. 100% of Register Nurses, Licensed Practical Nurses, Certified Nursing Assistances, and Temporary Certified Nursing Assistances staff educated on the facility policy for Notification of Physician of resident change in condition was completed by DON or Designee 4. The DON and/or the Minimal Data Set RN Nurse will audit resident's records for weight loss or changes in condition to ensure notification of MD/NP and responsible party is in the resident's charts, for 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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F 580	Continued From page 9 notified of thick yellow drainage from right eye. New order given for Ciprofloxacin [antibiotic] 0.3% eye drop solution to right eye TID x 5 days [three times a day for 5 days]." There was no evidence the Responsible Representative was notified of eye infection or the new treatment order. On 04/15/2022 at 2:00 P.M., the Director of Nursing (DON) was notified of findings. The DON confirmed she would expect the Physician and Responsible Representative to be notified for changes in condition. The facility staff provided a copy of their policy entitled, "Notification for Changes in Condition." Under the header, "Policy", an excerpt documented, "Changes may include but are not limited to accidents, incidents, transfers, changes in overall health status, significant medical changes ....." In Section II(a), it was documented, "When a change in condition is noted, the nursing staff will contact the resident representative." In Section III(b)(c), it was documented, "The attending practitioner must be immediately notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition. The nurse will record in the progress notes, the name of the person called, the time of each attempt to contact, and the telephone number attempted." On 04/15/2022 at approximately 4:30 P.M., the administrator indicated there was no further information or documentation to submit.	F 580		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		5/27/22

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§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

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(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

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F 623	Continued From page 12 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on family member interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to provide notice in writing, as soon as practicable, when a facility transfers or discharged a Resident to the hospital, to the Resident and Resident Representative (RR/RP) for 1 Residents (Resident #29) in a survey sample of 40 Residents. The findings included: On 4/13/22-4/14/22, a review of the clinical record for Resident #29 was conducted. This review revealed on the census tab of the electronic health record (EHR), Resident #29 had discharged on 3/15/22 and on 4/12/22, to the hospital. There was no further indication in the clinical record to indicate Resident #29 and/or his representative had received reason for the transfer in writing, prior to, or at the time of	F 623	1. Resident # 29 returned to facility on 4/19/22- A transfer/discharge notice was mailed to RP on April 15, 2022 2. The Admission Director audited the last 30 days Of residents transfers and discharges to identify residents and residents representatives who were not notified in writing of a transfer or discharge to hospital where staff failed to provide notice in writing, as soon as practicable, when a facility transfers or discharged a resident to the hospital, to the Resident and Resident Representative 3. The Regional Clinical Director) will in-service the Executive Director, Dietary Manager, Rehab Director, Social Worker, Activity Director, DON, ADON, and Unit Manager on the requirements of assuring	

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F 623	Continued From page 13 transfer/discharge. Review of the progress notes for Resident #29 revealed the following entry on 3/15/22, "resident with N/V [nausea and vomiting] all day blood tinged secretions not elevated with mediations that was ordered V/S [vital signs] 163/101 pulse 95 temp 98.5 r 98.5 Convergence called New order to send to ER [emergency room] to evaluate and treat [family member name redacted] notified". A progress note on 4/12/22, read, "Resident vomited after restarting feeding after 4 hours duration. Also has diarrhea. Notified NP [nurse practitioner]. Transferred to hospital. RP [responsible party] made aware. BS [blood sugar/glucose] 183. Review of the miscellaneous tab of the EHR revealed no documentation of a transfer notice that may have been provided to Resident #29 or their RP. Review of the assessment tab of the EHR revealed various documents that were titled, "COVID Hospital Transfer Form, eINTERACT Change in Condition Evaluation, eINTERACT Transfer Form", for the discharge on 3/15 and 4/12. Review of these forms revealed no evidence that the Resident and/or RP were provided copies of any of the forms. On 4/14/22 at 1:32 PM, Surveyor B requested that the facility staff provide any evidence of Resident #29 being provided a notice of transfer. On 4/14/22 at 5:37 PM, the facility Director of Nursing (DON) provided Surveyor B with a copy	F 623	residents and residents' representatives are notified in writing of the discharge or a transfer to hospital The Director of Nursing will in-service the facility's licensed nursing and licensed certified nursing assistances, and temporary nursing certified assistances on the requirements of assuring residents and residents representatives are notified in writing of discharge and or transfer to hospital Facility Nursing staff will provide Resident and residents representative Notification in writing of discharge and or transfer to hospital and maintain a copy of the document and document receipt of the transfer or discharge in Point click care with each residents Hospital transfer. Resident discharge from the facility will be reviewed daily in management meeting by the social worker to Ensure discharge letters were issued in writing to resident and Resident representative. 4. The Director of Nursing and Social worker will conduct an audit of all resident transfers /discharge letters to assure residents and residents representatives are in receipt of the discharge or transfer letter/document in writing and a copy is maintained at facility and documentation is placed in point click care. This will be completed 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month.	

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F 623	Continued From page 14 of the "COVID Hospital Transfer Form and eINTERACT Transfer Form". On 4/15/22 at 10:45 AM, an interview was conducted with LPN C. LPN C was asked to describe the process when a Resident is sent to the hospital and to describe what forms are completed. LPN C stated, "I do the COVID transfer form, E-Interact change in condition, E-interact transfer to hospital, ADT transfer to hospital [census function in EHR], follow-up note with the admitting diagnosis, ADT discharge [census function in EHR], and notification note that I notified the MD [doctor] and RP [responsible party]. LPN C was asked what happens with the forms she fills out. LPN C said, "I give the documents to the EMT [emergency medical technicians] in a folder". When asked, who are those documents for? LPN C said, "The hospital". LPN C was asked what is communicated to and/or given to the Resident and/or family. LPN C said, "I tell them where they are going and why". LPN C confirmed that she doesn't provide them [Resident or family] with any forms. On 4/15/22 at 10:55 AM, an interview was conducted with LPN D. LPN D was asked to discuss the process when a Resident is transferred to the hospital. LPN D discussed that she gets an order from the nurse practitioner or doctor to send the Resident out and completes the forms to include: COVID transfer, E-Interact change in condition, E-Interact transfer to hospital, follow-up note with diagnosis if they stay at the hospital and a note that she notified the nurse practitioner and RP. LPN D stated, "The Resident transfer form, resident profile page [face	F 623	5. Completion Date: 5/27/2022	

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F 623	Continued From page 15 sheet], bed hold and COVID transfer to hospital, are the documents that I give to the EMTs". LPN D was asked what communication and forms are given to the Resident and family, LPN D said, "I tell them they are going to the hospital". LPN D was asked if the Resident and/or family are given copies of any of the forms, LPN D said, "No ma'am, we give it to the EMTs, it goes to the hospital with them". On 4/15/22 at 11:14 AM, a telephone conversation was held with Resident #29's family member/responsible party. The family member was asked if she was provided any written documentation following Resident #29's discharge to the hospital. The family member said, "No ma'am, my sister was present". A review of the facility policy titled, "Transfer and Discharge Policy", was conducted. This policy didn't address the issuance of a transfer notice when being transferred to an acute care hospital. On 4/15/22 at 11:28 AM, Surveyor B spoke to the facility Administrator and notified him of the findings. The Administrator stated, "I figured when you asked for the policy that we didn't do it". On 4/15/22 at 2:20 PM, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the findings. No further information was received.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		5/27/22

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F 625	Continued From page 16 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on family member interview, staff interviews, facility documentation review and clinical record review, the facility staff failed to provide notice of bed hold policy to the Resident and Resident Representative (RR/RP) at the time of transfer, for 1 Residents (Resident #29) in a survey sample of 40 Residents. The findings included: On 4/13/22-4/14/22, a review of the clinical record	F 625	1. Resident # 29 returned to facility 2. The Admission Director audited all of the residents' charts discharged in the past 30 days for Bed Holds notifications to the resident/ responsible party upon transfer. 3. Education given to 100% of Register Nurses, Licensed Practical Nurses, Certified Nursing Assistances, and	

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F 625	Continued From page 17 for Resident #29 was conducted. This review revealed on the census tab of the electronic health record (EHR), Resident #29 had discharged on 3/15/22 and on 4/12/22, to the hospital. There was no further indication in the clinical record to indicate Resident #29 and/or his representative had received notice of the facility bed hold policy at the time of transfer/discharge. Review of the miscellaneous tab of the EHR revealed no documentation of the bed hold policy being discussed and provided to Resident #29 or their RP. Review of the assessment tab of the EHR revealed various documents that were titled, "COVID Hospital Transfer Form, eINTERACT Change in Condition Evaluation, eINTERACT Transfer Form", for the discharge on 3/15 and 4/12. Review of these forms revealed no evidence that the Resident and/or RP were provided the bed hold policy. On 4/14/22 at 1:32 PM, Surveyor B requested that the facility staff provide any evidence of Resident #29 being provided a notice of bed hold. On 4/14/22 at 5:37 PM, the facility Director of Nursing (DON) provided Surveyor B with a copy of the "COVID Hospital Transfer Form and eINTERACT Transfer Form". On 4/15/22 at 10:45 AM, an interview was conducted with LPN C. LPN C was asked to describe the process when a Resident is sent to the hospital and to describe what forms are completed. LPN C stated, "I do the COVID transfer form, E-Interact change in condition, E-interact transfer to hospital, ADT transfer to	F 625	Temporary Certified Nursing Assistances staff, Admission director and facility Social Worker on the Bed Hold Policy upon Transfer by the DON or designee. 4. The DON or designee will complete an audit of all residents' medical records who are transferred for bed hold policy and documentation in the resident's electronic medical records for 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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F 625	Continued From page 18	F 625		

hospital [census function in EHR], follow-up note with the admitting diagnosis, ADT discharge [census function in EHR], and notification note that I notified the MD [doctor] and RP [responsible party].

LPN C was asked if she has a discussion about bed hold, LPN C said, "Not from me, no".

On 4/15/22 at 10:55 AM, an interview was conducted with LPN D. LPN D was asked to discuss the process when a Resident is transferred to the hospital. LPN D discussed that she gets an order from the nurse practitioner or doctor to send the Resident out and completes the forms to include: COVID transfer, E-Interact change in condition, E-Interact transfer to hospital, follow-up note with diagnosis if they stay at the hospital and a note that she notified the nurse practitioner and RP. LPN D stated, "The Resident transfer form, resident profile page [face sheet], bed hold and COVID transfer to hospital, are the documents that I give to the EMTs". LPN D was asked what communication and forms are given to the Resident and family, LPN D said, "I tell them they are going to the hospital". LPN D was asked if the Resident and/or family are given copies of any forms such as bed hold, LPN D said, "No ma'am, we give it to the EMTs, it goes to the hospital with them".

On 4/15/22 at 11:14 AM, a telephone conversation was held with Resident #29's family member/responsible party. The family member was asked if she was provided any written documentation at the time of or following Resident #29's discharge to the hospital. The family member said, "No ma'am, my sister was present".

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F 625	Continued From page 19	F 625		

Review of the facility policy titled, "Bed Hold Policy" was conducted. This policy read, "1. In the event a resident returns to the hospital or goes on a leave, the following process will be followed by the facility: a. The Admissions Director or designee will notify the resident and/or responsible party of the days available under their Medicaid benefits or the private pay cost associated with holding the bed will be explained, within 24 hours of the patient leaving the facility, or the following business day if the patient leaves on the weekend or a holiday. b. The nurse or designee will obtain the residents or responsibly party's signature on the bed hold authorization form each time the resident leaves on a bed hold. If the bed hold authorization form cannot be signed prior to the resident leaving and needs to be mailed, it must be mailed certified return receipt requested by the Business Office Manager or designee. c. The Director of Social Service or designee will notify the resident or responsible party if a room reassignment is required during the time of the bed hold; the facility reserve the right in its sole discretion to reassign rooms while a resident is absent from the facility. d. The business office manager or designee will follow all state specific guidelines upon resident return regarding notifying resident or responsible party of amount of bed hold days used and left. e. If the payor type for a resident is Managed Care, the facility will follow the payor plan's guidelines".

On 4/15/22 at 11:28 AM, Surveyor B spoke to the facility Administrator and notified him of the findings.

On 4/15/22 at 2:20 PM, during an end of day

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F 625	Continued From page 20 meeting, the facility Administrator and Director of Nursing were made aware of the findings. No further information was received.	F 625		
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 interviews, staff interviews, clinical record reviews, facility	F 657	1. Resident # 11 Care Plan updated to reflect history of significant weight loss	5/27/22

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F 657	Continued From page 21 document reviews, and in the course of a complaint investigation the facility staff failed to review and revise the resident centered care plan for two Residents (Resident #11, and #93) in a survey sample of 40 Residents. Findings include: 1. For Resident #11, The facility failed to revise the Resident's nutritional care plan to reflect significant weight loss interventions. 1. Resident #11's admission/only "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 1-18-22, revealed the Resident was moderately cognitively impaired and required a mechanically altered diet. The Resident had no teeth, and required supervision of one staff person to eat for cueing and assistance. Review of the Resident's care plan revealed the following; Nutritional consult on admission, quarterly, and as needed. Monitor meal intake. Observe for signs of aspiration. Obtain weights as ordered, monitor for weight loss & weight changes. Provide meals per diet order. Provide snacks per facility protocol. The Resident's weight record was reviewed and revealed the following; 1-11-22 - 142 lbs standing 1-12-22 - 142 lbs standing 1-18-22 - 142 lbs standing	F 657	Resident # 93 Care Plan care plans reviewed and revised to reflect continent of bladder, Condom catheter and resident wears briefs for bowel incontinence. Resident Center inventions updated. 2. The DON/Designee audited 100 % of residents' care plan that had significant unplanned weight loss and in the last 30 days; care plans reviewed and revised to reflect diagnose of unplanned significant weight loss. Care plans reviewed and revised to reflect resident center inventions. Audit of 100% residents' care plan reviewed and updated to reflect accurate incontinence, continence and type of incontinent appliance used. 3. Licensed Nursing Staff educated on Care Plan reviewing and revising residents updates for unplanned significant weight loss, incontinence, continence and incontinent appliances by the DON or designee. Licensed Nursing Staff will be educated on Resident centered interventions. 4. The DON or the Minimal Data Set RN Nurse (MDS) Coordinator will audit 100% residents' chart for significant unplanned weight loss and Care Plan revisions/ updates weekly for 4 weeks, then monthly for 2 months. The DON or the MDS Coordinator will audit residents' charts for correct Care Planning of incontinence, continence and incontinent appliance 3 times a week for 4 weeks, then monthly times 2 months. Any	

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F 657	Continued From page 22 2-8-22 - 124.6 lbs standing 2-15-22 - 118.2 lbs standing 2-22-22 - 120.2 lbs standing 3-1-22 - 121.2 lbs wheel chair 3-21-22 - 123 lbs mechanical lift 4-1-22- -128 lbs mechanical lift 4-14-22 - 129 lbs mechanical lift [with surveyor present]. The Resident's admission assessment completed by Licensed Practical Nurse (LPN) G on 1-11-22 was reviewed and revealed the Resident weighed 142 lbs on admission, and the Resident was standing on a scale. On 1-18-22 a Dietary Nutritional Assessment was completed for care planning and the admission MDS submission to CMS (Centers for Medicare/Medicaid Services), and documented that the Resident weighed 142 lbs. On 4-8-22 the only other Dietary Nutritional Assessment in the clinical record was completed for care planning and the MDS first quarterly submission to CMS. The assessment documented that the Resident weighed 129 lbs, with fortified foods, and mighty shakes added to meals. The document recorded "no significant weight changes in the last 6 months" incorrectly. Physician orders for weight maintenance were as follows; Diet Ordered on 1-12-22 - Dysphagia mechanical soft texture, thin consistency liquids, bite size pieces for nutrition. Diet Ordered on 3-22-22 - Dysphagia advanced texture, thin consistency liquids. Both diet orders remained current on the physicians orders until	F 657	discrepancies resident's center intervention will be corrected immediately and findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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4-6-22 when the 1-12-22 diet was discontinued. Dietary personnel stated the orders were duplicates, and that is why one was discontinued, because they meant the same thing "mechanical soft."

Ordered on 1-18-22 - weekly weights for 4 weeks
Ordered on 1-21-22 - Fortified foods with meals, and mighty shakes with meals.

After 1-21-22 no orders for weight loss interventions were completed, nor were any of the orders descibed in the Resident's care plan for nursing. All interventions were ordered before the Resident experienced a 17% weight loss in one month, and no new interventions, nor orders for undesired weight loss occurred before survey on 4-12-22. The MDS assessment of 4-8-22, just 4 days prior to survey, documented no significant weight loss in error.

The Resident experienced a 24 lb weight loss in one month and 4 days (142 lbs to 118 lbs) from 1-11-22 to 2-15-22 which equalled a 17% loss.

On 4-14-22 at 5:00 PM, the Director of Nursing (DON), and Administrator were made aware of the issues with Resident #11 and her significant weight loss. The DON was asked what her expectation was for a Resident with weight loss, and she stated that the Registered Dietician should be made aware, and the physician and an assessment should be done and new interventions care planned immediately as soon as the weight loss was identified. They stated they had nothing further to provide.

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F 657	Continued From page 24 2. For Resident #93, the facility failed to revise the Resident's ADL (activities of daily living) incontinence care plan to include resident centered interventions to keep the resident's clothes, bed, and wheel chair dry. Resident #93's most recent MDS (minimum data set) assessment was dated 4-5-22. The document coded the Resident as always incontinent of bowel and bladder, fully intact with cognition, and was totally dependant on Staff for all activities of daily living to include toileting and hygiene. The Resident used a motorized wheel chair which he was able to maneuver himself without assistance as observed by the surveyor. The Resident's care plan was reviewed and revealed the Resident as incontinent of bowel and bladder, with interventions of the following only; Barrier cream after incontinence care. Assist with ADL's ....hygiene and toileting. No other direction was given for incontinence care to include incontinence briefs or when to provide hygiene. On 4-14-22 during the end of day meeting the Administrator and DON were made aware of the concerns and no further information was provided.	F 657		
F 660 SS=G	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation	F 660		5/27/22

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of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-
(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received

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F 660	Continued From page 26 from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and medical record and facility policy reviews the facility failed to provide Resident (R51) with essential discharge planning. This failure impacted R51's psychosocial wellbeing, causing him anxiety at times and desperation to return to his community. This is harm. The facility failed to meet this requirement by failing to:	F 660	1. Resident's #51 still resides in the center and has met with social worker to develop a discharge plan to return to the community via use of interpreter. 2. All resident currently residing in this facility have the potential to be affected by deficient practice. The administrator or	

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F 660	Continued From page 27 1. Ensure R51's discharge goals were clearly understood through the use of an interpreter. 2. Develop a discharge plan for R51 to return to his community. 3. Regularly evaluate R51 for his desire to return to his community and assist with resources to make his transition successful. Findings include: Observation on 04/12/22 at 11:00 AM, revealed R51 at the Receptionist's window. R51 was ambulatory, without the need of a walker or wheelchair to assist in mobility, and he was agitated. R51 is Korean and speaks only a few words of English. He stated " ...forty dollars-forty dollars!" and he waved a small black notebook at the Receptionist and the Business Office Manager (BOM). The BOM addressed R51's concern and they were attempting to communicate using a translation application on his phone. Review of an undated "Face Sheet" (a document with demographic and limited diagnostic information) found in the Electronic Medical Record (EMR) under the profile tab, revealed R51 was admitted to the facility on 02/14/17 with diagnoses including unspecified convulsions, seizures, and major depressive disorder. Review of R51's Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 02/19/22 revealed R51 is ambulatory per self with no assistive device required. He is assessed as independent requiring only oversight or cueing for his Activities	F 660	designee audited 100 % of all the charts of current residents to assess the provision of discharge planning and documentation in the chart 3. The Center's Social Worker provided education to all staff regarding the company language line contact information on May 5, 2022. The Administrator or designee completed re-education of the social worker related to the provision of medically-related social services to residents that may require it for discharge planning and regularly revisit during quarterly care planning for all residents. 4. The Administrator or designee will audit five resident's charts for compliance with discharge planning and documentation 3 x weekly for four weeks and monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans 5. Completion Date: 5/27/2022	

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of Daily Living (ADLs). The assessment indicated R51 had a Brief Interview for Mental Status (BIMS) score of 7 (of a possible 15 points). Previous MDS assessments were reviewed going back to R51's admission in 2017, and most of the MDS assessments were scoreless in this category due to the language barrier per the SW notes at the time.

Review of the Quarterly MDS with an ARD of 12/01/21 did not complete the BIMS Assessment. Review of the Quarterly MDS with an ARD of 10/19/21 coded the resident as an 11 meaning moderately impaired. Review of the Quarterly MDS with an ARD of 08/12/21 indicated the BIMS assessment should be complete but no score was noted.

Observations throughout the survey revealed R51 was rarely in his room. He walked the facility halls several times a day. He is very social with both staff and residents. In an interview on 04/13/22 at 10:15 AM Licensed Practical Nurse (LPN)B said ". . .[R51] has had a room to himself since COVID - when we had to make a lot of room changes. . .he tends to be territorial and that works better for him. . ." The LPN confirmed he is out of the room most days "to burn off energy. . ." During this same interview, LPNB and CNAA were asked about communicating with R51. They confirmed the device he wears around his neck is his cell phone and he has a translation application that he uses for Korean to English and vice versa. When asked if they felt this was effective, they both said yes, and added that R51 is very animated and used his body language when communicating his needs. This was observed to be true throughout the survey. LPNB also stated we can call his "wife" and gestured air quotation marks.

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Review of the residents EMR and hard chart at the nurse's station revealed a named resident representative (RR) and/or emergency contact identified as friend. The RR and her children were also listed under contacts. There was no documented evidence that R51 had been deemed unable to represent himself and make his own decisions since his admission. R51 has a language barrier and is frequently agitated (per the medical record review), because the language barrier hasn't been resolved by engaging a reliable interpreter. The EMR and hard chart were silent to documents that would deem the friend as an appropriate representative for healthcare and/or financial decisions. Nor was there documentation that one of the children was a deemed resident representative, but both had been notified by the facility of medical and financial concerns for R51.

In an interview with the Social Worker (SW) on 04/14/22 at 2:20PM, the SW was asked about communicating with R51. The SW stated, ". . .he has a device and if that doesn't work we can call his wife." When asked about documentation of the named girlfriend being deemed a representative to make decisions for, interpret for, and to be notified of changes for R51 both medical and financial, the SW said that she had only been at the facility for about a year but she would see what she could find related to social services and discharge planning provided to/for R51 since his admission.

Review of the Social Services notes since admission revealed the following:

07/25/17 - "Met with resident's girlfriend who had

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questions about filling out an application for [R51] new social security card ..." SW advised girlfriend.

08/17/17 - Care Plan meeting held. Resident declined and no contact from family ...Resident continue to be Full Code and long term."

06/14/18 - "Care Plan meeting held. Resident did not attend, no contact from family. Resident is long term and CPR."

03/08/19 - "Care Plan meeting held. Resident did not attend, no contact from family. Resident is long term and CPR."

03/17/20 - "[R51] is a 69yo [year old] long term care resident due to convulsions and muscle weakness. He is alert and oriented and can make needs known but does have difficulty with English as a second language. Only ask about returning to community on annual assessments ..."

10/15/21 - Resident visited SS (Social Services) with his cell phone to translate. Resident wanted money and green card and wants to go home. SW advised resident a call was placed to RP. . ."

11/16/21 - SW communicated with resident today on his app on telephone. Resident stated he was frustrated and wanted to know why he cant go home. . .SW communicated this is his home now and staff will take care of laundry. SW reminded resident that [named girlfriend] does not return calls from SW. . ."

01/27/22 - Resident at SW office agitated. SW uncertain what resident was saying because resident was yelling in addition to language

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barrier. . .he stated he came four times. . .SW attempts to get stepson on phone. . ."

02/02/22 - Conference call with SSA, and resident regarding resident income. . ."

During an interview on 04/14/22 at 3:30 PM, the SW was asked if the facility had ever made an attempt to engage an interpreter, without a potential conflict of interest, so that R51 could be clearly understood regarding his treatment and resident rights for appropriate care and discharge planning. The SW stated " ...there is a phone number we can call for an interpreter and I know they (BOM and R51) had a meeting using that interpreter line in the business office about his green card." When asked if she had ever engaged the interpreter line in her role as SW to ensure R51's needs were being met, the SW said, "No." When asked about the effectiveness of communicating through the translating device, due to its dependence on R51's understanding of what he is trying to ask/say, and the immense opportunity for misinterpretation the SW said " ...we do the best we can to understand him."

Review of the Nurse Practitioner and Nursing Progress notes in the EMR found in the Progress Notes tab revealed the following:

01/10/2019 - Nurse Practitioner Note ". . .language barrier makes difficult to communicate called wife to explain and interpret patient complaints."

10/17/2019 - Note text: visited resident in his room. . .Resident speaks Korean and some English but is usually understood. Resident nodded head up and down when I asked if he

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was ok. I asked if he had any problems and he smiled and said "good, good. . ."

10/02/20 - "Activity Note Text: Resident received a copy of Resident Rights and Ombudsman information." Surveyor asked Activities Director on 04/15/22 at 7:40 AM if it was provided in Korean and it was not. When asked if R51 attends activities regularly the AD said sometimes.

10/15/2021 - "Social Services [SS] "Note Text: On 10/24/21 resident became very upset and loud by the SS door because he thought the number of medications he was receiving was wrong. SW Unit Manager and Nurse finally explained his medications and was able to calm him down."

11/05/20 - "Social Services Note: [R51] is alert and oriented with a BIMS score of 14/15. He has difficulty making his needs known because English is his second language ...only ask about returning to community on annual assessment."

10/15/21- "Social Services Note: resident visited SS today with his cell phone to translate. Resident wanted money, green card and wants to go home. SW informed resident that a call was placed to RP and left a message."

11/16/21 - "Social Service Note: SW communicated with resident today on his app on telephone. Resident stated he was frustrated and wanted to know why he cant go home. . .SW communicated this is his home now and staff will take care of laundry. SW reminded resident that [named girlfriend] does not return calls from SW. . ."

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03/18/22 - "Nurse Practitioner Note:. . .Neuro: alert and oriented x4 [times four]. Follows commands, no neural deficits noted. Psych: appropriate mood, affect and judgment ..."

03/27/22 - "Physician Progress Note:. . .ROS [review of systems] awake alert - language barrier. . .Neuro: alert and oriented x4 [times four]. Follows commands, no neural deficits noted. Psych: appropriate mood, affect and judgment. . ."

In an interview with the Director of Nursing (DON) and the Administrator on 04/14/22 at 4:05 PM, the DON and Administrator were made aware of the concerns related to R51's language barrier as it related to resident rights and medically necessary social services. Neither were aware that the emergency contacts were not appropriate to act as R51's representative. They were advised that the facility must ensure he is clearly understood, and can speak for himself, by whatever means necessary. The DON agreed that he is high functioning and his level of care should be reassessed when the resident could be fully involved in the conversation. She confirmed no clear baseline had been established due to the language barrier. Both the Administrator and DON stated that situation would be clarified and taken care of immediately.

On 04/15/22 at 8:00 AM R51 was interviewed in his room using his interpretive app on his cell phone. The effectiveness of this app is questionable because it relies on R51 having a clear understanding of what he wants to ask or say. He did make clear that he is desperately trying to return to his Korean community. He was adamant through body language and the device

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that the listed RR was not an appropriate decision maker for him. He stated this was a "lover" but the relationship had ended and she hasn't return his calls for over a year. The resident had been journaling his situation and had multiple notebooks filled with notes since his admission. R51 offered them to read but they are written in Korean and this too, would require an interpreter. With patience R51 was able to communicate that he had a Pastor that would come to the facility to interpret for us. He trusted the Pastor and called him on his cell phone. The Pastor agreed to meet with the surveyor and R51 at 9:00 AM on 04/15/22.

With the interpreter/Pastor present in the facility on 04/15/22 at 9:10 AM, along with R51 and two surveyors, R51 was able to explain his situation as he understood it. R51 said that "two years ago he had a stroke and woke up here." Through the interpreter R51 said that he had needed rehab and was in a wheelchair for a short time. He has recovered remarkably, by all accounts, and wishes to return to his community. R51 confirmed the emergency contact/resident representative that the facility had been contacting was a former girlfriend/"lover," but that relationship had ended. When asked how long since the relationship had ended, R51 said since before COVID through the interpreter/Pastor, and he adamantly crossed his arms in the air and said, "no more." R51 was clear that the woman named should not be making decisions or receiving information about his situation. He stated he feels trapped and frustrated, and feels he is capable of caring for himself and is aware he should have the right to try.

Review of the facility's policy tilted "Policy and

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F 660	Continued From page 35 Standard Procedures - Subject: Discharge Planning - Category: Social Services - Effective: 07/17/2020" revealed, "A process [discharge planning] that generally begins on admission and includes each resident's discharge goals and needs, developing and implementing interventions to address discharge goals/needs and continuously reevaluating throughout the residents stay to ensure a successful discharge. . .1.) The discharge plan must be consistent with discharge rights set forth in 483.15(b). . .2.) Ensure the discharge needs of each resident are identified and result in a discharge plan ...work with the clinical team to ensure discharge needs are addressed. . .3.) Include regular reevaluation of residents to identify modifications needed. . .7.) Address the resident's goal and treatment preferences. . .8.) Document that a resident has been asked about their interest in returning to their community. . .a.) If the resident indicates interest in returning to the community the facility must document referrals to local agencies or appropriate agencies ...10.) Document and include in the resident's record the evaluation and discharge plan. . .a.). . .ll relevant information must be incorporated into the discharge plan to facilitate its implementation and avoid unnecessary delays in the resident's discharge. . ."	F 660		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		5/27/22

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F 677	Continued From page 36 Based on observation, Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure timely ADL (Activities of Daily Living) care for 2 Residents (#101, and #93) in a survey sample of 40 Residents. The findings included; 1. For Resident #101 the facility staff failed to fully dress the Resident, and to provide timely incontinence care, allowing the Resident to lay in urine soaked pants on one occasion, and to walk around in only a shirt, and a heavily urine soaked incontinence brief on a second occasion. Resident #101's most recent MDS (minimum data set) assessment was dated 3-23-22. The document coded the Resident as frequently incontinent of bowel and bladder, severely impaired cognition, and required extensive assistance from one staff member for toileting and hygiene. On 4-12-22 at approximately 12:30 PM during initial tour of the facility Surveyor C entered the room of Resident #101 and found her in bed uncovered dressed in sweat pants that were wet from the crotch area halfway to her waist, and a cotton short sleeve t-shirt. There was no blanket, nor top sheet on the bed, and she was covered from her waist up to her neck with a small 3 foot by 3 foot (lap robe) throw covering. The Resident was shivering and was asked if she was cold. She stated "I'm ok, thank you." At 1:00 PM - the Surveyor returned to the room after initial tour of the entire building was	F 677	1. Deficient Practice was corrected on 4/12/22 and 4/13/22 ADL care was provided to resident # 101 and #93 on 4/12 and 4/13 immediately. Wheelchair was cleaned and mattress changed on 4/13/22 2. All residents have the potential to be affected by this deficient practice.100% audit conducted by DON and unit managers to identify any other residents lying in bed with no covers, resident requiring incontinent care with brief change and clean clothing. Maintenance director to identify and clean all wheel chairs as per schedule. No other residents were found to be affected by this deficient practice. 3. DON, Unit Managers and/or Designee to educate all Registered Nurses, Certified Nursing Assistants, and Licensed Practical Nurses on providing daily resident ADL care including changing briefs and clean clothes, lying in bed with no covers and the process for wheel chair cleaning schedule. Policy related to ADL care reviewed with staff. 4. DON or designee will conduct 10 random ADL care and wheel chair cleanliness audits 3 x a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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completed and found the Resident exactly as before. On all halls of the building, and even at the entrance to the building the entire facility smelled strongly of urine.

At 2:45 PM - the Surveyor returned to the room and found the Resident exactly as before. On all halls of the building, and even at the entrance to the building the entire facility continued to smell strongly of urine. The Surveyor spoke to the Resident and realized she continued to need incontinence care and located 2 CNA's to Provide the incontinence care.

On 4-13-22 At approximately 10:00 AM Resident #101 was observed walking around her room near the window, by the bed of her room mate. The room door was open, and staff, visitors, and other residents were walking in the hallway looking in. Resident #101 was dressed only in a short sleeve cotton t-shirt and an incontinence brief, held up only by her hip bones, which was soaked and heavy with urine and hanging down swinging front to back as she walked. Licensed Practical Nurse (LPN) F approached as he saw the surveyor watching from the door of the room. He went to the Resident and walked her back to her bed, which was wet, covered her in her throw lap robe seen the day before, and a sheet. The Resident was shivering and LPN F was asked why the Resident did not have a blanket on her bed, and he replied "I don't know." LPN F was the IT (information technology) coordinator, and not general floor staff. LPN F did not give incontinence care and simply got the Resident back to bed, and continued down the hall.

The clinical record was reviewed and ADL (activities of daily living) documents revealed that

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Resident #101 received hygiene as follows;

4-12-22 completely dependant on staff Incontinence care at 2:01 AM, 2:59 PM, and not again until 7:00 PM.
4-13-22 completely dependant on staff Incontinence care at 1:12 AM, 11:24 AM, and not again until 7:09 PM.

The Resident's care plan was reviewed and revealed the Resident as incontinent of bowel and bladder, with interventions to include the following;

Barrier cream after incontinence care.
Keep skin clean and dry.
Resident requires assistance with toileting, wears adult briefs.
Check resident for incontinence, wash rinse dry perineum. Change clothing as needed after incontinence episodes.
Check as needed for incontinence episodes.
Provide incontinence care after each incontinence episode.

On 4-14-22 at the end of day debrief at 4:30 PM, the DON (Director of Nursing) was asked her expectation of hygiene and incontinence care for incontinent residents, and how often it should occur. The DON stated the residents should be checked at least every 2 hours and changed after each incontinent episode.

On 4-14-22 during the end of day meeting the Administrator and DON were made aware of the concerns and no further information was provided.

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2. For Resident #93 the facility failed provide incontinence care, resulting in a urine soaked bed, wheel chair, and clothing.

Resident #93's most recent MDS (minimum data set) assessment was dated 4-5-22. The document coded the Resident as always incontinent of bowel and bladder, fully intact with cognition, and was totally dependant on Staff for all activities of daily living to include toileting and hygiene. The Resident used a motorized wheel chair which he was able to maneuver himself without assistance as observed by the surveyor.

On 4-12-22 at approximately 12:00 PM during initial tour of the facility Surveyor C entered the room of Resident #93 and found him in bed uncovered dressed in sweat pants and a sweat shirt with staff in the room preparing to transfer him with a hoyer lift from the bed into his electric wheel chair for the day. The Resident was easily engaged in conversation and found to be oriented to person, place, time, history, and situation. The wheel chair smelled of urine, and the seat cushion had a glossy appearance and appeared to be wet. Staff stated it was damp, however, the Resident insisted on getting into the chair, and the Resident stated "What difference does it make, my bed is wet too, they don't answer my call bell when I get wet, so eventually it gets my bed and chair wet too."

When the Resident was safely in the chair the Resident's bed was inspected, and the mattress (air mattress) was wet and showed white staining in over lapping large concentric circles indicating saturation over an extended period of time. The staff stated that the stain could not be removed

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and it had been that way for a long time. The bed also smelled strongly of urine.

At 2:00 PM - the Surveyor returned to the room after initial tour of the entire building was completed and interviewed the Resident without staff present. On all halls of the building, and even at the entrance to the building the entire facility smelled strongly of urine.

On 4-13-22 At approximately 9:00 AM Resident 93 was observed and interviewed in his room. Resident #93 was dressed only in a shirt and an incontinence brief. The incontinence brief was soaked heavily with urine and the Resident stated "this is every day.... They are short staffed, and there just isn't enough staff to come in here but once or twice a day, that's why I get in my chair, so I can get out of this room." The Resident went on to say "look in that cabinet, it is full of condom catheters that I need to use, and have used for years. I want to use them, that would keep me dry and clean, I don't like stinking, and they won't let me use them." The surveyor inspected the cabinet and found it stacked with boxes of hundreds of condom catheters. The Resident stated "they won't let me use them because they don't want me to be able to go out of the facility, and with the condom catheters I would not get wet, so I could have more freedom."

The clinical record was reviewed and ADL (activities of daily living) documents revealed that Resident #93 received hygiene as follows;

4-12-22 completely dependant on staff Incontinence care at 6:42 AM, 2:59 PM, and not again until 6:48 PM.
4-13-22 completely dependant on staff

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Incontinence care at 1:06 AM, 10:54 AM, and not again until 6:15 PM.

The Resident's care plan was reviewed and revealed the Resident as incontinent of bowel and bladder, with interventions of the following only;

Barrier cream after incontinence care.
Assist with ADL's ....hygiene and toileting.

No other direction was given for incontinence care to include incontinence briefs or when to provide hygiene.

On 4-13-22 the DON was asked why the Resident had not been allowed his preference for condom catheters, and she stated they were afraid it would break down the Resident's skin.

On 4-13-22 at the end of day debrief, the DON notified the surveyor that they had received an order for the Resident to use the condom catheters. On that day the condom catheters were placed on the Resident's care plan, and on the following day 4-14-22, the Resident going out in his motorized wheel chair was also added to the care plan as ordered.

On 4-14-22 at the end of day debrief at 4:30 PM, the DON (Director of Nursing) was asked her expectation of hygiene and incontinence care for incontinent residents, and how often it should occur. The DON stated the residents should be checked at least every 2 hours and changed after each incontinent episode.

On 4-14-22 during the end of day meeting the Administrator and DON were made aware of the concerns and no further information was

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F 677	Continued From page 42 provided. Complaint Deficiency.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility documentation review, and clinical record review, the facility staff failed to provide an ongoing program to support a Resident's choice of activities based on the preference of the Resident for one Resident (Resident #65) in a survey sample of 40 Residents. The findings included: On 4/12/22, 4/13/22, 4/14/22, and 4/15/22, at various times during the day, Surveyor D observed Resident #65. Each observation revealed Resident #65 lying in bed. There was no television in the room, no radio, no reading material and no social stimulation or activities noted for Resident #65. An attempt to interview Resident #65 was made but was not successful due to her impaired cognition.	F 679	1. Resident's #65 has had a Television placed in her room. In addition to the TV placed the resident's room she has been joining other residents in the activities room. 2. All resident currently residing in this facility have the potential to be affected by deficient practice. The administrator or designee would audit 100% all the charts of current residents to assess resident's activities desires. 3. The Administrator or designee educated all Activities staff on the importance of documentation residents Activities Desires. The activities staff will attempt to place most requested items at resident bedside. 4. The Administrator or designee will	5/27/22

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F 679	Continued From page 43 On 4/13/22, Surveyor B conducted a review of the electronic health record for Resident #65. This review revealed the following: 1. Resident #65 had been admitted to the facility on March 2022. 2. No record of activity attendance or invite, (in room or group) for the past 30 days. There was an entry on 3/26/22, which noted, "Not applicable", for "activity offered to Resident". 3. A care plan entry dated 3/21/22, that read, "[Resident #65's name redacted] has little or no activity involvement. Resident is still adjusting to her surroundings". The intervention(s) for this care plan read, "Encouraging attendance to entertainment programs, large and small group activities, volunteer demonstrations, and religious activities". 4. There were no activity progress notes entered into the clinical record. 5. An "Activities Preferences Interview" form was conducted 3/14/22, that noted, Resident #65 liked cats. Had a current interest in: exercise, watching tv, keeping up with the news, and talking with staff. Resident #65 had a desire to "participate in daily activities with peers" and "join activities with peers". Resident #65 "needs assistance getting to/from activities". 6. Resident #65 had an MDS (minimum data set) (an assessment tool) conducted 3/12/22. This assessment coded Resident #65 with the following: "How important is it to you to keep up with the news? Very important. How important is it to you to have books, newspapers, and magazines to read? Very important". On 4/14/22 at 10:03 AM, an interview was conducted with Employee G, the activities director. Employee G said he makes the activity	F 679	audit five resident's charts for compliance with documentation weekly for four weeks and monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and Assurance Committee will determine the need for further audits and/or action plans 5. Completion Date: 5/27/2022	

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calendar/schedule. When asked about activity attendance he said, "at least 1-2 per week", is the goal for each Resident. He went on to say, "Activities are important because you need some type of coping skill to get through the hard times, you have to have activities you like to do, to get your mind off things". When asked about the documentation of attendance, Employee G said, "I try to document at the end of the day, my co-worker documents in a book".

On 4/14/22 at 10:10 AM, Surveyor B requested to see the activity assistant's notebook of activity attendance for the past 30 days.

On 4/14/22 at 2:54 PM, the facility Administrator provided a copy of the activity assistant's notes with regards to activity attendance for the month of March. These documents were reviewed and revealed notebook pages that had a list of the activities conducted for the day. No Resident names were noted on these pages. There were census pages [listing of Residents by room number] which revealed check marks by some of the names. Review of the pages revealed Resident #65's name with a check mark on 2 occasions, but no details with what activities she was invited to, if she attended or participated.

On 4/15/22 at 8:35 AM, an interview was conducted with Employee K, the activity assistant. Employee K reported that she conducts the group activities and does individual activities with Residents. Employee K said she keeps a notebook where she records what activities she did for the day and who attends. Surveyor B stated that the pages of her notebook had been reviewed and didn't include any Resident names to indicate they had attended activities.

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Employee K said she keeps a census list [resident listing] and "checks off who I seen and who participated in what activity".

Employee K was asked how she manages Residents who can't get to the activities independently. Employee K said, "I go get them". Employee K said she isn't aware of any frequency to which Residents should be provided, but she does try "divide by units or rooms and she tries to make sure everyone gets seen or an activity throughout the week".

Employee K was asked how attendance in recorded in the Resident's record. The activity assistance said her boss logs it in the computer, she reviews her notes with him at the end of the day. She had just received access to the EHR [electronic health record] and was learning the system, but currently doesn't record any attendance in the Resident's clinical record.

On 4/15/22 at 8:55 AM, an interview was conducted with the facility Administrator. He stated, "Activities should be going room to room, providing packets and one on one". When asked about Resident's activity attendance goals, he said, "At least once a week". The facility Administrator confirmed that the expectation is that activity attendance be documented in the clinical record. He added that the lack of documentation was brought to his attention last week and they have been working to get Employee K, the activity assistant access to the EHR.

On 4/15/22 at 8:55 AM, during the conversation with the facility Administrator a request for Resident #65's activity attendance since her

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F 679	Continued From page 46 admission on 3/7, was requested. On 4/15/22, mid-morning, the facility Administrator confirmed the facility had no evidence of Resident #65's activity attendance to provide the survey team. On 4/15/22, during an end of day meeting the facility Administrator and Director of nursing were made aware that Resident #65 was not being provided activities based upon her expressed preferences and interests. No further information was provided.	F 679		
F 692 SS=D	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		5/27/22

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F 692	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observations, Resident interview, staff interview, clinical record review, and facility document review, the facility failed to prevent significant weight loss for Two Residents (Resident #11, and #103) in a survey sample of 41 Residents. Findings include: 1. The facility failed to provide a therapeutic diet ordered by a physician and failed to provide supervision with eating which culminated in unplanned significant weight loss. 1. Resident #11's admission/only "Minimum Data Set (MDS)" assessment, with an Assessment Reference Date (ARD) of 1-18-22, revealed the Resident was moderately cognitively impaired and required a mechanically altered diet. The Resident had no teeth, and required supervision of one staff person to eat for cueing and assistance. Review of the Resident's care plan revealed the following; Nutritional consult on admission, quarterly, and as needed. Monitor meal intake. Observe for signs of aspiration. Obtain weights as ordered, monitor for weight loss & weight changes. Provide meals per diet order. Provide snacks per facility protocol. The Resident's weight record was reviewed and revealed the following;	F 692	1. Resident # 11 diet order verified and ordered correctly. Care plan updated to reflect correct meal assistance needed. Resident # 103 discharged from facility 2. Minimal Data Set RN Nurse reviewed all residents' care plans and updated them as needed to reflect correct meal assistance needed. All residents' diet reviewed for accuracy. All residents' medical records reviewed for undesired significant weight loss and dietary recommendation implementation timely. 3. All dietary staff and Nursing staff will be educated on Residents' diets by Registered Dietician. 100% Certified Nurse Assistants will be educated on meal percentages and accurate documentation. 100 % Licensed nursing staff educated on timely MD notification of weight loss and dietary recommendation implementation. 4. The ED or designee will audit 10 residents' meals and meal consumption 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. The ED or designee will audit 10 residents' meals for correct diet and texture weekly x 4, then monthly X -2. Findings will be brought to QAPI committee for review and recommendations for 1-month.	

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F 692	Continued From page 48 1-11-22 - 142 lbs standing 1-12-22 - 142 lbs standing 1-18-22 - 142 lbs standing 2-8-22 - 124.6 lbs standing 2-15-22 - 118.2 lbs standing 2-22-22 - 120.2 lbs standing 3-1-22 - 121.2 lbs wheel chair 3-21-22 - 123 lbs mechanical lift 4-1-22- -128 lbs mechanical lift 4-14-22 - 129 lbs mechanical lift [with surveyor present.] The Resident's admission assessment completed by Licensed Practical Nurse (LPN) G on 1-11-22 was reviewed and revealed the Resident weighed 142 lbs on admission, and the Resident was standing on a scale. On 1-18-22 a Dietary Nutritional Assessment was completed for care planning and the admission MDS submission to CMS (Centers for Medicare/Medicaid Services), and documented that the Resident weighed 142 lbs. On 4-8-22 the only other Dietary Nutritional Assessment in the clinical record was completed for care planning and the MDS first quarterly submission to CMS. The assessment documented that the Resident weighed 129 lbs, with fortified foods, and mighty shakes added to meals. The document recorded "no significant weight changes in the last 6 months" incorrectly. Physician orders for weight maintenance were as follows; Diet Ordered on 1-12-22 - Dysphagia mechanical soft texture, thin consistency liquids, bite size	F 692	The ED or designee will audit dietary recommendation for implementation 3 times a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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pieces for nutrition.
Diet Ordered on 3-22-22 - Dysphagia advanced texture, thin consistency liquids. Both diet orders remained current on the physicians orders until 4-6-22 when the 1-12-22 diet was discontinued. Dietary personnel stated the orders were duplicates, and that is why one was discontinued, because they meant the same thing "mechanical soft."

Ordered on 1-18-22 - weekly weights for 4 weeks
Ordered on 1-21-22 - Fortified foods with meals, and mighty shakes with meals.

After 1-21-22 no orders for weight loss interventions were completed, nor were any of the orders described in the Resident's care plan for nursing. All interventions were ordered before the Resident experienced a 17% weight loss in one month, and no new interventions, nor orders for undesired weight loss occurred before survey on 4-12-22. The MDS assessment of 4-8-22, just 4 days prior to survey, documented no significant weight loss in error.

The Resident experienced a 24 lb weight loss in one month and 4 days (142 lbs to 118 lbs) from 1-11-22 to 2-15-22 which equaled a 17% loss.

The facility's 4-13-22 lunch menu documented the following should have been served;

-Turkey with cranberry glaze
-Herbed green beans
-Sage bread dressing
-Dinner roll
-Caramel apple upside down cake

At 12:15 PM on 4-13-22 Resident #11 was

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observed in bed with a meal tray in front of her on a bedside table. No staff were there to cue or assist in any way. The tray contained sliced whole turkey meat, a serving of whole green bean pieces, a whole dinner roll, and an empty saucer. None of the food was chopped nor ground in any fashion. The Resident stated "I can't eat that mess, I don't have any teeth!"

A CNA (Certified Nursing Assistant) in the hallway was delivering trays to resident rooms and was asked if anyone was helping Resident #11 to eat, and she stated "We will after we finish delivering the trays, we don't have enough people to feed residents and pass trays at the same time."

At 1:15 PM Resident #11 was again observed, and was sleeping. The meal tray was untouched from the first observation, and cold. Another CNA in the hall way saw the surveyor enter the room and came in and removed the tray and stated "She refused to eat." The meat had never been cut nor prepared by staff for Resident consumption.

The meal consumption log was reviewed for Resident #11, and documented that the Resident had eaten 76% to 100% of her lunch meal on 4-13-22 in error.

On 4-14-22 at 5:00 PM, the Director of Nursing (DON), and Administrator were made aware of the issues with Resident #11 and her significant weight loss. The DON was asked what her expectation was for a Resident with weight loss, and she stated that the Registered Dietician should be made aware, and the physician and an assessment should be done and new interventions care planned immediately as soon

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as the weight loss was identified. They stated they had nothing further to provide.

2. For Resident #103, the facility staff failed to implement the dietician's recommendations for a fortified diet on 09/09/2020 and for a 2 cal supplement on 09/30/2020.

On 04/12/2022 and 04/13/2022, Resident #103's clinical record was reviewed. According to the Weight Flowsheet, Resident #103 weighed 138 pounds on 08/01/2020 and weighed 125 pounds on 09/03/2022 which was a 9.42% weight loss in one month.

The progress notes for August and September 2020 were reviewed. A nurse's note dated 09/03/2020 at 9:52 A.M. documented, "Note Text: Ate 25% or less x 1 day. Alternate meals and snacks offered and accepted. Nursing staff will continue to monitor." There was no evidence the physician or the responsible party was notified of Resident #103's significant weight loss.

An excerpt of a provider's note dated 09/07/2020 at 11:08 P.M., documented, "Patient doing well [n.p.] no distress." "Code status full [code]." The significant weight loss discovered on 09/03/2022 was not addressed in the provider note.

An excerpt of a therapy notification note dated 09/08/2020 at 10:02 A.M. documented, "Difficulty getting in/out of bed. Weakness upper/lower extremities."

Excerpts of a Registered Dietitian nutrition note dated 09/09/2020 at 5:50 P.M. (6 days after the significant weight loss was discovered)

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documented, "[Resident #103] triggers for significant weight loss (9.4% x 30 days)." Under the sub-header "Interventions", it was documented, "Resident's weight change and nutrition interventions were reviewed during the weekly IDT [interdisciplinary team] meeting with MD [medical doctor]/RD [registered dietician]/DON [Director of Nursing]/Nursing Unit Manager present. [Resident #103] is noted w/ significant weight loss x 30, 90, and 180 days BMI [body mass index] remains WNL [within normal limits] at this time. PO [oral] intake noted to be fair-good, consuming 25-100% meals -slight decline in PO intake maybe contributing to sig wt loss [significant weight loss]. Recommend adding fortified foods @ meals and monitoring via weekly weights x 4 weeks.

A physician's order dated 09/09/2020 documented, "Weekly weights ...every Tuesday."

The weekly weights were reviewed. According to the Weights Flowsheet, Resident #103 weighed 124 pounds on 09/13/2020; 118.5 pounds on 09/23/2020; 116 pounds on 09/29/2020; and 116 pounds on 10/03/2020.

A physician's order dated 09/23/2020 documented, "Regular diet Dysphagia Puree texture, Thin consistency, for fortified foods with meals." This order was dated was 20 days after the significant weight loss was discovered and 14 days after the dietitian's recommendation for fortified foods.

An excerpt of a Registered Dietitian nutrition note dated 09/23/2020 at 5:32 P.M. under the sub-header "Interventions" documented, "Resident's current weight and nutrition

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interventions were discussed during the weekly IDT meeting with MD/RD/SW [social worker]/ED [executive director]/Nursing Team present. Resident is noted with weight loss and downgrade in diet texture. PO intake remains poor-fair, consuming 0-75% meals. Recommend providing resident with fortified foods and magic cup [supplement] Q day [every day] for additional calories. Will continue to monitor via weekly weights and f/u PRN [follow up as needed]."

According to the Medication Administration Records for September and October 2020, Magic Cup was signed off as administered from 09/24/2020 through 10/07/2020.

An excerpt of a Registered Dietitian nutrition note dated 09/30/2020 at 8:13 P.M. under the sub-header "Interventions" documented, "Resident's weight and nutrition interventions were reviewed during the weekly IDT meeting with MD/ED/Corporate Nurse/RD/SW/MDS [minimum data set]/Nursing Team present. IDT team agrees that resident may benefit from 2cal supplement at this time. Will continue to monitor via weekly weights and follow up PRN [as needed]."

A nurse's note dated 10/05/2020 at 2:44 P.M. documented, "Ate less. Alternate snacks and meals offered and accepted. Nursing staff will continue to monitor."

An excerpt of a Registered Dietitian nutrition note dated 10/07/2020 under the sub-header "Interventions" documented, "Resident's weight change and nutrition interventions were reviewed during the weekly IDT meeting with MD/RD/Corporate Nurse/SW/MDS/Nursing Team

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F 692	Continued From page 54 present. IDT team reports that resident has had a significant decline s/p [status post] outbreak of COVID19. Resident is now dependent on staff for feeding and his PO intake remains poor-fair @most meals. Recommend providing resident w/ 2cal120cc BID [with 2 cal 120 cubic centimeters meaning milliliters twice a day] (~480kcal/20gprotein) at this time. Will continue to monitor via weekly weights and f/u prn." A physician's order dated 10/07/2020 documented, "2 cal supplement 120 cc two times a day for supplement." This supplement was ordered 8 days after the registered dietician recommended it on 09/30/2020. A review of the Medication Administration Record for October 2020 revealed that Resident #103 did not receive the supplement on 10/07/2020 due to hospitalization. On 04/15/2022 at 2:00 P.M., the Director of Nursing (DON) was notified of findings. When asked about the process for implementing the dietician's recommendations, the DON stated that the dietician will notify the nurse and the nurse will notify the physician. The DON also stated that the nurse will put the order into the electronic health record, notify the dietary team, and notify the family. When asked about the expectation for timeliness, the DON stated the expectation is the nurse will input the orders as soon as the dietician recommends them. On 04/15/2022 at approximately 4:30 P.M., the administrator stated they had no further information or documentation to submit.	F 692		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		5/27/22

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F 745	Continued From page 55 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review and clinical record review, the facility staff failed to provide medically related social services for one Resident (Resident #7) in a survey sample of 40 Residents. The findings included: For Resident #7, the facility staff failed to assist Resident #7 to obtain glasses after an eye examination on 10/22/2021. On 04/12/2022 at 11:25 A.M., Resident #7 was observed in his bed. Resident #7 was awake and the television was on. When asked if he had any concerns about the care he received at the facility, Resident #7 stated that he wanted to get glasses. Resident #7 stated he cannot see out of his right eye and he wants glasses to be able to see the television and read his books. Resident #7 stated he has trouble seeing close up and far away. Resident #7 was not wearing glasses at the time of the interview and stated that everything on the television was blurry. When asked if the facility staff offered him reading glasses, Resident #7 stated, "No." On 04/13/2022, Resident #7's clinical record was reviewed. According to the "Summary Ocular Progress Notes dated 10/22/2021 under the header "Diagnosis and Treatments", an excerpt	F 745	1. Resident #7 was visited by the social worker and arrangements for glasses done April 15, 2022 2. All residents have the potential to be affected. A100% audit of all eye examinations referrals within the last 30-days will be conducted to determine others that may have been affected by this deficient practice. 3. ED/designee will re-educate social' service on the Importance of following up on referrals to ensure residents medically related social services needs are met in a timely manner 4. ED/designee will monitor that all new medically social services referrals needs for residents are visited and addressed within 48-hours of referrals 3x a week for 4 weeks, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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documented, "Reordered lost glasses."

A social worker noted dated 10/25/2021 at 10:05 A.M. documented, "Note Text: Resident eyes were examined by [physician's name] with [company name] on 10/22/21; cataract exam. Resident has a prescription for frames, bifocal, high index, and tint, totaling $324.98. SW met with resident as he does not qualify for a MAPP adjustment, and [facility] is not his rep payee. Resident stated he was receiving $11140.00 in the community. SW contacted [social security] Customer Services [name] with resident. [name] stated resident has been receiving $126.00 [per month] SSA [social security administration] since 2020. Resident has $86.16 available on his [social security prepaid debit] card from SSA. SW encouraged resident to contact his family to ask for assistant [sic] with paying for the eyeglasses. Resident stated he was going to call his brother to come get him because if he cannot get eyeglasses this place is not a benefit for him." There was no evidence in the clinical record that the social worker offered Resident #7 reading glasses or utilized alternate resources to assist with obtaining eye glasses.

On 04/14/2022 at 11:20 A.M., the social worker was interviewed. When asked about Resident #7's eyeglasses, the social worker stated that she was working on it "right now." The social worker stated that [eyeglass company] wrote an eyeglass prescription for [Resident #7] but that Resident #7 didn't have the money to pay for the eyeglasses. The social worker stated that she was currently working on trying to reduce the cost of the glasses by making adjustments to the items on the invoice. When asked about the timeliness of assisting Resident #7 obtain eyeglasses, the

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social worker stated that "We didn't have a business office manager for awhile."

On 04/14/2022 at 1:30 P.M., the Business Office Manager, Employee M, was interviewed. Employee M indicated she had worked at the facility since February 2022. When asked who was Business Office Manager prior to her employment, Employee M stated a mobile Business Office Manager and a Business Office Manager from a sister facility covered the business office manager duties.

On 04/14/2022 at 1:40 P.M., the Human Resources Manager was interviewed. The Human Resources Manager confirmed that the Business Office Manager, Employee N, left the position in November 2021 and was replaced with a mobile Business Office Manager and a Business Office Manager from a sister facility.

The facility staff provided a job description for the social worker. An excerpt under the header "Purpose/Belief Statement" documented, "The position of Social Services Director provides planning, assessing, coordinating and implementation of services to enhance each resident's social and psychosocial wellbeing and assure care standards are met and the highest degree of quality resident care is provided at all times."

On 04/15/2022 at 2:40 P.M., the administrator and Director of Nursing were notified of findings. The administrator stated that Medicaid will now cover the script since the script was changed. At approximately 4:30 P.M., the administrator stated there was no further information or documentation to submit.

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F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on dining observations, resident and staff interviews, and review of the "Food and Drug Administration's Food Code 2017," the facility failed to provide foods that were palatable and maintained at appetizing temperatures for 3 of 40 sampled residents (R44, R86 and R88). Findings include: During the initial pool portion of the survey process on the afternoon of 04/12/22 and through the morning of 04/13/22 many alert and oriented residents were interviewed/screened. Some of the residents were observed with their meal trays during the interviews and were asked about the food quality in the facility. Residents (R)44, R86 and R88 said their food was frequently cold by the time it reached them. During an interview on 04/13/22 at 8:30 AM, R86 stated "it makes bad food worse. . ." On 04/14/22 at 12:00 PM, food temperatures were checked on the serving line and found to be at appropriate temperatures when the food was plated and left the kitchen on the tray cart. A test tray was requested and followed for a	F 804	1. The licensed nursing staff, certified nursing assistance and temporary nursing assistance and Department Heads educated on closing the food carts after removing a tray. This would allow the temperature of the cart to remain steady and keep the food at correct temperature. 2. All resident currently residing in this facility have the potential to be affected by deficient practice. 3. The Administrator or designee will complete re-education of the staff ensuring that meals are passed immediately when carts hit the floor. In addition, dietary staff will be re-educated to deliver the cart to the floor once the carts are full in the kitchen. 4. The Administrator or designee will audit five test trays for compliance weekly for four weeks and monthly for two months. Data collected will be forwarded to Quality Assessment and Assurance Committee for review and action as appropriate. The Quality Assessment and	5/27/22

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F 804	Continued From page 59 temperature check by the Dietary Manager (DM) and surveyor. The test tray was the last tray, on the last cart served on the 200 top hall. The temperatures were checked at 12:37 PM on 04/14/22. The hot foods tested at or above 140 degrees as required. However, the cold items were not maintained at optimal temperatures to remain appetizing. The unopened yogurt on the test tray was 51 degrees, and the container was 'sweating'. The yogurt was not under the food cover, but was uncovered and unopened on the tray and failed to hold it's temperature. Interview with the DM at time of the temperature taking confirmed the yogurt was not less than 41 degrees as recommended. A group meeting was held on 04/14/22 at 2:00 PM with six alert and oriented residents willing to participate in resident council. During this meeting the residents stated their food is often cold when they receive it in their rooms. They said no certain meal was worse than others and that it happens frequently. On 04/14/22 at 2:30 PM the DM was made aware of the resident's comments about cold food during the screening process and during the resident group meeting. The DM stated he would work on fixing that. The DM stated he would look for a facility policy regarding food temperatures when asked, but he said he wasn't sure there was a facility policy because they follow FDA recommendations. No policy was received prior to exiting the survey. Review of the "Food and Drug Administrations Food Code 2017: 7 Recommendations of the United States Public Health Service Food and Drug Administration," reviewed and current as of	F 804	Assurance Committee will determine the need for further audits and/or action plans 5. Completion Date: 5/27/2022	

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F 804	Continued From page 60 03/2022, revealed ". . .Foodborne illness in the United States is a major cause of personal distress, preventable illness and death. . .Epidemiological outbreak data repeatedly identify five major risk factors related to employee behaviors and preparation practices in food service settings as contributing to foodborne illness: o Improper holding temperatures, o Inadequate cooking, such as undercooking raw shell eggs, o Contaminated equipment, o Food from unsafe sources, and o Poor personal hygiene. . .The Food Code addresses controls for risk factors and further establishes 5 key public health interventions to protect consumer health. Specifically, these interventions are: demonstration of knowledge, employee health controls, controlling contamination, and time and temperature parameters for controlling pathogens. . .3-202.11 Temperature. (A) Except as specified in (B) of this section, refrigerated temperature control for food safety will be maintained at a temperature of 5oC (41oF) or below when served/received. . ..(D) Temperature control for food safety of cooked foods that is cooked to a temperature and for a time specified under §§ 3-401.11 - 3-401.13 and received hot shall be at a temperature of 57oC (135oF) or above. . ."	F 804		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/27/22

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F 880	Continued From page 61 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 62 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to develop and implement a water management plan for Legionella with regards to a risk assessment to identify where Legionella and other waterborne bacteria could grow, which has the ability to affect all Residents residing at the facility. The findings included: On 4/14/22, during review of the facility water management program the facility submitted an incomplete and inaccurate facility risk assessment, used to identify where Legionella and other waterborne bacteria could grow and spread in the facility water system. This was reviewed with the facility Administrator and Director of Maintenance, who confirmed the form	F 880	1. The Divisional Director of Facilities management instructed the administrator and Maintenance Director in proper completion of the Legionella Risk Assessment and water management plan. The surveyors were given a revised Legionella Assessment form on 4/15/22 2. All resident currently residing in this facility have the potential to be affected by deficient practice 3. The Divisional Director of Facilities management or designee will complete a re-education of Legionella Risk Assessment and surveillance for water management including utilization of surveillance tool for maintenance Director,	

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F 880	Continued From page 63 was not accurate and incomplete. During the review of the water management program, when asked about the water testing as noted as being conducted as per the facility assessment for Legionella, the maintenance director stated that the kitchen has the test strips and tests this. The maintenance director was asked to confirm that the kitchen staff are testing for Legionella and he stated, "Yes, they have the test strips that change color". On 4/14/22 at 4:00 PM, the facility Administrator stated that the Divisional Director of Facilities management was walking them through the form [Legionella risk assessment]. The facility Legionella policy was reviewed. It read, "...Surveillance for Legionella includes monitoring for appropriate levels of disinfectants in the public water system as well as the facility water system...4. Monitoring Environment. a. Maintenance performs routine water monitoring services documented in electronic surveillance systems..." Administrator was made aware of the lack of an appropriate and accurate water management program on 4/14/22, during the end of day meeting. On 4/15/22 at 7:52 AM, the facility Administrator provided a revised Legionella Assessment form and stated, "The form sent yesterday was completed incorrectly. Therefore, The maintenance director and area director completed a new form yesterday." No further information was provided.	F 880	Infection practitioner and Administrator. The facility risk assessment will be updated The center has reached out to the local health department on April 28, 2022 for education on Infection Control Polices. 4. The Maintenance Director, Infection Preventionist, and the Administrator will monitor the Legionella surveillance tool weekly for one month and act upon any areas that may indicate Legionella is present. 5 Completion Date: 5/27/2022	

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F 883 SS=D	Influenza and Pneumococcal Immunizations 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 immunization, unless the immunization is	F 883		5/27/22

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F 883	Continued From page 65 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 an influenza and pneumococcal immunization, unless medically contraindicated or they have already been immunized for 1 Residents (Resident #85), in a sample of 5 Residents reviewed for immunizations. The findings included: On 4/13/22, a clinical record review for Resident #85 was conducted. This review revealed the following: 1. Resident #85 had been admitted to the facility on 3/18/22. 2. 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. 3. All of the progress notes for Resident #85's	F 883	1. Resident #85 was offered Flu and Pneumonia Vaccine but declined on April 15, 2022 2. All residents have the potential to be affected. 100% audit will be done for all residents to ensure all residents have influenza and pneumococcal vaccinations or declination updated in PCC 3. Infection Preventionist /Designee will educate all Nurses on Flu and pneumonia immunization for all residents, unless the immunization is medically contraindicated for the resident using Communicare policy for influenza and pneumonia. All new admissions will be reviewed during clinical meeting daily to address immunization status of all new admission.	

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F 883	Continued From page 66 duration of his stay at the facility were reviewed. There was no indication of Resident #85 being offered or educated on the benefit of immunization for flu and pneumonia. 4. Review of the misc. (miscellaneous) tab revealed no evidence of vaccine administration or offering of either. 5. Review of the nursing admission assessment completed on 3/18/22, indicated Resident #85 was not immunized for the flu or pneumonia. 6. Review of the Medication Administration Records (MAR) revealed no evidence of the flu or pneumonia immunization being provided to Resident #85. On 4/14/22 at 10:26 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. On 4/14/22 at approximately 1:30 PM, Surveyor E reviewed the paper chart for Resident #85. This review was conducted with LPN F, the Medical Records Director present. Employee F confirmed there was no record of Resident #85 being educated or offered to receive or decline immunizations for flu and pneumonia. On 4/14/22 at 5:23 PM, an interview was conducted with Employee C, the facility infection preventionist. Employee C confirmed that she handles the vaccination effort within the facility.	F 883	4. DON and Infection Preventionist will review all new influenza and pneumococcal vaccination orders and ensure education is provided and documented prior to administration or declination of the influenza and pneumonia vaccine. This audit will be conducted 3 x weekly x4 and monthly x2. The audits will be reviewed by the QAPI committee monthly 5. Completion Date: 5/27/2022	

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F 883	Continued From page 67	F 883		

When asked to describe the process when an admission comes in with regards to immunizations, Employee C said, "When a Resident is admitted, the nurse has the consent for treatment, flu, pneumonia and COVID vaccines, after they receive consent, they enter it into [the electronic health record name redacted] if they consented or refused. The unit manager checks the next day to make sure it was done and I check behind them within 5 days. The next day [following admission] we review the chart and the medical records LPN [licensed practical nurse] uploads the consent into the misc. tab of the chart".

Employee C then reviewed the EHR for Resident #85 and confirmed she didn't see any information with regards to immunization for flu or pneumonia being offered, consented to, or refused. She said it is important to get immunizations to protect against various illnesses.

On 4/15/22 at 8:55 AM, the facility Administrator was made aware of the above findings.

On 4/15/22 at 9:30 AM, Surveyor B received a phone call from Employee C, the infection preventionist. Employee C said, "I spoke to [Resident #85's name redacted], he said he signed the forms on admission and gave them to the nurse, he declined the flu and pneumonia vaccines".

On 4/15/22 at 10:18 AM, Surveyor C visited Resident #85 in his room and found him to be alert, oriented x 4. Surveyor C inquired about flu and pneumonia vaccines. Resident #85 stated he had never been offered the flu or pneumonia vaccines and didn't sign any forms on admission.

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F 883	Continued From page 68	F 883		

Resident #85 said it wasn't until today that Employee C and LPN F came and tried to get him to sign forms and he refused. Surveyor C called Employee C to the room where Resident #85 again said he had never been offered the flu or pneumonia vaccines until she, [Employee C] came in there today and talked to him. Employee C confirmed she had talked to Resident #85 this morning because she wasn't here when he was admitted.

Review of the facility policy titled, "Resident Pneumococcal Vaccine" was reviewed. These policy read, "...A. Residents in the facility will be offered education regarding pneumococcal pneumonia. B. Residents in the facility will be offered the pneumococcal pneumonia vaccine, unless medically contraindicated or the resident has already been immunized. 1. Residents newly admitted to the facility will be asked if they have received a pneumonia vaccine in the past... 2. New admission residents will be offered the education and vaccine upon admission....III. Vaccination and Documentation...D. The documentation will include, at a minimum, that the resident 1. Received the pneumococcal pneumonia vaccine immunization -OR- the reason noted as either: a) due to medical contraindications -OR- b) Refused 3. AND the resident and/or the resident representative received education PRIOR to the immunization, regarding the benefits and potential side effects."

Review of the facility policy titled, "and "Resident Influenza Vaccine" was conducted. Excerpts from this document read, "B. 1. New admission resides will be offered the education and influenza vaccine upon admission in the event admission occurs during the influenza season,

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F 883	Continued From page 69 October 1 through March 31....III. Vaccination and Documentation...D. The documentation will include, at a minimum, that the resident 1. Received the influenza vaccine immunization -OR- 2. Did not receive the influenza vaccine immunization including the reason noted as either: a) due to medical contraindications -OR- b) Refused 3. AND the resident and/or the resident representative received education PRIOR to the immunization, regarding the benefits and potential side effects." On 4/15/22 at 2:30 PM, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the facility staff's failure to determine vaccine status and offer the influenza and pneumococcal vaccines and education to Resident #85 and document such in Resident records. No further information was provided.	F 883		
F 887 SS=D	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	F 887		5/27/22

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F 887	Continued From page 70	F 887		

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
(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

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F 887	Continued From page 71 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 a COVID vaccine for a Resident who was not vaccinated against COVID-19, for 1 Residents (Resident #85), in a sample of 5 Residents reviewed for immunizations. The findings included: On 4/13/22, a clinical record review for Resident #85 was conducted. This review revealed the following: 1. Resident #85 had been admitted to the facility on 3/18/22. 2. An admission nursing note dated 3/18/2022, read, "...COVID - 19 VACCINE RECEIVED No, resident is to be placed in isolation" 3. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #85. 4. All of the progress notes for Resident #85's duration of his stay at the facility were reviewed. There was no indication of Resident #85 being offered or educated on the benefit of immunization for COVID. 5. Review of the misc. (miscellaneous) tab revealed no evidence of vaccine administration or offering of the COVID vaccine. 6. Review of the nursing admission assessment	F 887	1. Resident #1 was offered COVID vaccine but declined on April 15, 2022 2. All residents have the potential to be affected by this deficient practice 100% audit will be completed for all resident□s COVID-19 status vaccine and update in PCC with status 3 IP/Designee will educate all Nurses on COVID 19 vaccine immunization for all residents, unless the immunization is medically contraindicated for the resident. Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects. The resident's medical record will include documentation that indicates the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; document refusal of vaccine, document vaccine administered in PCC. 4 DON/IP will audit all new residents for	

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F 887	Continued From page 72 completed on 3/18/22, indicated Resident #85 was not immunized for COVID. 7. Review of the Medication Administration Records (MAR) revealed no evidence of the COVID immunization being provided to Resident #85. Review of the listing of Resident's COVID immunization status form provided by the facility staff on 4/13/22, indicated Resident #85 was blank with no information recorded regarding COVID immunizations. On 4/14/22 at 10:26 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. On 4/14/22 at approximately 1:30 PM, Surveyor E reviewed the paper chart for Resident #85. This review was conducted with LPN F, the Medical Records Director present. Employee F confirmed there was no record of Resident #85 being educated or offered to receive or decline immunizations for COVID-19. On 4/14/22 at 5:23 PM, an interview was conducted with Employee C, the facility infection preventionist. Employee C confirmed that she handles the vaccination effort within the facility. When asked to describe the process when an admission comes in with regards to immunizations, Employee C said, "When a	F 887	COVID vaccine status within 48-hours of admission 3x a week for 4 weeks then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5. Completion Date: 5/27/2022	

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PETERSBURG HEALTHCARE CENTER	287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805

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Resident is admitted, the nurse has the consent for treatment, flu, pneumonia and COVID vaccines, after they receive consent, they enter it into [the electronic health record name redacted] if they consented or refused. The unit manager checks the next day to make sure it was done and I check behind them within 5 days. The next day [following admission] we review the chart and the medical records LPN [licensed practical nurse] uploads the consent into the misc. tab of the chart".

Employee C then reviewed the EHR for Resident #85 and confirmed she didn't see any information with regards to immunization for COVID being offered, consented to, or refused. She said it is important to get immunizations to protect against various illnesses.

On 4/15/22 at 8:55 AM, the facility Administrator was made aware of the above findings.

On 4/15/22 at 9:30 AM, Surveyor B received a phone call from Employee C, the infection preventionist. Employee C said, "I spoke to [Resident #85's name redacted], he said he signed the forms on admission and gave them to the nurse, he declined the flu and pneumonia vaccines but would accept the COVID. I had him sign new forms". Employee C was asked when Resident #85 would receive the COVID vaccine and Employee C said, "When we have the next vaccine clinic, we will have to schedule it with the pharmacy. We try to do at least once a week on Thursdays". Employee C was asked when the last vaccine clinic was and she said, "Last one was yesterday but he wasn't here".

On 4/15/22 at 10:18 AM, Surveyor C visited

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Resident #85 in his room and found him to be alert, oriented x 4. Surveyor C inquired about vaccines. Resident #85 stated he had never been offered the flu, pneumonia or COVID vaccines and didn't sign any forms on admission. Resident #85 said it wasn't until today that Employee C and LPN F came and tried to get him to sign forms and he refused. Surveyor C called Employee C to the room where Resident #85 again said he had never been offered the flu or pneumonia vaccines until she, [Employee C] came in there today and talked to him. Employee C confirmed she had talked to Resident #85 this morning because she wasn't here when he was admitted.

Review of the facility policy titled, "Resident COVID-19 Vaccine "was reviewed. This policy read, "...A. Residents residing in the facility are provided education in a manner they understand related to the risk/benefits of the COVID-19 vaccine. The resident and/or resident representative is provided at a minimum the Fact Sheet for Healthcare Recipients prior to signing the consent to receive the COVID-19 vaccine. If the vaccination requires multiple doses of vaccine, the resident or resident representative are again provided with education regarding the benefits and potential side effects of the vaccine and current information regarding those additional doses, including any changes in the benefits or potential side effects, before requesting consent for administration of any additional doses. The resident and/or resident representative will have the opportunity to ask questions and make an informed decision prior to consenting to receive the COVID-19 vaccine. 1. New admission residents will be provided education in a manner they can understand and offered the COVID-19

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F 887	Continued From page 75 vaccine prior to the first available vaccination date post admission...4. The resident or resident representative must sign a declination form each time a resident or resident representative is offered the COVID-19 vaccine and declines..." On 4/15/22 at 2:30 PM, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the facility staff's failure to determine vaccine status and offer the COVID vaccine and education to Resident #85 and document such in Resident records. 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 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	F 888		5/27/22

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(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 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

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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 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

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F 888	Continued From page 78 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 considerations; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to have a 100% vaccination rate on 04/15/2022 due to one Employee (Employee L) in a sample size of 101 total staff members. Specifically, Employee L was only partially vaccinated while employed as kitchen staff and the facility staff failed to schedule for the second vaccination dose in the series. The findings included: On 04/15/2022, the staff vaccination was reviewed. According to the matrix, the facility had 101 total staff, 98 staff fully vaccinated, two staff granted exemption, and one partially vaccinated	F 888	F-Tag 888 1. Identified staff was vaccinated on 4/16/2022. 2. All new hire staff have the potential to be affected by this deficient practice 100% audit will be completed to identify any staff not in compliance and that facility maintains documentation related to staff COVID-19 vaccination. 3. All newly hired staff will be fully vaccinated before start date upon hire. DON/ IP will utilize and maintain process	

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F 888	Continued From page 79 staff (Employee L) resulting in a facility vaccination rate of 99%. On 04/13/2022, the facility staff provided a copy of their policy entitled, "Employee COVID-19 Required Vaccination." In Section A under the header "Policy for Current Staff/New Hire Staff" and sub-header "New Hire Staff" an excerpt documented, "At minimum, the first dose of a two-dose vaccine or a one-dose must be given prior to providing any care, treatment, or other services for the facility and/or its patients, unless provided a religious or medical exemption. Vaccinated New Hire Staff are required to complete the second dose of a two dose vaccination at the time recommended by the vaccine manufacturer." In Section C entitled, "Proof of Vaccination" and sub-header "Documentation and Tracking" it documented, "Documentation and Tracking of staff primary and booster doses of the Covid-19 vaccine, accommodation submissions and approvals are documented, tracked, and secured electronically in Workday. The Human Resource Manager maintains all documents related to the Workday system." On 04/15/2022 at 12:10 P.M., Employee L, kitchen staff, was interviewed. When asked how long he had been working at the facility, Employee L stated "Three weeks." When asked if he had been vaccinated for COVID-19, Employee L stated he received the first dose but did not recall the date. When asked if he was scheduled to receive the second dose, Employee L indicated he was willing to receive a second dose but it had not been scheduled. On 04/15/2022 at 1:45 P.M., Employee D, Human	F 888	for tracking and securely documenting the COVID-19 vaccination status of all staff. 4. HR /Designee will audit and monitor that all new hires are vaccinated before hire date. Weekly audit x 4, then monthly X 2. Findings will be brought to QAPI committee for review and recommendations for 1-month. 5 Completion Date: 5/27/2022	

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Resources Manager, was interviewed. The Human Resources Manager provided a copy of Employee L's vaccination card and confirmed Employee L's date of hire was 03/20/2022. According to Employee L's COVID-19 vaccination card, Employee L received the first Pfizer dose on 03/25/2022 [meaning Employee L would be eligible for second dose on 04/15/2022]. When asked about tracking of the vaccine doses, the Human Resources Manager indicated that nursing does that.

On 04/15/2022 at 1:55 P.M., the Director of Nursing (DON) were notified of findings. When asked about the expectation for staff vaccination status, the DON stated the expectation was that all staff would be fully vaccinated. When asked about Employee L's vaccination status, thw DON stated that [Employee L] would receive his second dose in the series when he was eligible. When asked if it was scheduled, the DON stated indicated it was not formally scheduled but it could be done "next week" during their weekly vaccination clinic.

On 04/15/2022 at approximately 3:00 P.M., the Human Resources Manager confirmed Employee L's first day of working in the kitchen was 03/30/2022.

On 04/15/2022 at approximately 3:15 P.M., the administrator and DON were notified of findings.