| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495260 | A. BUILDING _____ B. WING _____ | C 05/24/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BEAUFONT HEALTH AND REHABILITATION CENTER | 200 HIOAKS ROAD RICHMOND, VA 23225 |

| (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 |
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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 05/22/22 through 05/24/22. 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<br><br>An unannounced Medicare/Medicaid standard survey was conducted 5/22/22 through 5/24/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey.<br>VA00054958-Substantiated with deficiency<br>VA00054192-Substantiated with deficiency<br>VA00053239-Substantiated with deficiency<br>VA00052744-Unsubstantiated<br>VA00052564-Substantiated without deficiency<br>VA00052480-Unsubstantiated<br><br>The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 46 resident reviews. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical | F 578 | | 6/28/22 |

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

Electronically Signed | 06/13/2022

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| F 578 | Continued From page 1<br>services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on facility documentation review, and staff interview the facility staff failed to comply with the requirements of advanced directives for 4 out of 46 residents on 05/24/22.<br><br>The findings included: | F 578 | The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and | |

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| F 578 | Continued From page 2<br><br>For Residents #25, #66, #102, and #359 the facility failed to provide written information concerning the right to formulate an advanced directive.<br><br>On 05/24/22, at approximately 1:30 p.m. a review of the electronic health record (EHR) for Residents #25, #66, #102, and #359 was conducted. The review noted that the record failed to contain Advanced Directives or written information about formulating an Advanced Directive.<br><br>The facility's policy and procedures with an effective date 03/24/20 were reviewed. The policies read that documents of declaration for advance directives that are approved by state law (i.e. Living Wills, Durable Power of Attorney, appointments for anatomical gifts/organ donations) will be placed in the medical record as provided or legally designated agent/representative.<br><br>On 05/24/22, at approximately 2:15 p.m., an interview with the Director of Nursing (DON was conducted. The DON searched the EHRs for Residents #25, #66, #102, and #359 but no written information about Advanced Directives or formulating Advanced Directives were found.<br><br>The Administrator and Director of Nursing were notified of findings on 5/23/22 at approximately 3:00 p.m. and stated they had no other findings to submit. | F 578 | state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F 578<br>1- Residents #25, #66, #102 and #359 have been afforded the opportunity to formulate advance directives.<br>2-Current residents have the potential to be affected.<br>3- The Admissions Department will be educated by the Administrator on offer of information regarding Advance Directives and requesting a copy of Advance Directives if the resident has Advance Directives and ensuring that Advance Directives are included in the medical record and are easily available to the direct care staff to convey upon transfer to the hospital.<br>4- The Admissions assistant/designees will complete a weekly review of resident Admissions to ensure that the resident was offered Advance Directives information if desired and that a copy is easily available in the medical record.<br>5- The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/DON are responsible for implementation of the plan of correction.<br>6. Date of completion: 6/28/2022 | |

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| F 600 | Continued From page 3 | F 600 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident interview, family interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to prevent abuse for one Resident (Resident #71) in a sample size of 46 Residents. Specifically, a nurse aide left Resident #71 on the floor after a fall and closed the room door on 12/20/2021.<br><br>The findings included:<br><br>On 05/22/2022 at approximately 12:45 P.M., Resident #71 and a family member were interviewed by Surveyor E. When asked about any concerns, Resident #71 and the family indicated that Resident #71 had a fall recently and had to crawl out toward the room door to get help. The family member also stated that she was made aware the facility did an investigation and | F 600 | F 600<br>1-No action taken for Resident # 71 due to the time frame had already passed. LPN F was immediately educated on abuse/neglect and the reporting of any allegations to the administrator and/or DON.<br>2-Current residents have the potential to be affected.<br>3-All facility staff will be educated by the DON/designee on the facilities policy for abuse and neglect and the reporting requirements to the Administrator/DON of allegations of abuse/neglect.<br>4-The DON/designee will complete an audit of the shift report 5x weekly to review changes in condition to ensure that any resident incidents or alleged abuse incidents are addressed appropriately. | 6/28/22 |

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| F 600 | Continued From page 4<br>the staff member was terminated.<br><br>On 05/23/2022 at approximately 9:30 A.M., the administrator was interviewed. When asked about any facility-reported incidents involving a staff member and [Resident #71], the administrator stated that the previous administrator did not conduct an investigation but when she herself learned about the allegation of abuse [by adult protective services], she investigated it. The administrator also stated that there were inconsistencies in the Temporary Nurse Aide (TNA)'s story (TNA C) so she was terminated and no longer works at the facility. The administrator explained that TNA C denied working with [Resident #71] that day but the facility investigation revealed that TNA C did indeed work with Resident #71 that day.<br><br>On 05/23/2022, Resident #71's clinical record was reviewed. A progress note written by Licensed Practical Nurse F (LPN F) dated 12/20/2021 at 12:41 P.M. documented, "Upon assessment pt. [patient] was noted to be sitting on the floor in front of the bathroom. Pt. was assessed [n.p.] without injury. No c/o [complaints of] pain or discomfort."<br><br>Resident #71's most recent Minimum Data Set with a quarterly Assessment Reference Date of 04/29/2022 coded Resident #71's Brief Interview for Mental Status as "15" out of "15" indicative of intact cognition. According to Resident #71's quarterly Assessment Reference Date of 10/27/2021 (prior to the incident), Resident #71's Brief Interview for Mental Status was coded as "9" out of possible "15" indicative of moderate cognitive impairment. | F 600 | 5-The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Administrator/DON are responsible for implementation of the plan of correction<br>6. Date of completion: 6/28/2022 | |

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| F 600 | Continued From page 5 | F 600 | | |

On 05/23/2022, the administrator provided a copy of the facility-reported incident (FRI) dated 03/31/2022 and the investigation documents involving Resident #71 and TNA C. A written statement by LPN F dated 03/31/2022 at 1:20 PM under the header "What did you observe?" documented "I heard the resident yelling when I came down the hall. The room door was shut, I opened the door but could not open all the way because the resident was on the floor near the door. I got in the door and resident was on the floor. I asked how she got there and she said she fell and the girl left me and went out of the room and shut the door. I helped her up and checked her over." Under the header, "Please identify any statements made by the resident" it was documented, "The resident stated that when asked how she got on the floor the resident stated I fell and the girl just left me and shut the door."

An excerpt of a letter written by the administrator [undated] entitled, "Please find below the follow up from incident reported on 03/31/2022" documented, "A thorough investigation was completed on this alleged incident. There was evidence that [Resident #71] sustained a fall on 12/20/2021 and became the fall in question. After that determination, staff members on that shift who responded to the incident were interviewed. One staff member [TNA C] stated that she was not aware of a fall with [Resident #71] although [Resident #71] described her as the person assisting. She [TNA C] was suspended pending investigation. Upon further investigation and documentation [TNA C], who stated that she only worked with resident once and did not assist her on that day, was noted to have documented ADL [Activities of Daily Living] care in [Resident #71]'s

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| F 600 | Continued From page 6 | F 600 | | |

chart on the day in question. Due to staff interviews, documentation support, and several inconsistencies in [TNA C]'s account of that day, the facility does substantiate this allegation. [Resident #71] still currently resides at the facility. The alleged TNA has been terminated."

On 05/23/2022 at approximately 1:30 P.M., TNA C's employee file was reviewed with Employee H, the Human Resources Manager. TNA C's certificate of nurse aide training was dated 05/24/2021. TNA C's date of hire was 10/26/2021 and date of termination was 04/20/2022. The criminal background check dated 10/21/2021 indicated that no criminal records were identified.

On 05/24/2022, the facility staff provided education training records for TNA C. Abuse training for TNA C was completed on 11/03/2021 and 03/11/2022.

On 05/24/2022 at 12:00 P.M., LPN F was interviewed by Surveyor D and Surveyor E. LPN F confirmed her written statements pertaining to the investigation. When asked if she reported [Resident #71]'s statement "I fell and the girl just left me and shut the door" to the Director of Nursing (DON) or her supervisor, LPN F stated that she did not report it to the DON or supervisor and added, "Maybe I should have, I wasn't thinking about it at the time." LPN F confirmed she had received abuse training. When asked about the process for reporting allegations of abuse, LPN F indicated she would fill out a complaint form/service concern form and notify the DON or supervisor "immediately."

The facility staff provided a copy of their policy entitled, "Abuse/Neglect/Misappropriation/Crime".

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| F 600 | Continued From page 7<br>Under the header "Policy" it was documented "There is a zero tolerance for mistreatment, abuse, neglect ... against a patient of the Healthcare and Rehabilitation Center." In Abuse Policy Number 704 entitled "Administrative Reference Guide" in Section 5(a) an excerpt documented "Abuse means ... the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain a patient's physical, mental, and psychosocial well-being." In Section 5(b) an excerpt documented "Neglect means a willful failure to provide timely and consistent services, treatment or care to a patient which are necessary to obtain or maintain the patient's health, safety or comfort." In Section 5(b)(2) documented "Examples include but are not limited to (2) reckless disregard of or indifference to precautionary measures to protect the health and safety of the patient." | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other | F 609 | | 6/28/22 |

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| F 609 | Continued From page 8<br>officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Resident interview, family interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to report an allegation of abuse for one Resident (Resident #71) in a sample size of 46 Residents.<br><br>The findings included:<br><br>On 05/23/2022 at approximately 9:30 A.M., the administrator was interviewed. When asked about any facility-reported incidents involving a staff member and [Resident #71], the administrator stated that the previous administrator did not conduct an investigation but when she herself learned about the allegation of abuse [by adult protective services], she investigated it. The administrator also stated that there were inconsistencies in the Temporary Nurse Aide (TNA)'s story (TNA C) so she was terminated and no longer works at the facility. The administrator explained that TNA C denied working with [Resident #71] that day but the facility investigation revealed that TNA C did | F 609 | F609<br>1-LPN F was immediately educated on the policy for abuse and neglect and the reporting requirements.<br>2-Current residents have the potential to be affected.<br>3- All facility staff will be educated by the DON/designee on the facilities policy for abuse and neglect and the reporting requirements to the Administrator/DON of allegations of abuse/neglect.<br>4-The DON/designee will complete an audit of the shift report 5x weekly to review changes in condition to ensure that any resident incidents or alleged abuse incidents are addressed appropriately.<br>5-The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Administrator/DON are responsible for implementation of the plan of correction | |

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| F 609 | Continued From page 9<br>indeed work with Resident #71 that day.<br><br>On 05/23/2022, Resident #71's clinical record was reviewed. A progress note written by Licensed Practical Nurse F (LPN F) dated 12/20/2021 at 12:41 P.M. documented, "Upon assessment pt. [patient] was noted to be sitting on the floor in front of the bathroom. Pt. was assessed [n.p.] without injury. No c/o [complaints of] pain or discomfort."<br><br>On 05/23/2022, the administrator provided a copy of the facility-reported incident (FRI) dated 03/31/2022 and the investigation documents involving Resident #71 and TNA C. A written statement by LPN F dated 03/31/2022 at 1:20 PM under the header "What did you observe?" documented "I heard the resident yelling when I came down the hall. The room door was shut, I opened the door but could not open all the way because the resident was on the floor near the door. I got in the door and resident was on the floor. I asked how she got there and she said she fell and the girl left me and went out of the room and shut the door. I helped her up and checked her over." Under the header, "Please identify any statements made by the resident" it was documented, "The resident stated that when asked how she got on the floor the resident stated I fell and the girl just left me and shut the door."<br><br>On 05/24/2022 at 12:00 P.M., LPN F was interviewed by Surveyor D and Surveyor E. LPN F confirmed her written statements pertaining to the investigation. When asked if she reported [Resident #71]'s statement "I fell and the girl just left me and shut the door" to the Director of Nursing (DON) or her supervisor, LPN F stated | F 609 | 6- Date of completion: 6/28/2022 | |

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| F 609 | Continued From page 10<br>that she did not report it to the DON or supervisor and added, "Maybe I should have, I wasn't thinking about it at the time." LPN F confirmed she had received abuse training. When asked about the process for reporting allegations of abuse, LPN F indicated she would fill out a complaint form/service concern form and notify the DON or supervisor "immediately."<br><br>The facility staff provided a copy of their policy entitled, "Abuse/Neglect/Misappropriation/Crime". In Policy Number 705 entitled, "Mandated Reporting" an excerpt in Section 1 documented "Employees will be trained as to the responsibility to immediately report to the Administrator, the Assistant Administrator, or the Director of Nursing (and in their absence the immediate supervisor) any and all suspected or witnessed incidents of patient abuse, neglect ..."<br><br>On 05/24/2022 at approximately 3:30 P.M., the administrator was notified of concerns. | F 609 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, facility documentation review, and staff interview the facility staff failed to accurately code Resident #31's minimum data set at sections N0300 and N0350.<br><br>The findings include:<br><br>On 05/23/22, an electronic health record (EHR) | F 641 | F641<br>1-The MDS was modified to reflect accurate coding for section N0300 and N0350 for Resident #31.<br>2-An audit for MDS(s) completed in the last 30 days will be completed to ensure sections N0300 and N0350 are coded accurately. | 6/28/22 |

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| F 641 | Continued From page 11<br>review at approximately 2:00 p.m. of Resident #31's MDS was conducted. At sections N0300 (record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days) and N0350 (record the number of days insulin injections were received during the last 7 days or since admission /entry if less than 7 days) were each coded as a 7.<br><br>Subsequently, a record review of Resident #31's physician pharmacy orders in the EHR did not substantiate the MDS Coordinator's coding of 7 at N0300 and N0350. That is, there was no insulin order present in the EHR.<br><br>On 05/23/22, at approximately 2:30 p.m., the MDS coordinator was interviewed. The MDS coordinator searched the referenced MDS at sections N0300 and N0350 in the EHR. As a result, the MDS coordinator verbally acknowledged both sections (N0300 and N0350) were coded individually as 7.<br>The MDS coordinator searched the record for an insulin order to substantiate the coding of sections N0300 and N0350 of the annual MDS with no results.<br><br>The Administrator and Director of Nursing were notified of findings on 5/23/22 at approximately 3:00 p.m. and stated they had no other findings to submit. | F 641 | 3-The Regional Director of Clinical Reimbursement/designee will educate the MDSC on accurately coding section N0300 and N0350.<br>4-The MDSC/designee will complete 5 MDS(s) weekly to ensure section N0300 and N0350 to e is coded accurately.<br>5-The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Administrator/DON are responsible for implementation of the plan of correction.<br>6- Date of completion: 6/28/2022 | |
| F 658 SS=E | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, | F 658 | | 6/28/22 |

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| F 658 | Continued From page 12<br>must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility documentation review, and clinical record review and in the course of a complaint investigation, the facility staff failed to provide multiple care and services in accordance with professional standards and according to physician orders for two Residents (Resident #259, #159) in a survey sample of 46 Residents.<br><br>The findings included:<br><br>1a. For Resident #259 the facility staff failed to provide medications timely.<br><br>On 5/22/22 and 5/23/22, a closed clinical record review was conducted. The physician orders and medication administration records (MAR's) were reviewed for Resident #259's entire stay at the facility, which was from November 2021, through February 2022.<br><br>On 5/23/22, the facility staff provided Surveyor F with a listing of medication administration times for several specific days. Review of these documents revealed the following:<br>* On 12/21/21, medications scheduled to be administered at 9 AM, were not administered until 4:10 PM.<br>* On 1/8/22, medications scheduled to be administered at 9 AM, were administered at 11:25 AM, medications scheduled for 9 PM, were administered at 11:43 PM.<br>* On 1/21/22, medications scheduled to be administered at 9 AM, were administered at 12:14 PM. | F 658 | F658<br>1-Residents #259 and 159 were discharged from the facility.<br>2-Current residents have the potential to be affected.<br>3-The DON/ designee will educate all Nurses on the 5 R(s) of medication administration. In addition, the education will include the giving the medications on time (one hour before or on hour after scheduled time). Also, included in the education is notification to the MD/RP when medications are not given or given late.<br>4-The Unit Manager/designee will complete weekly audits of the Medication/Treatment administration report residents to ensure that the residents are receiving their medications and treatments as ordered and on time and ensure appropriate notification to the physician.<br>5 The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Admin/DON are responsible for implementation of the plan of correction.<br>6- Date of completion: 6/28/2022 | |

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* On 1/23/22, medications scheduled to be administered at 9 PM, were administered at 11:46 PM.
* On 1/24/22, medications scheduled to be administered at 9 AM, were administered at 10:49 AM.

A review of the progress notes for Resident #259 was conducted, with attention to the above dates of when medications were administered late. There were no notes to indicate the doctor or nurse practitioner were notified of medications not being given on time, nor that they agreed to or ordered for the medications to be administered later.

On 5/23/22 at 1:46 PM, an interview was conducted with LPN B. When asked to explain when medications are to be given, LPN B said, "An hour before and an hour after scheduled".

On 5/23/22 at 2:25 PM, an interview was conducted with Employee E, the nurse practitioner. When asked about the administration of medications, the nurse practitioner said meds are to be given within an hour of the time ordered to be given.

On 5/23/22 at 10:15 AM, an additional interview was conducted with Employee E, the nurse practitioner (NP). The NP was asked about the importance of and risks to Residents if medications are not given on time with sufficient time between doses. The NP said, "It is concerning because they are getting a larger dose all at once if they are given too close together".

On 5/24/22 at 10:46 AM, an interview was

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conducted with LPN E. LPN E was asked to explain the timeframe of when medications are to given. LPN E said, "Times are attached to the medications and you have an hour before and an hour after to administer". LPN E said, the administration of medications and treatments get documented on the MAR and TAR (treatment administration records).

On 5/24/22 at 11:06 AM, an interview was conducted with the Director of Nursing (DON). The DON stated, "We have 4 med passes, 9 AM, 12 noon, 5 PM, and 9 PM. Medications are to be given within the hour before and the hour after". The DON was asked why it is important the medications be given on time. She said, "Residents have different medications and illnesses, which determines why need to get medications on time". The DON was asked what the process is if a Resident misses a dose or medications are given late, she said, "The physician should be notified and will give orders". When asked where the communication with the doctor would be located, the DON said, "We have a book at the nurses station they use to communicate to the provider and it gets documented in the Resident's progress notes". During this interview, the DON was made aware that Resident #259 had multiple instances of medications not being administered timely.

On 5/24/22 at approximately 3 PM, the Director of Nursing identified Lippincott as the facilities' professional standards of nursing practice followed.

A review was conducted of the facility policy titled, "Administration Procedures for All Medications". This policy read, "...III. 5 Rights (at a minimum).

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| F 658 | Continued From page 15<br>At a minimum, review the 5 rights at each of the steps of medication administration..."<br><br>According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, "Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, follow facility policy and procedures, document appropriate information in the medical record, and follow physician's orders which should not have been followed, such as orders containing medication dosage errors".<br><br>Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)<br>"Rights of Medication Administration: 1. Right patient...2. Right medication...3. Right dose... 4. Right route... 5. Right time: check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. 6. Right documentation: Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.7. Right reason: Confirm the rationale for the ordered medication.... 8. Right response...<br>Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. Accessed online at: www.nursingcenter.com. | F 658 | | |

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On 5/24/22, during an end of day meeting the facility Administrator and DON were made aware of the above findings.

No further information was provided.

1b. For Resident #259, the facility staff failed to provide wound care treatments as ordered by the physician.

On 5/22/22 and 5/23/22, a closed clinical record review was conducted. The physician orders, treatment administration records (TAR's), and progress notes were reviewed for Resident #259's entire stay at the facility, which was from November 2021, through February 2022.

The review revealed a physician order dated 11/30/21, that read, "Clean abdominal wound with normal saline, pat dry, cover with saline moistened gauze and abd pad- every shift for wound care". This order remained active until Resident #259's discharge on 2/19/22. There was also a progress note from the nurse practitioner on 11/30/21, that read, "...with the ongoing concern for another fistula development from abscess to the midline wound, will start IV antibiotics, dc po [discontinue by mouth antibiotics] when PICC [Percutaneously Inserted Central Catheter, is a medical device that is placed into a vein to allow access to the bloodstream] in place".

Review of the TAR's for December, January and February revealed a total of 35 occurrences of wound care not being documented as provided. Specifically, December had 6 occasions/shifts where the wound treatment was blank. January

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had 20 occurrences that were blank, with no documentation and February had 9 occasions with no evidence of wound treatments being provided.

On 5/23/22 at 1:46 PM, an interview was conducted with LPN B. LPN B stated if there is a blank "it means it was not given, if I didn't give a medication or perform a treatment I would put the reason in the nursing notes".

On 5/24/22 at 10:46 AM, an interview was conducted with LPN E. LPN E was asked where she documents when wound treatments are performed. LPN E said, "In PCC [electronic computer system] on the TAR". When asked what a blank means, LPN E said, "I've never come across that". LPN E was asked why is it important to perform wound treatments as ordered by the physician. LPN E said, "Because you don't want it to get infected and it is to help with the healing process".

On 5/24/22 at 11:06 AM, AN interview was conducted with the Director of Nursing (DON). The DON was asked where treatments are documented and she said, "On the TAR". When asked why it is important to do treatments as ordered by the physician, she said, "Wounds can deteriorate or get infections, it is important to make sure they are done". The DON was asked to observe the TAR for Resident #259 and confirmed the observation of blanks as previously noted. When the DON was asked what the blank would indicate she said, "It appears it was not documented". The DON said she could not confirm or deny if the treatment was performed based on the documentation. The DON further confirmed that she does expect staff to document

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immediately following the treatment.

On 5/24/22 at approximately 3 PM, the Director of Nursing identified Lippincott as the facilities' professional standards of nursing practice followed.

The facility policy regarding physician orders was requested. The policy received titled, "Physician Orders" was reviewed and revealed that it only addressed orders at the time of admission.

According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, "Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, follow facility policy and procedures, document appropriate information in the medical record, and follow physician's orders which should not have been followed, such as orders containing medication dosage errors".

On 5/24/22, during an end of day meeting with the facility Administrator and Director of Nursing, they were made aware of the above findings.

No further information was provided.

Complaint Related Deficiency.

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2) For Resident #159 medications were not given.

A review of Resident #159's clinical record was conducted. This review revealed the Resident did not receive the following medications on 8-9-21.

Trihexyphenidyl 2 milligrams (mg) every day at bedtime (9:00 p.m.) for antispasmodic Parkinson's drug.
Amantadine 100 mg 4 times per day (9:00 p.m.) for Parkinson's.
Ativan 0.5 mg 4 times per day (9:00 p.m.) for anxiety.
Dantroline 25 mg 4 times per day (9:00 p.m.) for muscle relaxation.
Tylenol extra strength 500 mg 2 tablets every 8 hours for pain.

There was no documentation of the facility staff using medication from the Stat box.

There were valid Physicians Orders for the medications.

On 5-23-22 at 1:37 PM, an interview was conducted with the LPN administering drugs on the unit. The LPN stated, "if meds (medications) are not available, staff are to try to get them out of the (in-house stock of medications), if they can't they are to call the pharmacy and physician.

The DON (Director of Nursing confirmed the process for reordering medications, which she said, "there are several options, and you can press the reorder button in the computer or call the pharmacy". When asked when meds are to be ordered, the DON said, "When meds get down

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| F 658 | Continued From page 20<br>to a 7 day supply we will go ahead and order them to prevent them from running out, we have a back up pharmacy that can deliver meds as well".<br><br>On 5-23-22, during the end of day debriefing, the Administrator and DON (Director of Nursing) were notified of the issue, both stated they had nothing further to provide. | F 658 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews, facility documentation review, and clinical record review and during the course of a complaint investigation, the facility staff failed to provide ADL assistance with regards to bathing/showering, for a Resident who was dependent upon staff to maintain personal hygiene, for one Resident (Resident #259) in a survey sample of 46 Residents.<br><br>The findings included:<br><br>On 5/22/22 and 5/23/22, a closed clinical record review was conducted. This review revealed Resident #259 scheduled shower days were, Wednesday and Saturdays. The clinical record revealed no evidence that Resident #259 was offered a shower on the following dates: 11/27/21, 12/15/21, 12/25/21, 12/29/21, 1/1/22, 1/15/22, 1/26/22, and 1/29/22. | F 677 | F 677<br>1-Resident #259 was discharged from the facility.<br>2- Current residents have the potential to be affected.<br>3-The DON/ designee will educate all Licensed Nurses and CNAs on the provision and documentation of bed baths and showers.<br>4-The Unit Manager/ designee will review the ADL documentation on a weekly basis to ensure that a shower or bed bath was provided and documented appropriately.<br>5- The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Admin/DON are responsible for implementation of the plan of correction. | 6/28/22 |

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| F 677 | Continued From page 21<br>Review of Resident #259's MDS (minimum data set) (an assessment tool) coded the Resident as having required extensive assistance of on staff member for bathing.<br><br>On 5/23/22, the facility staff provided the survey team with a shower schedule which did reveal Residents are scheduled for two baths/showers per week.<br><br>On 5/23/22 at 1:46 PM, an interview was conducted with LPN B. LPN B was asked how often Residents are showered and she said there is a shower schedule and she expects the CNA's to give baths/showers as per the shower schedule.<br><br>On 5/24/22 at 10:35 AM, an interview was conducted with CNA B. CNA B was asked to discuss Resident's showers and baths. CNA B said, "It is supposed to happen twice a week". CNA B went on to say that they have shower rooms, none of the Residents have showers in their own room and no one is permitted to shower alone, without supervision for safety reasons. CNA B said she documents each time a shower is given or offered to a Resident in the computer [the electronic health record of the Resident].<br><br>On 5/24/22 at 10:46 AM, an interview was conducted with LPN E. LPN E stated Residents are showered twice weekly. LPN E further explained that there is a shower book that has a schedule of days Residents are get baths and the CNA giving the bath documents it after the shower is provided.<br><br>On 5/24/22 at 11:06 AM, an interview was conducted with the Director of Nursing (DON). | F 677 | 6- Completion date: 6/28/2022 | |

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The DON was asked about Resident showers. She stated, "We have a shower schedule, each Resident has certain days and we have a shower room where they are given. It is documented in POC [the system the CNA's use to chart]. When asked the frequency, the DON said "They have 2 shower days per week, unless they want more".

During the above interview with the DON, she was asked to review the documentation with regards to Resident #259's showers. The DON said she would like an opportunity to review the information and get back with Surveyor F.

On 5/24/22 at 1:06 PM, the DON and Surveyor F discussed Resident #259's showers. The DON stated that from 12/26-12/29, Resident #259 was on the COVID unit and would not have gone to the shower room during that time. The DON stated that for the other days she was able to see that personal hygiene was provided to Resident #259. The DON stated that personal hygiene included "mouth care, peri care, washing their face and combing their hair and a partial bath". The DON confirmed that the facility follows the RAI (Resident Assessment Instrument) for ADL (activities of daily living) coding.

A review was conducted of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, dated October 2019. This document on page G-1 read, "... Personal Hygiene: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers)..."

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On 5/24/22 at 2:24 PM, another conversation with held with the Director of Nursing. The DON confirmed that she had no further documentation to indicate Resident #259 was offered or provided with a bath or shower on 11/27/21, 12/15/21, 12/25/21, 12/29/21, 1/1/22, 1/15/22, 1/26/22, and 1/29/22. She could only confirm that personal hygiene was provided on those days.

The facility policy regarding ADL care and baths/showers was requested. The facility provided a facility policy titled, "Shift Responsibilities for CNA". This policy was reviewed and it read, "Certified Nursing Assistants (CNAs) will be given shift responsibilities/patient assignments at the beginning of each shift. 1. CNAs will report to a designated unit at the beginning of a shift to obtain the shift responsibilities/patient assignment as determined by a licensed nurse. 2. Obtain patient assignment at the beginning of each shift from/with a licensed nurse. Examples of general report information includes but is not limited to; the patient's name, room and bed, scheduled appointments, bathing needs, special health care needs, etc. 3. Provide pertinent patient information to the on-coming shift, such as tasks not completed, etc. 4. Perform all shift responsibilities/assignments that promote quality of care; make rounds, identify and address any immediate patient needs, promptly respond to call lights and notify the licensed nurse of any pertinent patient findings (reddened skin, etc.)".

On 5/24/22, the facility Administrator and Director of Nursing were made aware of the concern that Resident #259 was not provided or offered showers on the days noted above.

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| F 677 | Continued From page 24<br>No further information was received.<br><br>Complaint related deficiency. | F 677 | | |
| F 760 SS=E | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on Observation, Staff interview, clinical record review, and facility document review, the facility failed to prevent significant medication errors regarding 4 medications for two Residents, (Resident #29 & #259) in a sample of 46 residents.<br><br>The findings included;<br><br>1. For Resident #29, the Resident was given two doses of an anticoagulant significant drug, instead of the single dose ordered by the physician.<br><br>Resident #29 was admitted to the facility on 11-28-17. The Resident's diagnoses included atrial fibrillation, chronic ischemic heart disease, and valve replacement, requiring anticoagulant medication therapy.<br><br>On Monday 5-23-22 at 8:00 a.m., during the Medication administration pour and pass observations with LPN (G), Resident #29's medications were observed while being prepared for administration, and was observed receiving those medications. The Resident was observed receiving 16 total medications to include the | F 760 | F760<br>1-Resident #259 was discharged from the facility. Resident #29 is receiving his Coumadin as ordered.<br>2-Current residents have the potential to be affected.<br>3-The DON/ designee will educate all Nurses on the 5 R(s) Medication Administration, documentation and requirements of physician notification.<br>4-The Unit Manager/ designee will complete weekly audits of the Medication administration report residents to ensure that the residents are receiving their medications and treatments as ordered and that the physician is notified appropriately. The Unit Manager/designee will complete 3 med pass observations of Nurses each week to ensure that the 5 R(s) Rights of Medications are followed appropriately<br>5- The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Admin/DON are responsible for | 6/28/22 |

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| F 760 | Continued From page 25<br>following medications of concern;<br><br>Warfarin 5 milligrams (mg), and Warfarin 7.5 mg. both given for a total of 12.5 mg given by LPN (G).<br><br>After medication pour and pass observations were completed, a review of Resident #29's clinical record was conducted. This review revealed the following excerpts from the physician's orders:<br><br>Ordered 5-13-22, Warfarin Sodium 5mg tablet one every day on Tuesday, Friday, and Sunday. Ordered 5-13-22, Warfarin Sodium 7.5mg tablet one every day on Monday, Wednesday, Thursday, and Saturday.<br><br>Resident #29 had received a double dose of the blood thinning medication in error. The LPN, Director of Nursing, and Administrator were made aware immediately. The Resident was not exhibiting signs of bleeding at that time.<br><br>On 5-23-22, during the end of day debriefing, the Administrator and DON (Director of Nursing) were notified of the issue, both stated they had nothing further to provide.<br><br>2a. For Resident #259, the facility staff failed to administer a physician ordered intravenous antibiotic on four occasions.<br><br>On 5/22/22 and 5/23/22, a clinical record review was conducted of Resident #259's closed electronic health record. | F 760 | implementation of the plan of correction.<br>6- Completion date: 6/28/2022 | |

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Review of the physician orders revealed an order dated 1/6/22, that read, "Meropenem Solution Reconstituted 500 MG Use 500 mg intravenously every 6 hours for pelvic abscesses".

Resident #259's medication administration record (MAR) revealed that on 1/14/22, 1/15/22, 1/19/22, and 1/24/22, she had not been administered Meropenem [an antibiotic] as ordered by the physician.

The progress notes were reviewed and no indication was noted of the antibiotic being administered, the doctor being notified or any orders to alter the previously scheduled treatment/medication order(s).

On 5/23/22 at 1:46 PM, an interview was conducted with LPN B. LPN B stated that medications are given within an hour of the scheduled time and documented on the MAR. LPN B was asked what it means if the MAR is blank, she said, "If blank it wasn't given". LPN B went on to say in such an instance she would document in the nursing notes why the medication was not given.

LPN B was asked to explain the risk of missing doses of IV antibiotics. LPN B said, "It wouldn't be complaint and would have to start the therapy again".

On 5/23/22 at 2:25 PM, an interview was conducted with the nurse practitioner (NP). The NP said she recalled Resident #259 very well as she was a clinically complex case. The NP said she recalled talking to the surgeon regarding Resident #259 on several occasions to assist with treatment decisions. During the interview, the NP

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stated she recalled the daughter of Resident #259 expressing concern of Resident #259 missing doses of the IV antibiotic. The NP said, "The Resident and daughter weren't aware of the labs and stop dates you have to have with antibiotics, so I would order treatment for 4-6 weeks, then try to stop it. The stop date was in place and then I would re-initiate it. So it wasn't that she actually missed doses, it was due to the start and stop dates".

Further review of the clinical record was conducted following the above interview with the Nurse Practitioner. This additional review revealed that the order for Meropenem given on 1/6/22, had no stop date indicated. It was not discontinued until 2/14/22, when treatment was changed to an oral antibiotic in preparation for her to discharge home.

On 5/24/22 at 10:15 AM, an additional interview was conducted with the nurse practitioner. The NP was made aware that based on the clinical record, Resident #259 had missed 4 doses of her IV antibiotics in January. The NP said she was not aware of this. When asked what the possible risks are when such antibiotics are missed she said, "Well 2 things come to mind. 1. Whatever we are treating has the ability to come back and second, it could develop a resistance".

On 5/24/22 at 10:46 AM, an interview was conducted with LPN E. LPN E was asked about medication administration and documentation of such. LPN E said medication administration is documented on the medication administration record. When asked what blanks would mean, she stated she had never encountered that.

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On 5/24/22 at 11:06 AM, an interview was conducted with the Director of Nursing (DON). The DON confirmed that the administration of medications is recorded on the MAR and is documented immediately following the administration. The DON was reviewed the MAR for Resident #259 and confirmed the findings of the IV antibiotic not being recorded as being administered on 1/14/22, 1/15/22, 1/19/22, and 1/24/22. When asked what the blanks indicated, the DON said, "I see there is not a signature, it appears that there is a missed signature". When asked if this would indicate the medication was not given, the DON said, "It appears the medication was here since the dose prior and the dosed after that one was administered so it appears that it wasn't signed off". The DON was asked if there was evidence anywhere else that the antibiotics were given as ordered. The DON said without talking to the nurse that was working at that time she had no way of knowing.

2b. For Resident #259, the facility staff administered medications six hours late. When the second dose of medications was administered 5-6 hours later, this had the potential to cause adverse outcomes due to insufficient time having lapsed between doses of antihypertensive medications and anticoagulants being administered.

During a clinical record review of Resident #259's electronic health record it was noted that on 12/21/21 the resident was transferred to ER via EMS [emergency medical services]".

Further review revealed no further notes to indicate when Resident #259 returned to the

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facility. Hospital records from the ER visit that were scanned into the record and were reviewed. This revealed that Resident #259 was diagnosed with an atrial flutter and treated with bolus IV diltiazem [antiarrhythmic medication] [Diltiazem is a calcium channel blocker. It works by relaxing the muscles of your heart and blood vessels. Diltiazem is used to treat hypertension (high blood pressure), angina (chest pain), and certain heart rhythm disorders.]

Review of the medication administration records revealed that Resident #259's medications scheduled for 9 AM on 12/21/21, included but were not limited to: Eliquis Tablet 5 MG [blood thinner] and Metoprolol Tartrate [antihypertensive/blood pressure medication]. These two medications as well as other medications scheduled for administration at 9 AM, were signed off as being administered at 4:10 PM.

Resident #259 was scheduled to receive a second dose of the same medications, Eliquis and Metoprolol Tartrate again at 9 PM, each day. On 12/21/21, her 9 PM, dose of medications was noted to have been administered at 9:50 PM. This was only five hours and 40 minutes since her last administration.

On 5/24/22 at 10:15 AM, an interview was conducted with the nurse practitioner (NP). The NP was asked to explain the timing of medications ordered to be given twice daily. The NP said, "When medications are ordered morning and night it is 9 AM and 9 PM, if they are ordered BID [twice a day] it is typically 9 AM and 5 PM. It depends on who puts the order in".

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The NP was asked about anticoagulants and blood pressure medications, she said, "I like to spread it out every 12 hours". The NP was asked, what are the risk of getting consecutive doses of those two medications too close together? She said, "With Eliquis it is concerning because they are getting a larger dose all at once and the next 12 hours they would be at an increased risk for bleeding. The other could make the blood pressure drop too low and at would be at risk for a hypotension event".

The NP was told of the medications given to Resident #259 on 12/21/21. The NP was asked what the process is when a Resident is sent to the emergency room and returns with regards to the medications they may have missed while away from the facility. The NP said, "When they come back it would be communicated and if I recall she came back midafternoon. I would not assume we would give the 9 AM, medication late. The instructions we get from the hospital aren't always complete and since we don't always know what they were administered in the hospital I would pick up where we are, so she wouldn't get medications that were not administered in her absence until the next scheduled dose".

The NP was made aware that Resident #259 was treated in the hospital with IV diltiazem and then administered her 9 AM, scheduled medications at 4:10 PM, and again at 9:50 PM, which included but were not limited to: Eliquis and Metoprolol Tartrate. The NP said, "Yeah, that is something, I would have told them to resume her evening dose of medications and not go back and administer the morning dose". The NP agreed that this could have caused significant problems for Resident #259. She concurred with the

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Survey team's concern and said, "If I had given those orders it would have been more like around noon, I would not have agreed to them being given at 4 PM".

On 5/24/22 at 10:46 AM, an interview was conducted with LPN E. LPN E was asked to explain what happens if a Resident is out of the facility at their scheduled time for medications to be administered. LPN E said, "You would document resident is away from the facility and let the MD [medical doctor] or NP know. You have to notify the doctor that the Resident is back and find out what they want to do. You wouldn't go back and administer the medications that were missed because you don't know what they got while in the hospital".

LPN E was asked what the risk is if blood thinner and blood pressure medication doses are given too close together. LPN E said, "It will make the blood too think and the can bleed more easily and that is something you definitely don't want to do with blood thinner. With blood pressure medications the first dose is still working if you give the second dose too soon, it can drop their blood pressure too low, they can get dizzy or may pass out altogether, have a syncope episode, or breathing problems. It is very dangerous".

On 5/24/22 at 11:06 AM, an interview was conducted with the Director of Nursing. The DON was asked to explain the process if a Resident misses a dose of medication or it is given late. The DON said, "The physician should be notified and will give orders on what to do". When asked what is done in the event the Resident is out of the facility at the scheduled administration of medication time. The DON said, "We can put the

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meds on hold and administer when they return but we check with the doctor to what they want to do". The DON was made aware of the above concerns regarding Resident #259's medications on 12/21/21.

On 5/24/22 at approximately 3 PM, the Director of Nursing notified Surveyor F that she had looked and Resident #259's discharge paperwork from the hospital was signed at 11:37 AM. She said the facility is just down the street from the hospital so the Resident was likely in the facility around noon. When asked if she had any evidence of what time the Resident returned she said no. When asked to provide evidence of where the doctor or nurse practitioner was notified and gave orders to administer the medications at 4:10 PM, she indicated there was not such documentation.

Review of the facility policy titled, "Administration Procedures for All Medications" was conducted. This policy read, "...III. 5 Rights (at a minimum) at a minimum, review the 5 rights at each of the steps of medication administration... IV. Administration...7. After administration, return to cart, replace medication container, and document administration in the MAR or TAR..."

Additional Guidance from Lippincott's Nursing Center, read, "Rights of Medication Administration: 1. Right patient...2. Right medication...3. Right dose... 4. Right route... 5. Right time: check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. 6. Right documentation: Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For

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| F 760 | Continued From page 33<br>example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.7. Right reason: Confirm the rationale for the ordered medication.... 8. Right response...Reference: Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. Accessed online at: www.nursingcenter.com.<br><br>On 5/24/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above findings.<br><br>No further information was provided.<br><br>Complaint related deficiency. | F 760 | | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations<br>CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(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;<br>(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;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative | F 883 | | 6/28/22 |

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| F 883 | Continued From page 34<br>was provided education regarding the benefits and potential side effects of influenza immunization; and<br>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.<br><br>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-<br>(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;<br>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;<br>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and<br>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an influenza vaccine for 1 resident out of 5 residents reviewed for influenza | F 883 | F 883<br>1-Resident #57 was offered and agreed to the influenza vaccination when available for administration. | |

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| F 883 | Continued From page 35<br>immunization.<br><br>The findings included:<br><br>The facility staff failed to provide influenza immunization for Resident #57.<br><br>On 5/24/22, clinical record review was performed for Resident #57 and revealed the last documented influenza immunization occurred on 9/30/20. A physician's order dated 5/22/14 read, "Flu Vaccine Annually as indicated".<br><br>There was no documentation of the flu vaccine being offered, refused, contraindicated, or administered for 2021.<br><br>An interview was conducted with the Director of Nursing who accessed the clinical records for Resident #57 and verified the findings. A facility policy on influenza immunization was requested and received.<br><br>Review of the facility policy, effective date 2/6/20, entitled, "Influenza & Pneumococcal Vaccinations", subheading "Policy", read: "Vaccination against influenza will be offered to Center patients and staff annually" and subheading "Procedure", item 1-c, read, "Influenza vaccine should be given annually".<br><br>The Facility Administrator was updated. No further information was provided. | F 883 | 2- Current residents have the potential to be affected.<br>3-The DON/ designee will educate all Licensed Nurses and the Infection Preventionist on offering the influenza documentation and documenting acceptance or refusal of the vaccination.<br>4-The Infection Preventionist/ designee will complete monthly audits to ensure that residents were offered and received the influenza vaccination as indicated.<br>5- The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Admin/DON are responsible for implementation of the plan of correction.<br>6- Completion date: 6/28/2022 | |
| F 886 SS=E | COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including | F 886 | | 6/28/22 |

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| F 886 | Continued From page 36 | F 886 | | |

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 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.

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| F 886 | Continued From page 37<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms<br>consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.<br><br>§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.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state<br>and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 5 Residents, Residents #106, #69, #62, #104, and #310, in a sample of 8 Residents reviewed for new admission COVID-19 testing.<br><br>The findings included:<br><br>For Residents #106, #69, #62, #104, and #310, the facility staff failed to conduct COVID-19 testing upon their admission to the facility.<br><br>On 5/23/22, a clinical record review was conducted and revealed no evidence of any COVID-19 testing for the previously referenced | F 886 | F 886<br>1-Residents #106, # 62, #104 and #310 were discharged. Resident #69 no longer requires Isolation precautions.<br>2- The Infection Preventionist will audit residents admitted to the facility in the past 7 days to ensure that they were tested for COVID appropriately.<br>3-The DON/ designee will educate all Licensed Nurses and the Infection Preventionist on the COVID testing requirements for resident admissions.<br>4-The Infection Preventionist/ designee will complete weekly audits of resident admissions to ensure that residents were tested for COVID appropriately.<br>5- The results of the review will be discussed at the monthly QAPI meeting. | |

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| F 886 | Continued From page 38<br>Residents.<br><br>On 5/23/22 at approximately 2:30 PM, an interview was conducted with the facility Infection Preventionist (IP) who confirmed the facility conducts COVID-19 testing for all residents in accordance with CDC (Centers for Disease Control and Prevention) recommendations. The IP was asked about the facility's protocol for testing newly admitted residents for COVID-19 and she stated, "all new admits are tested [for COVID-19] within 5-7 days after their admission to our facility, we rely on the first [COVID-19] test to be conducted by the hospital sending them to us, we don't accept them unless they have been tested before their arrival here". The IP verified the findings for the previously referenced Residents, however was unable to provide any evidence of COVID-19 testing being performed after admission to the facility.<br><br>The IP reviewed a copy of the CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, and confirmed it was utilized in facility's COVID-19 policies and practices. The IP was asked to review page 4 of the previously referenced CDC document, subheading, "Testing", item 3, which read, "Newly-admitted residents and residents who have left the facility for (greater than) 24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection; immediately and, if negative, again 5-7 days after their admission". Following her review, the IP stated, "I thought I could use the test from the hospital". The Director of Nursing was also in attendance during the interview and confirmed the facility | F 886 | Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis.<br>The Admin/DON are responsible for implementation of the plan of correction.<br>6- Completion date: 6/28/2022 | |

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| F 886 | Continued From page 39<br>policy and CDC guidance for COVID-19 testing of newly admitted residents.<br><br>Review of the facility's policy related to COVID-19 testing for newly admitted residents was conducted and was found to be in accordance with current CDC guidance.<br><br>On 5/23/22, during the end of day meeting, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided. | F 886 | | |