STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495190	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTHCARE OF WILLIAMSBURG	1811 JAMESTOWN ROAD WILLIAMSBURG, VA 23185

(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 05/10/22 through 05/12/22. 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 05/10/2022 through 05/12/2022. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey. VA00055135- Substantiated with Deficiency VA00054824-Substantiated with Deficiency VA00053331-Substantiated with Deficiency The census in this 90 certified bed facility was 86 at the time of the survey. The survey sample consisted of 33 resident reviews.	F 000	This plan of correction is respectfully submitted as an allegation of compliance.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550	Cross reference to 12VAC 5-371-220(E) 1. Center staff purchased resident #24 clothing to maintain dignity. 2. Housekeeping supervisor/designee will audit all current residents' clothing and ensure clothing is returned from the laundry timely. 3.Housekeeping supervisor/designee will educate all laundry staff on laundry schedule and the timely return of personal clothing. The Unit Manager/designee will educate all clinical staff on maintaining resident dignity to include resident preferences of dressing in personal clothing.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 6/7/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure a Resident's right to a dignified existence for 1 Resident (#24) in a survey sample of 33 Residents. For Resident #24, the facility staff failed to dress the Resident in her own clothing, and instead	F 550	4. The housekeeping supervisor/designee will complete daily audits of the laundering and return of personal clothing 4 days per week for 4 weeks, then 3 days per week for 4 weeks and report findings to the QAPI committee.	06/15/22

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F 550	Continued From page 2	F 550		

dressed her in a hospital gown. The Resident expressed embarrassment and requested her own clothing for appointments and anytime she was out of her room or out of the facility.

The findings included;

Resident #24's most recent MDS (minimum data set) assessment was dated 3-17-22. The document coded the Resident continent of bowel and bladder, No Cognitive impairment, and required extensive assistance from one staff member for bathing, however, with set up help could dress herself.

On 5-11-22 at approximately 11:30 a.m., during Resident Council meeting, the Resident stated her clothing had been removed to the laundry 2 weeks prior and she had not received them back. After the meeting, the surveyor went to the Resident's room and inspected the chest of drawers, and closet. There were no clothes in either place.

After the inspection of the Resident's room, the surveyor proceeded to the laundry and interviewed Employee (H), and Employee (F). The employees described the clean personal laundry as being housed in a particular room after it was laundered. They proceeded to the room which was located in the old therapy department, and some distance from the laundry. There they found a large laundry bin piled with unfolded laundry, and racks full of Resident clothing mixed together so that no one Resident's clothing could be distinguished from another Resident's clothing.

The employees were asked why the clean

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F 550	Continued From page 3 laundry was not in the Resident rooms, and further asked where Resident #24's laundry was in particular. They stated they could not tell which was hers, and that staffing was short and the laundry had not been folded or delivered because of that, but the Laundry Manager Employee (F) stated she had developed a new system, and was implementing a new house keeping system as well, she went on to say she had only worked in the facility for about 4 months, and she had come from a well known hotel chain. When asked how long it would be before Resident #24 could get her clothing, as she complained it had been 2 weeks since she sent it to laundry, and Employee (F) stated "we will get it to her this week." On 5-11-22 at the end of day debrief at 4:30 PM, the DON (Director of Nursing) was asked her expectation of clothing for residents to wear in public. The DON stated the residents should be dressed in their own clothing every day if they wished. On 5-12-22 at 11:30 a.m. the Administrator told the surveyor that clothing articles had been purchased for Resident #24, and that the laundry services would be fixed immediately so that clothing is returned to Residents the day after they were received for service. On 5-12-22 during the end of day meeting the Administrator and DON were made aware of the concerns and no further information was provided.	F 550		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11)	F 577	1. Survey results were placed in an accessible location during the survey.	

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F 577	Continued From page 4 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview, the facility failed to post survey results in a place readily accessible to Residents. The findings included: On 05/11/2022 at approximately 10:30 A.M., a resident Council meeting was conducted. There were six residents in attendance. When the group was asked if they knew where the survey results were located, all of the residents in the meeting	F 577	2. Administrator/designee will inform the residents at a council meeting on June 6, 2022 of the new location for the survey results. 3.The administrator/desinee will inform all residents and all staff of the new location for the survey results and place signage to ensure the results are easily identifiable. 4. The administrator/designee will monitor the location for accessability, weekly for 4 weeks and report findings to the QAPI committee.	06/15/22

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F 577	Continued From page 5 indicated they did not know where the survey results were located. On 05/11/2022 11:04 A.M., the binder containing the survey results was observed in a glasstop display table in the front lobby. The glass top display was situated in the corner with a chair and a side table on each side. There was approximately 18" clearance to approach the glass top display table which is not wheelchair accessible. Also, the glass top display table had a heavy, glass frame positioned on the top making it difficult to open. The Health survey and Emergency Preparedness survey result binders were both in the case making it difficult to lift either binder out of the display box. On 05/11/2022 at 11:09 A.M., the administrator was notified of findings. The administrator stated the binders will be put in a more accessible place.	F 577		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this	F 582	1. The center staff informed resident #286 of her right to an Advanced Benificiary Notice (ABN). Resident #286 declined an appeal or demand bill. 2. The center admissions staff will inform each resident in writing at the time of admission, periodically during the residents' stay or when eligible of services available in the center and of charges for services not covered under Medicare/Medicaid or by the center's per diem rate. 3. Administrator/designee will educate social service staff on ABN policy and process. 4. Administrator/designee will audit resident records for Medicare conversions or Medicaid eligibility weekly for 6 weeks to ensure compliance. Findings will be reported to the QAPI committee.	06/15/22

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F 582	Continued From page 6 section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff	F 582		

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F 582	Continued From page 7 failed to complete a SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) for 1 Resident (Resident #286) in a survey sample of 3 Residents reviewed for Beneficiary Notifications. For Resident #286, the facility staff failed to provide a SNF ABN notice prior to skilled care services ending. As a result of this deficient practice Resident #286 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services, known as a demand bill. The findings included: Resident #286, was admitted to the facility on 3/18/22, for skilled care following a hospitalization for a fall resulting in a right hip fracture. Resident #286 was discharged from a Medicare covered Part A stay on 4/6/22, she remained in the facility. Review of the clinical record revealed the facility staff issued a NOMNC (notice of Medicare non-coverage) which contained Resident #286's signature of receipt of the notice on 4/4/22. The clinical record revealed no evidence of an ABN (Advanced Beneficiary Notice) being issued. The progress notes made no reference with regards to an ABN. However, a blank ABN form was scanned into the electronic health record under the miscellaneous tab. On 05/12/22 at 9:55 AM, an interview was conducted with the facility Administrator, in the absence of the social worker. The Administrator stated the ABN is issued if a Resident files for an	F 582		

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F 582	Continued From page 8	F 582		

appeal and loses their second level of appeal on the NOMNC. He went on to say, "That is when we issue the ABN. We have not had any demand bills or ABN's". The Administrator was informed that the ABN is a separate document that is issued and is not based upon a NOMNC response.

A review of the facility policy titled, "Advance Beneficiary Notice-ABN", was conducted. It read, "An ABN will be utilized to notify resident of the possibility that Medicare will not pay for the item(s) or service(s) that are described on the form....1. The facility will give a completed copy of the ABN far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice....2. The resident must comprehend the contents. If the resident is unable to comprehend the contents of the notice, it must be delivered to and signed by an authorized representative..."

CMS identifies when the ABN is required to be issued in their document titled "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)" read, "Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:

" Not medically reasonable and necessary; or
" Considered custodial".

"The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for

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F 582	Continued From page 9 SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services". Accessed online at: https://www.cms.gov/search/cms?keys=ABN The Administrator was informed on 5/12/22 at 11:20 AM, of the failure of facility staff to provide Resident #286 with a SNFABN notice prior to skilled care services ending, which would have allowed Resident #286, to make a decision about continuation of services and have Medicare make the coverage determination. On 5/12/22, during an end of day meeting the facility Administrator, Director of Nursing and Corporate staff were made aware of the above concern. The Administrator stated they had no further information to provide with regards to this. No further information was provided.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584	Cross reference to 12VAC 5-371-370 (A) 1. Center maintenance staff hung resident #28's picture on the wall during survey. 2.The administrator/designee's will inspect all resident rooms to ensure a homelike environment is provided. 3.DON/designee will educate all center management staff in regard to resident dignity and providing a homelike environment. 4.Social services/designee will monitor 5 resident rooms for a homelike environment weekly for 6 weeks and report findings to the QAPI committee.	06/15/22

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F 584	Continued From page 10 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review the facility staff failed to provide one Resident (Resident #28) with a homelike environment, in a survey sample of 33 Residents. For Resident # 28, the facility staff failed to hang a framed picture (a portrait of the resident as a young child drawn by her brother). The findings included:	F 584		

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F 584	Continued From page 11 Resident # 28's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/22/2022 was coded as a quarterly assessment. Resident # 28 was coded as having a BIMS (brief interview for mental status) score of 15 indicating no cognitive impairment. Resident # 28 was coded as being totally dependent on one to two staff persons for activities of daily living. On 5/10/2022 at 12: 15 p.m. .during the initial tour, there was an observation of a large framed personal picture sitting on the floor behind the wardrobe. It was not hanging up on the wall. A Resident interview was conducted with Resident # 28 who stated her brother drew it (the picture" for her as a Christmas gift and framed it. Resident # 28 stated it was a picture of her as a young child. Resident # 28 stated she would like to have it on the wall but "Maintenance has been busy, he will get to it." Resident # 28 stated it had been on the floor for a long time. On 5/11/2022 at 9:30 a.m., the framed picture was observed still sitting on the floor behind the wardrobe. On 5/11/2022 at 4:00 p.m., the picture was still on the floor. On 5/11/2022 at 5:05 p.m., during the end of day debriefing, the Administrator and Director of Nursing were informed of the findings. The Director of Nursing stated she would have the Maintenance Director hang the picture immediately.	F 584		

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F 584	Continued From page 12 On 5/12/2022 at 9:00 a.m., Licensed Practical Nurse H was observed in the doorway of Resident # 28's room preparing to pass medications. Resident # 28 was lying in the bed. The framed picture was observed hanging on the wall to the right of the bed. Resident # 28 was smiling and stated the Maintenance Director hung the picture on the wall the previous evening. Resident # 28 stated she was very happy to have it on the wall. LPN-H stated as soon as she made rounds that morning, Resident # 28 told her that her picture had been hung up on the wall. LPN- H stated Resident # 28 was "really happy." No further information was provided.	F 584		
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	F 657	Cross reference to 12VAC 5-371-250 (G) 1. Resident #7's care plan was reviewed by the center interdisciplinary team and modified to reflect the resident's current needs. 2. DON/MDS/clinical designee audited all current residents' care plans and updated to reflect current needs. 3. DON/designee will educate MDS staff on updating care plans to reflect residents' current needs. 4. DON/designee will audit 20% of resident care plans weekly for 5 weeks and report findings to QAPI committee.	06/15/22

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F 657	Continued From page 13	F 657		

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 observation, resident interview, staff interview, clinical record review, and facility documentation review facility staff failed to revise the resident's care plan for one resident (Resident 7) in a sample size of 33 residents.

Resident #7's care plan was not re-evaluated or additional interventions added related to the ongoing complaints of tooth pain.

The findings included:

On 05/12/22, at approximately 1:43 p.m. Surveyor E asked Resident 7 how was lunch. Resident 7 stated that he could not eat that. The basis for not being able to eat the lunch as served according to Resident 7 was explained as having been served a piece of beef that was too tough and caused the resident's tooth to hurt. Resident 7 went on to state "I could not eat that beef, my tooth is still hurting from trying to eat it." The resident was observed to be eating chocolate candy to supplement the meal that resident felt unable to eat to being too tough.

Resident 7 stated he keeps snacks at the bedside because the food is too tough to eat. Resident 7 went on to explain that the food is

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F 657	Continued From page 14 often too tough and the tough food bothered (hurt) the resident's tooth when attempting to chew the tough food presented by the facility. On 05/12/22 at approximately 11:00 a.m. the electronic health record (EHR) was reviewed. Resident 7's care with a target completion date of 3/1/22 was noted to be the most current care plan on record. The care plan addressed the resident's concern and treatment for tooth pain. That is, the care plan has a focus that states: has an infection of the mouth, chief complaint of tooth pain. The goal: will minimize the risk of complications related to infection through the review. Interventions included: Will monitor oral cavity for inability to tolerate foods. Subsequently, there was no re-evaluation or additional interventions related to the ongoing complaints of tooth pain. Resultantly, resident has experience on-going oral pain for a period of approximately two months. The facility's Policies and Procedures for Dentist Services (last revised 11/27/17) stipulates if dental consult/referral unable to be obtained within 3 days the nurse will evaluate and document changes in ability to eat and drink. Review ability with physician and obtain orders as indicated. On 5/12/22 the EHR does not exhibit a plan of care that demonstrates a 3-day reassessment as to resident's ability to eat; nor, is there evidence of review of ability with physician within a 3 day interval with new orders. The Administrator and Director of Nursing were notified of findings on 5/12/22 at approximately 2:00 p.m. and stated they had no other findings to submit.	F 657		

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F 658	Continued From page 15	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to provide care and services based on the professional standards of nursing practice for Two Residents (Resident # 168 & Resident #7) in a survey sample of 33 residents. Findings included: For Resident # 168, the facility staff failed to obtain neurological checks per policy after a fall with a head injury. Resident # 168's diagnoses included but were not limited to: Unsteadiness on Feet, Difficulty Walking, Hypertension, and Syncope. The most recent MDS (Minimum Data Set) was an initial assessment, dated 4/10/2022 was reviewed. Resident # 168 was coded as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. Resident # 168 was coded as requiring limited physical assistance of 1 staff person for Activities of Daily Living except required total assistance of one staff person for bathing. Review of the closed clinical record was conducted on 5/10/2022 -5/12/2022.	F 658	Cross reference to 12VAC 5-371-200(B)(1)(ii) 1. Resident #168 no longer resides in the center. Resident #7's TED hose are being applied per physician's order. 2.DON/designee completed an audit of all resident falls in the last 30 days to identify adherence to the neurological check policy. DON/designee completed an audit of all residents with physician orders for TED hose to ensure commpliance with the order. 3. DON/designee will educate all clinical staff on the neurological check policy and following physician orders for TED hose application. 4.DON/designee will audit all falls, neurological checks and TED hose application 5 times per week for 4 weeks and report findings to the QAPI committee.	06/15/22

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F 658	Continued From page 16 Review of the Progress Notes revealed documentation of: 4/13/2022 a 07:06 a.m.- Nursing Progress Note Residents bathroom call light was on, answered call light and found Resident lying on floor of bathroom in room #_____ (room number redacted) . Resident was lying on stomach with head facing wall and feet and legs in bathroom doorway. Resident was assessed for injuries could move all extremities WNL's (within normal limits) without c/o (complaint of) pain or discomfort voiced. Pupils reactive. Resident hit head on floor, obtained laceration over eye brow with light bruising and goose egg. Resident was awake and alert answering questions appropriately. Resident helped staff roll him over on hoyer lift pad and hoyer lifted to bed. Resident with c/o pain to left side of forehead rated pain an 5/10,medicated with Tylenol 1000 mg._____of (name of physicians group redacted) notified of fall and injuries to forehead _____(name redacted) LPN (Licensed Practical Nurse) 11-7 Supervisor and _____ (name redacted) notified of fall and injuries to forehead. Continuing to monitor." The next Progress Note was a Medication Administration Note on 4/13/2022 at 8:07 AM documenting the administration of Tramadol 50 milligrams one tablet (ordered for one tablet every 6 hours as needed for pain.) Then Medication Administration Note on 4/13/2022 at 9:07 AM documenting the administration of SalonPas Pain Patch-apply to back topically one time a day for pain. Medication Administration Note on 4/13/2022 at	F 658		

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F 658	Continued From page 17 13:51 (1:51 PM) documenting the administration of Tramadol 50 Milligrams one tablet-effective-Follow up pain scale was rated as "2". The next Nursing Progress Note was dated 4/13/2022 at 17:05 (5:05 PM) and stated Resident # 168's granddaughter called the facility and inquired about Resident # 168's fall. The nurse informed the granddaughter that the facility staff could not discuss anything with her since she was not the RP (Responsible Party) listed in the clinical record. The nurse documented that the granddaughter became upset and stated "she was going to call the cops and hung up the phone. Minutes later rescue squad showed up, and resident was taken to the ER (Emergency Room) for eval & TX (evaluation and treatment. RP made aware. MD (medical doctor) was here in facility and supervisor called and made aware." According to the Progress Notes, on 4/13/2022 at 2252 (10:52 PM), Resident # 168 returned to the facility via stretcher. Resident alert and verbal." Review of the Nurse Practitioner's Progress note dated 4/13/2022 revealed the following excerpts: "Chief complaint: Headache, recent fall "Had a fall today. Slipped in bathroom and hit left side of face. Has bruise of left eye Complains of headache, moderate intensity Headache has improved No change in mental status No vomiting Complains of intermittent blurry vision States he feels okay right now" Under PLAN was written:	F 658		

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F 658	Continued From page 18 "While plan of care was being discussed, the EMT (Emergency Medical Technicians) showed up. Granddaughter had called 911 as she felt the patient was in urgent need of evaluation. Given blurry vision and headache, CT scan of head may be beneficial." On 5/11/2022 at 11:15 AM, an interview was conducted with the Administrator who stated the facility had written a summary of the events surrounding the fall and the transport to the Emergency Room. Review of the Summary report revealed the following documentation: Resident # 168 was found on the floor of the bathroom at midnight on 4/13/2022. Neurochecks were done at 1:05, 1:20, 1:35 and 150 AM. From 2:15-2:23 AM: the nurse performed a fall risk assessment, administered pain medication (Tylenol 500 milligrams two tablets) for complaints of pain in the left side of the head, pain rated as a 5 out of ten. When reassessed for pain, Resident # 186 reported the pain medication helped and rate the pain at 2 out of 10. The next Neurocheck was conducted at 4:50 AM. There was no documentation of any other Neurochecks being done prior to Resident # 186 being transported to the Emergency Room after 5 PM on 4/13/2022. On 5/12/2022 at 9:50 AM, a copy of the Facility's policy on Neurological checks was requested from the Director of Nursing and received. Review of the Facility Policy and Procedure on	F 658		

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F 658	Continued From page 19 Neurological Evaluation, effective 11/30/2014, Revision 09/14/2021 revealed the following Procedures: 4. Perform neurological checks as follows unless otherwise ordered by the physician. a. Every 15 minutes x 8 then, b. Every 30 minutes x 4 then, c. Every 60 minutes x 4 then, d. Every 8 hours x 8 or until 72 hours is completed. 5. Document neurological checks, vital signs and observations on the appropriate form or electronic equivalent. 6. Notify Physician of changes in condition 7. Place completed form in medical record." During the end of day debriefing on 5/12/2022, the facility Administrator, Corporate Nurse consultant and Director of Nursing were informed of the findings. The documentation showed Neurochecks were completed 5 times from 1:05-4:50 AM. No other Neurochecks were documented. The Director of Nursing stated the nurses should have completed the neurological checks as per the facility's policy and procedure. The Director of Nursing stated "that was deficient" and that the staff had been educated about the policy on Neurochecks. No further information was provided. COMPLAINT DEFICIENCY For Resident #7 the facility staff failed to ensure physician orders for applying Thrombo-Embolic Deterrent (TED) hose were followed.	F 658		

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F 658	Continued From page 20 On 05/10/22 at approximately 1:43 p.m. Resident 7's TED hose were noted to be at the bedside. Surveyor E asked Resident 7 as to the frequency that the Ted hose were worn. Resident 7 stated that they were applied for therapy. In addition, Resident 7 stated that the TED hose are to be worn daily. Resident 7 granted Surveyor E permission to view both legs. No TED Hose were seen. Both legs were edematous (swollen with an excessive accumulation of fluid). On 05/11/22 at approximately 2:18 p.m. per direct observation, Resident 7 did not have TED hose applied to either leg. Both legs demonstrated edema. Resident 7 stated the TED are only applied like two to three times per week when I go to therapy. On 05/12/22 at approximately 9:00 a.m. per review of the electronic health record (EHR) of physician orders last reviewed on 5/10/22 noted an active order with a start date of 6/03/22 at 7 a.m. prescribing: "TED hose apply every morning remove at night." On 5/12/22 at approximately 10:22 a.m. per direct observation of Surveyor E, Resident 7 did not have TED hose applied to either leg. Both legs were edematous. On 5/12/22 an interview with Registered Nurse (RN) B was conducted. RN B stated that she is aware of the need for residents to have TED hose applied per the electronic health record (EHR). RN B proceeded to make known that she does not apply the TED hose for the resident(s). Accordingly, the TED hose, per RN B - are applied by the certified nursing assistant (CNA).	F 658		

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F 658	Continued From page 21 RN B stated that the CNAs are not aware of the need to have TED hose applied without notification of licensed nurse. RN B stated that the licensed nurse is aware of the resident's need to have TED hose applied based on review of the EHR. RN B stated that the CNA duty caring for Resident 7 was not made aware of the need to place the TED hose to the legs of Resident 7 this morning. The Administrator and Director of Nursing were notified of findings on 5/12/22 at approximately p.m. and stated they had no other findings to submit.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to treat a pressure sore for one Resident (Resident #84) of the 33 residents in the survey sample.	F 686	Cross reference to 12VAC 5-371-20 (C)(1) 1. Resident #84 no longer resides in the center. 2.DON/designee reviewed all clinical records of residents admitted in the last 30 days to identify residents with pressure areas and ensured a treatment order was in place. 3. DON/designee will educate all nurses on admission assessments and ensure treatment orders are written when appropriate. 4.DON/designee will audit all new admission clinical records 5 times per week for 4 weeks and report findings to the QAPI committee.	06/15/22

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F 686	Continued From page 22 For Resident #84, the staff failed to assess, and treat, an unstageable coccyx pressure sore. The findings included; For Resident #84, the staff failed to provide a baseline assessment and treatment for an unstageable coccyx pressure sore from 4-27-22 through 5-3-22 (7 days). Resident #84 was originally admitted on 4-27-22. Diagnoses for Resident #84 included but were not limited to; an unstageable coccyx pressure sore. Resident #84's admission Minimum Data Set (an assessment protocol) was not submitted at the time of survey as the Resident was a new admission. Staff stated Resident #84 was completely dependent, on 1-2 staff members for all Activities of Daily Living care. The Resident was incontinent with an indwelling foley urinary catheter for the pressure sore, and able to answer questions appropriately when questioned. On initial tour of the facility on 5-10-22 at approximately 11:30 a.m., Resident #84 was sleeping, and her husband and daughter were in the room with her. They were interviewed. The Resident was laying on an "alternating air mattress bed" meaning that the bed is constantly filled with blowing air to help reduce pressure points on the body of a user. The Resident's daughter and spouse stated the facility had not treated the pressure sore for approximately a week when she first arrived, however, she had a dressing on it now. The Resident woke during the interview and stated she was in pain, and her	F 686		

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bottom hurt all the time.

A review of Resident #84's clinical record was conducted during the survey. The review revealed no treatment orders for the pressure area from admission until 5-3-22, when they were added to the treatment record to be instituted on 5-4-22 by staff for a dressing, Prostat supplement for wound healing, and weekly skin checks.

The only "Weekly Skin Integrity Review" document in the clinical record was signed as complete on 5-6-22, and documented "Site - Sacrum - treatment in place, Skin not intact." No description, nor measurement was documented on the form, even though those areas were available on the form, they were left blank.

The only "Pressure Ulcer Wound Rounds" document in the clinical record was signed as complete on 5-6-22, and documented "Present on admission, Sacrum, Pressure, length 5.5 centimeters (cm), width 2.0 cm, depth unknown, unstageable, tissue type yellow slough, drainage sero-sanguinous (clear blood tinged)."

The first Wound physician visit occurred during survey on 5-11-22. The wound physician notes revealed the first evaluation of the pressure sore by the wound doctor and documented "Length 5.2 cm, width 6.2 cm, depth 1.5 cm, moderate serous drainage, 70% slough, 30% granulation tissue, and the wound was surgically debrided with a scalpel, and a new dressing order was issued (15) days after admission, and the wound had worsened.

Treatment and Medication Administration records (TAR's/MAR's) as well as physician orders were

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reviewed and revealed no treatment orders for the month of April 2022.

On 5-12-22 wound observations were conducted with the Unit manager nurse, and ADON (Assistant Director of Nursing). Muscle was observed centrally in the wound. The wound was beefy red and dry, no slough was present in the wound. The Unit manager nurse measured the wound, and it was noted that there was a 2 centimeter undermining present under the distal base of the wound toward the anus. The wound measured 5.2 cm length, 6.2 cm width, and 2.0 cm depth. The wound was full thickness, stage 4, with exposed muscle, and bone seen protruding under a thin covering of tissue.

The nursing Care plan describes to nursing staff what interventions should be provided during care for each resident. The care plan must be person centered and give measurable specific interventions and goals.

The original admission baseline care plan for pressure sores was focus dated for 5-4-22, was obtained and reviewed . The document was found to be revised on 5-10-22. The 5-4-22 care plan was the first document derived for the Resident in the facility after 8 days in the facility. No direction was given as to use of the air mattress.

Facility policies were reviewed and revealed that weekly skin assessments were to be performed. As previously stated, "Body audits" wound evaluation documents available in the clinical record appear to show these assessments were not being performed until a week after admission.

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F 686	Continued From page 25 The facility Administrator, and DON (Director of Nursing) were asked for the April treatment record for this Resident and they stated there was no treatments in April of 2022 for this Resident. They were informed of the findings during an end of day briefing on 5-11-22, at approximately 5:00 p.m. They were again notified of findings on 5-12-22 at the end of day debrief at approximately 4:00 p.m.. The facility stated they had no further information to present at the time of exit at 5:15 p.m.	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. 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 mitigate a fall hazard for 1 Resident (Resident #135) and failed to utilize a mechanical lift during a transfer from the wheelchair to the bed for 1 resident (Resident #32) in a sample of 33 Residents, resulting in harm for both Residents. The findings included: 1) Resident #135 fell while left alone in the shower room on 2-4-22 at 5:45 a.m., resulting in a fractured upper femur (hip area). This is harm.	F 689	Cross reference to 12VAC 5-371-220(A) 1. Resident #135 no longer resides at the center. Resident #33 was transferred to the ER for evaluation and treatment on May 1, 2022 and returned with an ortho immobilizer, orders for a follow up with an orthopedic physician and to monitor change of condition. The orthopedic appointment is scheduled for May 12, 2022. Resident #33's pain is being monitored and managed. The employees involved in the incident are no longer employed at the center. The DON/ designee educated the transport provider in following lift protocols. 2. All residents" lift/transfer status were reviewed by the DON/designee and upated where necessary on May 13, 2022. 3. DON/designee will educate all clinical staff on mitigation of fall hazards and fall prevention and proper transfer procedures. a) Transfer assessments will be completed upon admission and reviewed by DON/designee to ensure positive outcomes. b)Resident kardex will be updated with the results of transfer assessments. c)Resident care plans will be updated to reflect the resident transfer status. d)DON/designee will educate all licensed nurses on pain management. e)DON/designee will observe a transfer by clinical staff to ensure appropriate procedure is followed.	

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F 689	Continued From page 26 Resident #135 was sent out to the Emergency room on 2-4-22 after the fall and fracture, and returned on 2-14-22 after a 10 day stay. The fractured hip was deemed inoperable at the hospital, and the Resident was sent back to the facility for convalescence. The Resident was no longer in the facility at the time of survey, and so a closed record review was conducted. The Resident's MDS assessment revealed that the Resident required extensive assistance, or was totally dependent for all activities of daily living with 1 to 2 staff member assistance due to stroke and left sided hemiparesis (paralysis). The Resident required extensive assistance with bathing, and was always incontinent of bowel and bladder. The Resident was cognitively impaired and suffered from seizures. The Resident's Nursing care plan and CNA (Certified Nursing Assistant) Kardex care plan were reviewed and revealed that staff were aware of the Resident's needs and deficits. The documents revealed A Hoyer/mechanical lift was utilized for all surface transfers. The Resident was a known fall risk, with a history of falls, and required hands on staff assistance for all activities of daily living. A "Report of Resident Fall" investigation document was requested and received. The document revealed the following description of the incident: 2-4-22 at 5:45 a.m., "Resident was found on the shower floor next to her shower chair. Resident states she was reaching for soap on the floor when she fell out of the chair onto her left hip.	F 689	4. DON/designee will observe 3 transfers per week for 4 weeks and report findings to QAPI committee.	06/15/22

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The Hoyer lift was used to return her to her chair and then returned to bed."

"Fall to floor unwitnessed." "was the Resident attended by an employee - No." "Location - In her shower chair in the shower" "Wearing slippers and gripper socks" "Was the Resident injured - Yes, Major injury left hip, Pain" "Physician notified at 6:00 a.m. 2-4-22", "sent to emergency room" "Mother of Resident notified at 7:00 a.m. on 2-4-22."

The investigation also showed that Staff moved the Resident from the floor, and lifted her in a mechanical lift, to place her back in the shower chair. The Resident was transferred down the hallway in the shower chair while complaining of pain, and put in bed after the fall and fracture. The Resident was then left in bed for nursing to contact the doctor, family, and call EMS.

On 5-12-22 at 10:45 a.m., a meeting was held with the Administrator and DON (Director of Nursing). They were asked if they were aware of the incident and both answered "we are now." They were asked what happened as a result of the staff leaving the Resident alone in the shower room. They stated the employee was terminated. The DON was asked if it was a standard practice to leave Residents unattended in the shower room, and she stated "No, that should have never happened." The DON stated "All of our interventions for falls are on the Resident's care plans". When asked what the course of events are after a Resident falls, the DON replied "We assess the Resident, seek medical intervention as needed, supervise, write a plan in the care plan, and educate staff on the change."

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F 689	Continued From page 28 The facility Fall Protocol and policy were requested and supplied. Review of the facility documents revealed that the Resident would be evaluated for fall risk, and precautions, needs, and supervision care planned appropriately. On 5-12-22 at the end of day meeting at 4:45 p.m., Resident #135's fall and lack of supervision was reviewed again with the Administrator and Director of Nursing (DON). No further information was provided. 2) For Resident #32, the facility staff failed to utilize a mechanical lift during a transfer from the wheelchair to the bed on 04/28/2022 resulting in a left distal tibial fracture. This is harm. On 05/10/2022 at 5:00 P.M., the administrator was interviewed. When asked about the investigation and five-day follow up of an incident involving Resident #32, The administrator stated that Resident #32 got a broken distal tibia fracture from an inappropriate transfer by nursing aide trainees. A copy of the investigation was requested. On 05/11/2022, Resident #32's clinical record was reviewed. Diagnoses included but were not limited to nondisplaced fracture of left tibial spine dated 05/03/2022 and hemiplegia and hemiparesis following cerebral infarct affecting right dominant side dated 09/22/2017.	F 689		

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F 689	Continued From page 29 According to Resident #32's care plan, an intervention initiated on 01/14/2021 associated with ADL [activities of daily living] Self-care performance deficit related to decreased mobility, under the header "Transfer" documented, " The resident requires mechanical lift- full - with two staff assistance for transfers." A change in Condition form dated 04/28/2022 at 1:00 P.M. under the header "Situation" documented, "Resident reports twisting left ankle during transfer from chair to the bed." In Section 9 under the sub-header "Pain Evaluation" it was documented that [Resident #32] had a new onset of pain in the left ankle at an intensity of "5" out of "10" meaning moderate intensity. Under the sub-header "Review and Notify", it was documented that the primary care clinician was notified and recommended an ace wrap. A Change in Condition form dated 04/28/2022 at 10:45 P.M. under the header "Situation" documented "? [complaint of] left ankle and foot pain, slight swelling noted." In Section 9 under the sub-header "Pain Evaluation" it was documented that [Resident #32] had a new onset of throbbing pain at an intensity of "8" out of "10" meaning severe intensity. Under the sub-header "Review and Notify", it was documented that the primary care clinician was notified and recommended an x-ray. A progress note dated 04/29/2022 at 8:20 A.M. documented, "Resident reports twisting left ankle during transfer from the wheelchair to the bed. On call physician and family notified. Physician recommends ace wrap to ankle. X-ray scheduled."	F 689		

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A progress note dated 05/01/2022 at 7:24 A.M. documented, "Resident C/O [complains of] pain in her lower left extremity when staff was giving care, she moaned and groaned whenever the extremity was touched or moved. She is unable to wiggle the toes or move the left foot. Pain medication given, N/P [nurse practitioner] contacted regarding the pain."

An x-ray report dated 05/01/2022 under the header "Conclusion" documented, "Nondisplaced distal tibial fracture."

An excerpt of a progress note dated 05/01/2022 at 1:18 P.M. documented, "EXRAY [sic] results in, resident has a fractured ankle. Order obtained from the N/P to send resident to the ER [emergency room] for further evaluation ..."

On 05/11/2022, the administrator provided a copy of the investigation involving Resident #32. A written statement dated 05/02/2022 by Temporary Nursing Aide G (TNA G) documented, "On Thursday [Resident 32] was in her wheelchair when coming from the beauty shop. I was not aware of how she had gotten into the wheelchair. Me and another aide put her back in the bed. I took one side of her and the aid took the other side to put her back in bed. Resident 32 didn't have a Hoyer pad under her. There was no way of getting a Hoyer pad under her."

A written statement written by Temporary Nurse Aide H (TNA H) documented, "I and another CNA [sic] was going to put [Resident 32] in her bed after coming back from a hair appointment, and there was not a Hoyer [mechanical lift] pad under her. Me and another CNA [sic] thought it

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would be best to lift the patient [name] under her arms, also putting the bed down as far as it could and stand and pivot her onto the bed, when we first tried it the patient did say "0W" so we put her back onto her chair and waited a few minutes, and tried lifting her again putting her onto the bed."

A written statement by Registered Nurse B (RN B) dated 05/02/2022 documented, "On 04/28/2022 [Resident #32] returned from dialysis and the transport company transferred her to the wheelchair from the stretcher. By the time I could inform them she is a hoyer lift, they had left the building."

A written statement dated 05/02/2022 by Licensed Practical Nurse C (LPN C), unit manager, documented, " "When interviewing [Resident 32], Resident stated during transfer that two staff members assisted her back to bed by going under her arms. Resident stated she then twisted her leg when the staff transferred her back to bed."

On 05/11/2022 at approximately 2:25 P.M., Resident #32 was interviewed. When asked about how her left ankle was broken, Resident #32 stated that it happened when 2 staff members tried to lift her to stand and her "leg got twisted." When asked if she fell to the floor, Resident #32 indicated the 2 staff members put her in the bed and she did not fall to the floor.

On 05/11/2022 at 5:00 P.M., the administrator and Director of Nursing (DON) were interviewed. When asked about the incident involving Resident #32, the DON stated they began the investigation on 05/01/2022 once the xray results

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F 689	Continued From page 32 were known. The administrator stated once they learned about the inappropriate transfer by the two nurse aide trainees, the nurse aide trainees were terminated.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide consistent oxygen therapy for one Resident (Resident #29) in a survey sample of 33 Residents. The findings included: On 05/10/2022 at 3:30 P.M., Resident #29 was observed in his wheelchair in his room. Resident #29 was receiving oxygen via nasal cannula from the oxygen tank situated on the back of the wheelchair. The oxygen tank gauge indicated the oxygen level in the tank was in the red zone (meaning it was nearly or actually empty). When asked if the oxygen was flowing, Resident #29 removed the nasal cannula and determined there was no airflow coming out of the ports. At approximately 3:40 P.M., Licensed Practical	F 695	1. Resident #29 no longer resides in the center. 2.DON/designee will audit all clinical records to identify residents with oxygen orders. 3. DON/designee will educate all nursing staff on monitoring oxygen tank levelsl 4.DON/designee will monitor all oxygen tank levels 5 times a week for 4 weeks and report findings to the QAPI committee.	06/15/22

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Nurse G (LPN G) and this surveyor entered the room for an observation. LPN G observed Resident #29's oxygen tank and verified the oxygen tank was empty. LPN G checked Resident #29's oxygen saturation level and it was 97%. LPN G then went to get a new oxygen tank.

On 05/10/2022, Resident #29's clinical record was reviewed. A physician's order dated 06/12/2021 documented, "Respiratory: Oxygen -Continuous 2liters/min [2 liters per minute] every shift." The care plan was reviewed. A focus with a revision date of 02/18/2022 entitled "[Resident #29] has COPD [chronic obstructive pulmonary disease] AEB [as evidenced by] oxygen use and inability to lay flat in bed" included but was not limited to the following intervention: "OXYGEN SETTINGS: O2 via NC 2L/Min [oxygen via nasal cannula at 2 liters per minute] continuously."

On 05/11/2022 at approximately 8:15 A.M., the administrator was notified of findings.

On 05/11/2022 at approximately 2:10 P.M., Resident #29 was observed in his wheelchair in his room. The oxygen tank on the back of his wheelchair was again observed to be in the red zone (meaning it was nearly or actually empty). When asked if the oxygen was flowing, Resident #29 stated the oxygen was flowing through the ports. At approximately 2:15 P.M., LPN C and this surveyor entered Resident #29's room for an observation. LPN C verified the oxygen was nearly empty and needed to be changed again. LPN C stated that she had been checking on it all morning but now that it was in the red zone, it should be changed. LPN C then exchanged the oxygen tank for a full tank.

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F 695	Continued From page 34 On 05/11/2022 at 5 P.M., the administrator and Director of Nursing were notified of findings. The facility staff provided a copy of their policy entitled, "Oxygen therapy." However, the policy did not address the process of monitoring portable oxygen tanks to ensure continuous oxygen therapy.	F 695		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §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, clinical record review, and facility documentation review, the facility staff failed to provide consistent social services for one Resident (Resident #14) in a sample size of 33 Residents. The findings included: On 05/10/2022 at 12:25 P.M., Resident #14 was observed in bed in her room. During the course of a brief interview, Resident #14 indicated that she was feeling depressed and stated, "I got personal problems." Resident #14 also indicated she was on medication for depression. On 05/11/2022, Resident #14's clinical record was reviewed. One medical diagnosis listed for Resident #14 included but was not limited to major depressive disorder.	F 745	1. Resident #14 is being offered counseling services. 2. All residents will be interviewed by administrator/ designee's to deterimine the need for additional social services. 3. Administrator/designee will educate social service staff on offering of additional services to resident where appropriate or determined by need. 4.Administrator/designee will review 5 psycho-social evaluations weekly for 6 weeks and report findings to the QAPI committee.	06/15/22

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A review of Resident #14's physician's orders revealed an order dated 03/22/2022 for the medication Wellbutrin for depression.

The social services notes were reviewed. The most recent social services note was dated 12/28/2020 [over 16 months ago].

A document entitled, "Trauma Informed Care Evaluation (TICE) dated 04/19/2022 documented in Part I, Section 1 a traumatic event that happened to Resident #14 on Mother's Day. In Part II dated 04/21/2022 entitled, "Social Services: Complete during initial evaluation and update care plan as indicated" in Section 5 indicated that, per Resident #14's response, Mother's Day is a trigger that worsens the traumatic event recorded in Part I, Section 1.

The social services care plan was reviewed. The care plan did not address the traumatic event documented on the TICE form or the trigger (Mother's Day).

The progress notes for May 2022 were reviewed. There were no notes associated with psychosocial assessment or monitoring on or around Mother's day [05/08/2022].

On 05/12/2022 at 12:40 P.M., Employee L, the Director of Social Services, was interviewed. When asked how often Residents are seen by Social Services, the Director of Social Services stated she will see Residents if they call for her, if there is a "big change" with the care plan, or annually. When asked why there were no social services notes since December 2020 for Resident #14, the Director of Social Services stated that she just started working at the facility

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in March 2022. The Director of Social Services also stated that this has been one of her concerns that Residents were not seen often enough by Social Services. The Director of Social Services also stated that she spends a lot of her time on the skilled nursing unit as opposed to long term care [Resident #14 is a long-term care Resident]. The Director of Social Services then referred to Resident #14's clinical record and stated that there was a psychosocial evaluation by Social Services on 02/24/2022 and the care plan was last updated on 03/08/2022. When asked about the TICE form for Resident #14, the Director of Social Services stated that the TICE form was completed for all Residents in April 2022 as part of a Plan of Correction for a previous survey. When asked about the content of the TICE form for Resident #14, the Director of Social Services stated that "We concluded there was nothing we could do to help her" regarding the traumatic event listed on the document.

On 05/12/2022 at approximately 1:15 P.M., the administrator and Director of Nursing were notified of findings. At 4:20 P.M., the administrator confirmed there were no social services notes since December 2020 and one psychosocial evaluation since then dated 02/24/2022. The facility staff provided a copy of the job functions for the Director of Social Services. In Section 12 under the header "Duties and Responsibilities", it was documented, "Provide/arrange for social work services as indicated by resident/family needs."
The facility staff provided a copy of their policy entitled, "Assessments - Social History and Psychosocial Assessment." In Section 4, it was documented, Social Services will complete the Social Services Progress Review quarterly, with

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F 745	Continued From page 37 significant changes, and as needed." On 05/12/2022 by the end of the survey, the administrator stated they had no further information or documentation to submit.	F 745		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. 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;	F 880	Cross reference to 12VAC 5-371-180(A) 1.CNA B and LPN B were provided education by the DON/ designee on proper wearing of PPE as required for infection control. 2.The administrator/designee reviewed all employee records to determine staff who are not up to date with vaccination requirements and ensure those staff wear the appropriate PPE. 3. Administrator/designee will educate all staff on the proper use of PPE including face mask and eye protection. 4. Administrator/designee will montor staff usage of PPE including eye protection and face mask as determined by CDC guidance and the center's Pandemic Plan 5 times per week for 4 weeks and report findings to the QAPI committee.	06/15/22

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F 880	Continued From page 38 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to adhere to infection control practices to minimize the spread of COVID-19 within the facility based	F 880		

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F 880	Continued From page 39	F 880		

on CDC (Centers for Disease Prevention and Control) recommendations and facility policy, on one of three nursing units, having the potential to affect multiple Residents residing on that unit.

The findings included:

1. CNA B, who was not vaccinated for COVID-19 failed to wear an N-95 mask and eye protection while passing meal trays and interacting with multiple Residents.

On 5/10/22 and 5/11/22, a review of the staff vaccination record revealed that CNA B had an approved non-medical exemption for COVID-19 and therefore was not vaccinated for COVID-19.

On 5/11/22 at 2PM, CNA B, who is not vaccinated for COVID-19, was observed passing meal trays to Residents, wearing a procedure mask and no eye protection. CNA B was interviewed, she stated that the mask she was wearing she had purchased herself because she can't breathe while wearing an N-95 (medical respirator). When asked, what is the facilities expectation regarding PPE (personal protective equipment) since you are not vaccinated? CNA B said, "To wear an N-95".

On 5/11/22 at approximately 2:05 PM, the facility Administrator was made aware of the above observation and interview with CNA B.

On 5/11/22 at 2:14 PM, during an interview with the Administrator, he stated he had gone to the unit and observed CNA B wearing an N-95 and goggles. When the Administrator questioned CNA B about the surveyor's observation CNA B told the Administrator that she had just come

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F 880	Continued From page 40	F 880		

back from lunch and had forgotten to change her mask. The Administrator stated that CNA B was immediately re-educated on the PPE requirements. A copy of the in-service education was provided to the survey team.

Review of the facility policy titled, "Employee COVID-19 Vaccinations", with a revision date of 3/23/22, was conducted. This policy read, "...4. Exempted Employees and Reasonable Accommodation: a. Individuals who request and are granted a medical or religious exemption through the company's exemption review process, or who need to delay vaccination due to CDC recommendations, will receive reasonable accommodations. b. These accommodations will include the need for additional precautions to mitigate the transmission and spread of COVID-19, in compliance with CDC, CMS, and other applicable regulatory guidance. c. Current guidance, which is subject to change, requires the use of Universal Source Control depending on Community Transmission rates and regular testing for all unvaccinated personnel working in Care Centers. i. Testing will occur at least weekly unless community transmission dictates more frequent testing ii. Staff will use Respirators as source control..."

The CMS (Centers for Medicare and Medicaid Services) memo "Ref: QSO-22-07-ALL, Revised 4/05/2.: SUBJECT: Revised Guidance for the Interim Final Rule -Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination", was reviewed. In the "Long-Term Care and Skilled Nursing Facility Attachment A-Revised" document, it read, "...§483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and

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F 880	Continued From page 41 procedures to ensure that all staff are fully vaccinated for COVID-19.... (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..." On 5/11/22, during an end of day meeting, the facility Administrator and Director of Nursing notified the survey team that CNA B was no longer employed with the facility. No additional information was provided. 2. LPN B failed to wear a mask/face covering in a manner to cover the nose and mouth. On 5/11/22 at approximately 2:00 PM, LPN B was observed at the nursing station with her procedure mask pulled below her chin, not covering her nose or mouth. On 5/11/22 at approximately 2:05 PM, the facility Administrator was made aware of the above observation and interview with LPN B. Review of the facility policy titled, "COVID-19 Pandemic Plan", was conducted. This policy read, "...Implement universal source control for all staff per CDC guidance..." CDC (Centers for Disease Control and Prevention) gives guidance in their document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic". This document read,	F 880		

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F 880	Continued From page 42 "...Implement Source Control Measures: Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing..." Accessed online 5/11/22 at web address: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html On 5/12/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above concern. No additional information was provided.	F 880		
F 883 SS=E	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	F 883	1. Resident's #9, 81 and 287 were offered the Pneumococcal Vaccine. 2. Quality review conducted by the Director of Clinical Services/designee of all residents who are eligible or want the Pneumococcal Immunizations. Influenza Immunization is currently out of season and not offered. 3. All Nurses educated by the Director of Clinical Services/ designee regarding Vaccinations of Residents (Pneumococcal Vaccine/ Influenza Vaccine), Provide Immunizations as ordered by Physician 4. Director of Clinical Services/designee to conduct quality monitoring to ensure that residents' identified will have vaccine administered as per order with documentation or refusal documented, and consent and education to responsible party or resident with documentation, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks. The findings of these quality monitoring's to be reported to the QAPI committee. Quality Monitoring schedule will be modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	06/15/22

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F 883	Continued From page 43 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 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to implement their immunization policy and ensure each Resident is offered influenza and pneumococcal immunization, for 3 Residents	F 883		

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F 883	Continued From page 44 (Resident #9, #81, and #287), in a sample of 5 Residents reviewed for immunizations. The findings included: On 5/10/22, clinical record reviews were conducted for the sampled Residents with regards to immunization for flu and pneumonia. This review revealed the following: 1. In Resident #9 electronic health record (EHR) there was no documentation with regards to the pneumonia vaccine status of Resident #9. There was evidence that Resident #9 had refused the flu vaccine for the 2020-2021 flu season. There was no evidence of her being offered the flu shot for the 2021-2022 flu season. Review of the misc. (miscellaneous) tab revealed no evidence of vaccine administration or offering of the vaccine for flu and pneumonia. Review of the Medication Administration Records (MAR) revealed no evidence of the pneumonia or flu immunization being provided to Resident #9. 2. On Resident #81's EHR, there was no recorded information with regards to pneumonia immunization(s). Review of the misc. tab, nursing notes and MAR(s) revealed no evidence of the pneumonia vaccine being offered to Resident #81. 3. On Resident #287's EHR there was no information recorded with regards to flu or pneumonia immunization status. Review of the remainder of the EHR revealed no evidence of Resident #287 being asked or offered either of the immunizations. The miscellaneous tab of the EHR contained a document from the Virginia Immunization Information System that indicated	F 883		

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F 883	Continued From page 45 Resident #287 was not up to date with flu or pneumonia immunizations. On 5/11/22 at approximately 2:20 PM, an interview was conducted with the Director of Nursing (DON). During this interview, the DON accessed the clinical record of Resident #9, 81, and 287 and confirmed the above findings. The DON further stated that vaccines have been ordered and will be in on Friday. A review was conducted of the facility policy titled, "Influenza, Prevention and Control of Seasonal". This policy read, "...Vaccination: 2. all residents and staff are offered the vaccine unless there is a medical contraindication..." The facility policy titled, "Pneumococcal Vaccine" was reviewed. This policy stated, "...1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility.... 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission..." The facility policy titled, "Vaccination of Residents" was reviewed. This policy said, "Policy Statement. All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated. 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. 2. Provision of such education shall be documented	F 883		

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F 883	Continued From page 46 in the Resident's medical record..." On 5/11/22 at 4:54 PM, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above concerns. On 5/11/22, following the end of day meeting, the DON communicated to Surveyor F that she had talked to the pharmacy and confirmed that pneumonia vaccines were not part of the order that had been placed for immunizations. No further information was provided.	F 883		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this	F 886	1. Center is not currently in an active COVID-19 outbreak. The current community rate of transmission is high. Staff who are not up to date with COVID-19 vaccination or have medical/religious waiver are tested at least twice weekly. 2. Quality review conducted by the Director of Clinical Services/designee of all current staff to identify who is not up to date with their vaccination status or with exemption to determine who is subject to testing. 3. The Regional Director of Clinical Services has educated the Executive Director and Director of Clinical Services on the Centers for Medicare/Medicaid Services (CMS) process on COVID testing as of to include; testing of all staff and residents in response to an outbreak-any single new infection in staff or resident. Facility will monitor the county positivity rate every other week and adjust the frequency of performing staff testing accordingly. All Facility and contracted Staff educated by the Director of Clinical Services/designee regarding The Facility COVID-19 Pandemic Plan as it relates to COVID-19 Testing for Residents and Staff 4. The Executive Director/Director of Clinical Services/ designee to conduct quality monitoring to ensure testing is conducted based on parameters and factors specified to identify and prevent transmission of COVID-19, 3 x weekly x 4 weeks, 2 x weekly x 4 weeks.	

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F 886	Continued From page 47 paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by:	F 886	The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	06/15/22

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F 886	Continued From page 48 Based on staff interviews and facility documentation review, the facility staff failed to conduct routine COVID-19 testing in accordance with the CDC recommendations for 5 facility staff (RN D, CNA B, CNA D, LPN D and LPN E), who were not up-to-date with COVID vaccinations, in a survey sample of 5 staff reviewed for COVID testing. The findings included: The facility staff failed to conduct routine testing of facility staff who were not fully vaccinated for COVID-19 as per the guidance from CDC and the facility policy. On 5/10/22, during the entrance conference, the facility Administrator was provided a copy of the entrance conference worksheet and asked to submit documentation related to COVID-19 testing, to include the facility's testing plan, log of the level of community transmission, and if there were any testing issues and contact with the local and state health departments with regards to testing issues. On 5/10/22, the facility submitted an employee vaccination matrix and employee testing records for the month of April 2022 and May 2022. On 5/10/22 and 5/11/22, video calls were held with the Director of Nursing (DON) and the Corporate Nurse Consultant. During the video calls, COVID vaccination cards for the sampled employees was reviewed. It revealed: * RN D received COVID vaccinations on 1/13/21 and 2/3/21. RN D had not received any COVID-19 vaccine boosters. * CNA B, had an approved non-medical	F 886		

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F 886	Continued From page 49 exemption on file and had not received any doses of a COVID-19 vaccine. * CNA D had received 2 doses of a multi-dose primary vaccine for COVID-19 and was not boosted, but eligible for a booster dose. * LPN D had received 2 doses of a multi-dose primary vaccination series and was not boosted and was eligible for a booster dose. * LPN E, had also received 2 doses to complete the primary vaccination series but had not received a booster dose, even though eligible. Review of the facility submitted document indicating the tracking of the community rate of COVID transmission revealed the following: 4/17/22, community rate of transmission was substantial which indicated twice weekly testing for all staff who were not up-to-date with COVID vaccinations. 4/24/22, the community rate of transmission was moderate, which would still indicate the facility should test twice weekly since they have not been at a lower rate for two consecutive weeks. 5/1/22, the community rate of transmission was high, which required twice weekly testing of staff who were not up-to-date. 5/8/22, the community rate of transmission remained high, which would indicate twice weekly testing of staff who were not up-to-date with COVID vaccinations. Review of the testing logs revealed the following: * RN D was tested for COVID-19 on the following dates: 4/7, 4/12, 4/14, 4/19, and 4/22. * CNA B was tested for COVID-19 on the	F 886		

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	495190	A. BUILDING _____ B. WING _____	C 05/12/2022

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F 886	Continued From page 50 following dates: 4/7, 4/12, 4/14, 4/19, 4/22, 4/29, and 5/6 * CNA D was tested on: 4/19 * LPN D was tested on: 4/7, 4/12, 4/14, 4/19, and 4/22. * LPN E was not on the staff testing log. On 5/12/22 at 9:26 AM, an interview was conducted with the DON and the Corporate Nurse Consultant. They both indicated that "routine testing is performed based on the community transmission rate and is performed on all staff who are eligible for a booster and have not received it". During this same call, the DON accessed the COVID-19 testing log and confirmed the above testing dates for each of the employees as noted above. During the above interview, the DON also stated, "[RN D's name redacted] is a prn [as needed] person and came in to help me during the outbreak. [CNA D's name redacted] is prn, she may be out on leave, but she is not a regular worker. [LPN E's name redacted] has only been here a couple of weeks". On 5/12/22 at 1:12 PM, the DON provided Surveyor F with additional testing occurrences which were as follows: RN D was also tested on 4/26/22. CNA B was also tested on 5/10/22. CNA D was tested on 4/26/22. LPN D was tested on 4/26 and 5/11 LPN E was tested on 5/12/22. On 5/12/22, timecards for the above employees were requested and received. They revealed the employees worked the following dates and therefore were available for testing during the	F 886		

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F 886	Continued From page 51 week prior to this survey. RN D worked 4/14, 4/19, 4/22, 4/26, 4/29, 5/5, and 5/11 CNA B worked 4/21, 4/22, 4/24, 4/25, 4/27, 4/28, 4/30, 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/9, 5/10, and 5/11. CNA D worked 4/23, 4/24, 4/25, 4/26, 4/27, 4/30, 5/1, 5/2, 5/3, 5/7, 5/8, 5/9, 5/10, and 5/11. LPN D worked 4/21, 4/22, 4/23, 4/24, 4/25, 4/26, 4/27, 4/29, 5/3, 5/4, 5/5, 5/7, and 5/11. LPN E worked 5/7, 5/8, 5/9, and 5/11. The only occurrence of LPN E being tested was after the facility was made aware that LPN E was not up to date and had not evidence of any testing. A review of the facility policy titled, "COVID-19-Pandemic Plan" with an effective date of 3/11/22, was conducted. This policy on page 11 read, "...Expanded Screening Testing of Asymptomatic Staff: Test all staff who are not up to date with the recommended COVID-19 vaccine doses based on the extent of the virus in the community, using the community transmission level available from the CDC...If staff work infrequently in centers with substantial to high community transmission, the staff member should be tested within 3 days before their shift (including the day of the shift)...If the community transmission level decreases to a lower level of activity, the center should continue testing staff at the higher frequency level until the community transmission level has remained at the lower activity level for at least two weeks before reducing testing frequency..." A review of the CMS (Centers for Medicare and Medicaid Services) QSO Memo 20-38-NH, with a revision date of 3/10/22, was conducted. This memo stated, " "Up-to-Date" means a person has received all recommended COVID-19	F 886		

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F 886	Continued From page 52 vaccines, including any booster dose(s) when eligible..." Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community. Routine Testing Intervals by County COVID-19 Level of Community Transmission Level of COVID-19 Community Transmission Minimum Testing Frequency of Staff who are not up-to-date: Low (blue) = Testing Not recommended, Moderate (yellow) = Once a week testing, Substantial (orange) = Twice a week testing, High (red) = Twice a week testing..." The CMS memo went on to read, "...The facility should test all staff, who are not up-to-date, at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week. Facilities should monitor their level of community transmission every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above. o If the level of community transmission increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity level are met. o If the level of community transmission decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the level of community transmission has remained at the lower activity level for at least two weeks before reducing testing frequency. The guidance above represents the minimum testing expected..."	F 886		

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F 886	Continued From page 53 On 5/12/22, during the end of day meeting the facility Administrator and DON were made aware that facility staff who are not up-to-date with COVID immunizations were not being tested twice weekly as per their facility policy and CDC guidance. No further information was provided.	F 886		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interviews, staff interviews, and clinical record reviews, the facility staff failed to maintain a functioning call bell system for two Residents (Resident #30, Resident #34) in the sample size of 33 Residents. 1) For Resident #30, the facility staff failed to ensure the call light was functioning on 05/10/2022. 2) For Resident #34 (roommate of Resident #30), the facility staff failed to ensure the call light was functioning on 05/10/2022. Also, the outer covering at the distal end of the call light cord was torn exposing the inner wire insulation.	F 919	1. Resident #30 has a call bell within reach and functioning Resident #34 was provided a new call bell and call bell is within reach and functioning 2. Quality review conducted by the Administrator/ designee to ensure current resident have a functioning call bell within reach and free from tears or exposed wires or exposed inner wire insulation 3. Administrator/designee will educate All staff that every resident is to have a functioning call bell within reach to call for staff assistance 4. The Administrator/designee to conduct random quality monitoring of 10 residents for 3 x weekly x 4 weeks, then 2 x weekly x 4 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services / designee.	06/15/22

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F 919	Continued From page 54 The findings included: 1) On 05/10/2022 at approximately 12:30 PM, Resident #30 was interviewed. When asked about any concerns about the care received at the facility, Resident #30 stated her call light was not working. This surveyor observed Resident #30 press the call button to activate the call light. No overhead sound was made and the central light near Resident #30's room did not light up. Resident #30's most recent Minimum Data Set with an Assessment Reference Date of 03/25/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for transfers, toileting, and bed mobility were coded as requiring extensive assistance from staff. 2) On 05/10/2022 at approximately 12:45 P.M., Resident #34 was interviewed. When I asked about any concerns about the care received at the facility, Resident #34 stated her call light had not been working since she arrived a few months ago. This surveyor observed the call light and noted that the cord was broken/torn exposing the inner wire insulation near the hub of the call light. When asked if the facility staff were aware the call light was not functioning, Resident #34 stated she	F 919		

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F 919	Continued From page 55 notified staff "a long time ago." Resident #34's most recent Minimum Data Set with an Assessment Reference Date of 03/29/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for personal hygiene was coded as "2" meaning requiring limited assistance from staff. On 05/10/2022 at approximately 12:50 P.M., Certified Nursing Assistant F (CNA F) was notified. CNA F entered the room of Resident #30 and Resident #34, checked the call lights, and verified both call lights were not functioning. CNA F stated that sometimes they don't work. On 05/11/2022 at approximately 8:15 A.M., the administrator was notified the call lights are not functioning for Resident #30 and Resident #34 (sharing a room). The administrator stated that once their shared bathroom cord was reset, both the call lights in the room are now functioning.	F 919		