STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495097	A. BUILDING _____ B. WING _____	R-C 06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARHAM HEALTH CARE & REHAB CEN	2400 E PARHAM ROAD RICHMOND, VA 23228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An Emergency Preparedness first revisit to the standard survey, conducted 4-25-22 through 04-27-22, was conducted 06-07-22 through 06-08-22. Corrections are required for compliance with 42 CFR Part 483.73 emergency preparedness regulations. The census in this 180 certified bed facility was 149 at the time of the survey.	{E 000}		
{E 015} SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.	{E 015}		7/12/22

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

Electronically Signed | 06/24/2022

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{E 015}	Continued From page 1 (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: On the afternoon of 6/8/22, the facility Administrator was asked to provide evidence that the facility has developed policies for sewage and waste disposal during an emergency. The following was provided by the Administrator: 1. The Biohazard Waste policy 2. The Emergency Communication policy. The Administrator was asked to provide the policy for sewage for services with the waste disposal	{E 015}	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged	

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{E 015}	Continued From page 2 company that will service the facility during an emergency. The Administrator pointed out the Communication Policy which read: "The internal Emergency Call List for staff as well as the External Emergency Call list for Federal, State, Regional and Emergencies will be maintained timely." The Administrator was unable to produce a policy that specifically addresses sewage and waste disposal during an emergency. On 6/8/22 during the end of day meeting the Administrator was made aware of the concerns during the end of day meeting and no further information was provided.	{E 015}	deficiencies cited have been or will be corrected by the date or dates indicated. E015 1. The Emergency Preparedness policy has been updated to include procedures related to sewage and waste disposal. 2. Current residents in the center have the potential to be affected 3. The Administrator /Maintenance director will be educated by the VP of operations/designee on requirements to maintain current policy related to sewage and waste disposal 4. The VP of operations or designee will review the required policy related to sewage and waste disposal and update and needed 5. Results of the review will be presented to the QAPI Committee for review and recommendation. Once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid first Revisit survey was conducted 6/7/22 through 6/8/22 as the result of a standard survey conducted 4/24/22 through 4/27/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey. VA00055347- substantiated without deficiency; VA00055202- substantiated with deficiency;	{F 000}		

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{F 000}	Continued From page 3 VA00055209- substantiated with deficiency. The census in this 180 certified bed facility was 149 at the time of the survey. The survey sample consisted of 17 resident reviews.	{F 000}		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and in the course of a complaint investigation the facility staff failed to provide activities of daily living care to one resident, Resident #1400, in a sample of 17 residents. The findings included: Resident #1400 was a closed record review. On 06/08/22 at approximately 9:22 a.m., an interview was conducted with Staff L. Staff L stated that the point-of-care system (POC) was used to track whether or not residents receive a bath. On 06/08/22 at approximately 12 p.m., review of POC documentation showed that Resident #1400 did not receive a bath between the dates of 04/12/22 - to - 04/18/22. Per POC documentation the first bath Resident #1400 received was on 04/19/22. The Administrator and Regional consultants	F 677	F677 1. Resident # 1400 no longer resides in center 2. Current residents in the center have the potential to be affected 3. Staff development coordinator or designee will educate all Clinical staff on requirement to provide and document ADL specific to bathing provided to residents 4. Unit manager or designee will complete a weekly review of ADL documentation related to resident bathing. 5. Results of the review will be presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	7/12/22

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F 677	Continued From page 4 made aware on 06/08/22 at approximately 1:00 p.m. and stated that they have no other findings to submit.	F 677		
{F 812} SS=D	Complaint deficiency Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility staff failed to maintain a clean and sanitary food prep area. Specifically, Uncooked raw food (meatballs, frozen vegetables) was observed to be present on a food prep table unattended open to air thus exposing them to contaminants. The food prep table holding the unattended food was	{F 812}	F812 1. Dietary employees are currently displaying appropriate standards related to maintaining a safe and sanitary food preparation area. 2. Current residents have the potential to be affected 3. Regional Dietary consultant or designee will educate all Dietary Staff on	7/12/22

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{F 812}	Continued From page 5 commingled with one soiled previously worn facemask, and staff personal items, to include (keys, cell phone, and sunglasses). The findings included: On 06/08/22 at approximately 09:15 a.m. during observation of the kitchen - on the back food preparation table, there was noted to be raw meatballs open to air in a silver rectangular pan, and frozen vegetables in an open plastic bag, unattended. On the same prep surface as the meatballs and frozen vegetables, a worn face mask, personal car keys, personal cell phone, and personal sunglasses were observed resting on the food preparation table. The Kitchen Manager acknowledged the presence of the aforementioned items on the food preparation table. The Kitchen Manager acknowledged that the mask had been worn as demonstrated by the shape of the mask. According to "ServSafe" Fourth Edition manual page 10 it states: "....This shared responsibility extends to ensuring that consumer expectations are met and that food is unadulterated, prepared in a clean environment, and honestly presented." The Administrator and Regional consultants made aware on 06/08/22 at approximately 1:00 p.m. and stated that they have no other findings to submit.	{F 812}	maintaining a safe and sanitary food preparation area. 4. Regional Dietary consultant or designee will complete weekly audits of Food preparation area to ensure a safe and sanitary preparation area is maintained 5. Results of the review will be presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	{F 842}		7/12/22

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{F 842}	Continued From page 6 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	{F 842}		

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{F 842}	Continued From page 7 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one Resident (Resident #1700) in a survey sample of 17 Residents. The findings included: For Resident #1700, the facility staff failed to maintain an accurate and complete clinical record with regards to immunization status. On 6/8/22, a clinical record review was conducted	{F 842}	F842 1. Resident #1700 no longer resides in center 2. Current residents have the potential to be affected 3. Staff development coordinator or designee will educate all Licensed Nurses on requirement to maintain accurate clinical record related to immunization status. 4. Unit managers or designee will complete random weekly review of patient	

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{F 842}	Continued From page 8 of Resident #1700's electronic health record. This review revealed the following: Resident #1700 had been admitted to the facility on 6/3/22. On the immunization tab of the electronic health record (EHR) there was documentation that indicated Resident #1700 had received the first dose of a COVID-19 primary vaccination series. This information was entered as historical data with a date of 6/6/22. For the flu and pneumonia immunizations, it read, "Consent required". All of the progress notes for Resident #1700 were reviewed, which included but were not limited to: social work, nursing and medical providers, from admission through the date of review. There was no indication of Resident #1700's vaccination status. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the immunizations being provided to Resident #1700. Review of the misc. tab was a document titled, "Admission Alert" which had a hand written note that read, "up to date with COVID vaccines", which had no supporting evidence of COVID immunizations and no information with regards to flu and pneumonia immunizations. On 6/8/22 at 9:41 AM, an interview was conducted with LPN B. LPN B was asked where immunization records/information is found for Residents. LPN B said, under the immunization tab in the EHR. On 6/8/22, a video call was held with the onsite	{F 842}	clinical record related to documentation of immunization status 5. Results of the review will be presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	

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{F 842}	Continued From page 9 survey team and surveyors E and F and the facility leadership to include the Administrator, corporate nurse consultant (CNC) and regional director of operations (RDO). During this meeting, the facility staff confirmed that the information regarding Resident #1700's vaccination status was not in the clinical chart, the chart only showed one dose of a COVID vaccine being provided and no information was noted with regards to flu and pneumonia vaccination status. On the afternoon of 6/8/22, the facility Administrator provided Surveyor E with Resident #1700's vaccine status pulled from VIIS (Virginia Immunization Information System) which indicated Resident #1700 had received her primary vaccination series for COVID-19 as well as one booster dose and had received the flu vaccine and pneumonia vaccines. The facility staff confirmed that this information was not in the clinical record of Resident #1700 and should have been. During the end of day meeting, the facility administration confirmed that the Resident's vaccination status should be documented within the clinical record. They were made aware that for Resident #1700, her immunization status was not documented accurately, as it indicated she only had 1 dose of the primary vaccination series for COVID-19, and had no information regarding flu and pneumonia immunization status. No further information was provided.	{F 842}		
{F 883} SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	{F 883}		7/12/22

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{F 883}	Continued From page 10 immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	{F 883}		

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{F 883}	Continued From page 11 (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 (Resident #110, 1135, and 1600), in a sample of 6 Residents reviewed for immunizations. The findings included: On 6/7/22 and 6/8/22, clinical record reviews were conducted for the sampled Residents with regards to immunization for flu and pneumonia. This review revealed the following: 1. Resident #110 had been admitted to the facility on 3/18/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the pneumonia vaccine status of Resident #110. Review of the misc. (miscellaneous) tab, assessment tab, and progress notes revealed no evidence of vaccine administration or offering of such.	{F 883}	F 883 1. Residents #110, #1135 influenza and pneumonia immunization status has been updated in electronic medical record. Resident #1600 no longer resides in center 2. Current residents have the potential to be affected 3. Staff Development coordinator or designee will educate all Licensed Nurses on the requirement to offer /document influenza and pneumonia immunization status in resident electronic medical record 4. Director of nursing or designee will review 10 residents weekly to ensure documentation of resident influenza and pneumonia immunization status in electronic medical record. The review will also include documentation the resident /resident representative have been offered information related to influenza and pneumonia immunizations. 5. Results of the review will be	

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{F 883}	Continued From page 12 Review of the Medication Administration Records (MAR) revealed no evidence of the pneumonia immunization being provided to Resident #110. Resident #110 had an active physician order dated 5/18/19, that read, "Pneumonia Vaccine per Protocol". 2. Resident #1135 was admitted to the facility on 11/27/2018. Review of the immunization tab of the EHR revealed "consent refused" for the flu and pneumonia immunizations. Review of the remainder of the EHR revealed no further information with regards to flu and pneumonia immunization discussions and had no supporting evidence of who refused, the Resident or her responsible party, when the refusal took place or who had the discussion with the Resident and/or responsible party. 3. Resident #1600 was admitted to the facility on 6/2/2022. Review of the immunization tab of the EHR revealed no information with regards to flu and pneumonia immunization status. Review of the remainder of the EHR to include but not limited to the misc. tab, assessment tab, progress notes and medication administration record revealed no evidence of the facility staff discussing the immunizations with the Resident, obtaining consent or refusal of the immunizations. There was a progress note from the nurse practitioner dated 6/3/22, that under the list of medications read, "Pneumovax 23 Injectable 25 MCG/0.5ML, Dosage:0.5, Frequency:One Time Only one time only". The physician orders revealed orders dated 6/2/2022, that read, "Flu Vaccine Annually as indicated and Pneumonia Vaccine per Protocol". The MAR (medication	{F 883}	presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	

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{F 883}	Continued From page 13	{F 883}		

administration record) revealed no evidence of the immunizations being provided to Resident #1600.

On 4/25/22 at 11:39 AM, an interview was conducted with LPN B. LPN B was asked where immunization records/information is found for Residents. LPN B said, under the immunization tab in the EHR. LPN B was asked to explain the admission process with regards to immunizations for Residents. LPN B said, "When we get report I ask the nurse to tell me the immunization status. I have a list of questions to ask and then document under the immunization part of the record". LPN B said the importance of Residents being immunized is, she said, "Basically so they don't come here and end up getting something. We try to make sure everyone is protected".

On 6/8/22, a video call was held with the onsite survey team and surveyors E and F and the facility leadership to include the Administrator, corporate nurse consultant (CNC) and regional director of operations (RDO). During this meeting, the facility staff reviewed and confirmed that in their plan of correction they had indicated that the vaccination information for Resident #110 and #1135 was updated in the clinical chart. The CNC accessed the clinical record for Resident #110 and #1135 and confirmed that it was not there and she didn't know how why. She (the CNC) also accessed the information regarding Resident #1600's vaccine status and confirmed there was no information noted regarding his/her flu and pneumonia immunization status or being offered the immunizations.

During the above call it was discussed that even though Resident #1600 was admitted after the flu

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{F 883}	Continued From page 14 season, because a physician order was in place, the Resident should have been immunized. The corporate facility staff agreed. Review of the facility policy titled, "Influenza & Pneumococcal Vaccinations" was conducted. This policy read, "...Vaccination against influenza will be offered to Center patients and staff annually. Vaccination against pneumonia will be offered to Center patients as indicated. 1. c... The center will check the immunization status of patients admitted during the flu season. Those who have not had a flu shot will be offered on upon admission." On 6/8/22, during an end of day meeting the facility Administrator and corporate staff were made aware of the above concerns. No further information was provided.	{F 883}		
{F 886} SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with	{F 886}		7/12/22

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{F 886}	Continued From page 15 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. §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.	{F 886}		

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{F 886}	Continued From page 16 §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: 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 2 Residents, Residents #1600, and #1700, in a sample of 4 Residents reviewed for COVID-19 testing. The findings included: For Residents #1600, and #1700, the facility staff failed to conduct COVID-19 testing upon their admission to the facility. On 6/8/22, a clinical record review was conducted and revealed the following: 1. Resident #1600 was admitted to the facility on 6/2/22. Resident #1600 had a physician order dated 6/2/22, that read, "COVID-19 testing per MD [medical doctor] or CDC [Centers for disease prevention and control] recommendation". Review of the MAR (medication administration record) revealed an entry that read, "COVID 19 POC (Point of Care) test by BinaxNOW, BD Veritor or Sofia. One time only for Test for COVID 19 for 1 Day Document Results -Order Date- 06/02/2022". There was an entry on 6/2/22, which indicated to see nursing notes. The nursing notes read, "Accidental order. Tested in hospital" [sic]. There was no further indication in	{F 886}	F 886 1. Resident #1600, #1700 no longer reside in center 2. Current residents have the potential to be affected 3. Staff development coordinator or designee will educate all Licensed Nurses on requirement to test and document Covid 19 status upon admission to center. 4. Director of nursing or designee will complete random weekly review of new admission to center to ensure Covid 19 testing was completed and documented in electronic medical record. 5. Results of the review will be presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	

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{F 886}	Continued From page 17	{F 886}		

the clinical chart to indicate that any COVID testing had been performed upon admission.

2. Resident #1700 had been admitted to the facility on 6/3/22. The entire clinical record was reviewed to include but not limited to: progress notes, care plan, medication administration record, results tab and miscellaneous tabs, with no indication of any COVID testing being performed on admission.

On 6/8/22 at 9:41 AM, an interview was conducted with LPN B. LPN B was asked about COVID testing of admissions. LPN B said, "Before they come we find out if they were tested at the hospital". When asked if any COVID testing is done once they arrive at the facility she stated, "No".

On 6/8/22, a video call was held with the onsite survey team and surveyors E and F and the facility leadership to include the Administrator, corporate nurse consultant (CNC) and regional director of operations (RDO). During this meeting, the CNC confirmed that if a Resident is tested at the hospital prior to admission they have not been testing the Residents upon their admission to the facility. The CNC confirmed that the facility follows CDC guidance. During this call the facility staff were made aware that Resident #1600 and #1700 had no evidence of COVID testing upon admission. The facility staff confirmed the findings.

Review of the facility's policy titled, "COVID-19" was reviewed. This policy read, "Newly admitted patients and patients who have left the facility for > 24 hours, regardless of vaccination status,

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{F 886}	Continued From page 18 should have a series of two viral tests for COVID-19; immediately after admission/readmission to the center and, if negative, again 5-7 days after their admission/readmission". Review 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 was reviewed. This document read on page 4, "Testing", item 3, "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-CoV2 infection; immediately and, if negative, again 5-7 days after their admission". On 6/8/22, 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}		
{F 887} SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education	{F 887}		7/12/22

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{F 887}	Continued From page 19 regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that	{F 887}		

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{F 887}	Continued From page 20 includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to offer COVID vaccination(s) to one Resident (Resident #1600), in a sample of 4 Residents reviewed for immunizations. The findings included: The facility staff failed to provide evidence that Resident #1600 was offered, educated and provided/or declined COVID vaccination. On 6/8/22, a clinical record review for Resident #1600 was conducted. This review revealed the following: Resident #1600 was admitted to the facility on 6/2/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #1600. All of the progress notes for Resident #1600 were reviewed, which included social work, nursing and medical providers, to include from admission through the date of review. There was no indication of Resident #1600 being offered or educated on the benefit of immunization for COVID.	{F 887}	F887 1. Resident #1600 no longer resides in the center. 2. Current residents have the potential to be affected. 3. Staff development coordinator or designee will educate all Licensed Nurses on requirement to offer /educate and document Covid 19 vaccine status to residents not fully vaccinated. 4. Director of nursing or designee will complete a weekly audit related to administration /education /documentation of Covid 19 vaccine to residents not fully vaccinated. 5. Results of the review will be presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	

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{F 887}	Continued From page 21	{F 887}		

Review of the misc. (miscellaneous) tab revealed no evidence of vaccine administration or offering of the COVID vaccine. There was a document scanned into the EHR that was titled "Admission Alert" that indicated Resident #1600 would have to be quarantined upon admission, due to not being vaccinated for COVID-19.

Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #1600.

On 6/8/22 at 9:41 AM, an interview was conducted with LPN B. LPN B was asked where immunization records/information is found for Residents. LPN B said, under the immunization tab in the EHR. LPN B was asked to explain the admission process with regards to immunizations for Residents. LPN B said, "Usually the admissions director makes sure we know the immunization information before they come in. If they are not immunized then we get a consent form signed and nursing gives the immunization if they agree, if they decline they sign that they are declining".

LPN B confirmed that COVID immunizations are maintained in house and are available at all times.

On 6/8/22, a video call was held with the onsite survey team and surveyors E and F and the facility leadership to include the Administrator, corporate nurse consultant (CNC) and regional director of operations (RDO). During this meeting, the facility staff confirmed that the information regarding Resident #1600's vaccine status and

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{F 887}	Continued From page 22 evidence of him/her being offered the COVID vaccine was not in the clinical chart and said, "The consent forms may be in the office". When asked if they expected this information to be in the chart, the facility CNC said, "Yes". Review of the facility policy titled, "COVID-19" was reviewed. This policy read, "...5...The center should continue to encourage vaccination among new admissions..." CDC (Centers for Disease Control and Prevention) provides the following guidance to nursing facilities in their document titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes". This document read, "...New Admissions and Residents who Leave the Facility: Create a Plan for Managing New Admissions and Readmissions....In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine...COVID-19 vaccination should also be offered". Accessed online 4/27/22, at web address: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030153017 On 6/8/22, during an end of day meeting the facility Administrator and corporate nurse consultant and regional director of operations were made aware of concerns regarding COVID immunizations for Resident #1600. They also confirmed that they follow CDC guidance. No further information was provided.	{F 887}		
{F 888}	COVID-19 Vaccination of Facility Staff	{F 888}		7/12/22

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{F 888} SS=D	Continued From page 23 CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in	{F 888}		

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{F 888}	Continued From page 24 paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements;	{F 888}		

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(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
{F 888}	Continued From page 25	{F 888}		

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

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for

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	495097	A. BUILDING _____ B. WING _____	R-C 06/08/2022

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{F 888}	Continued From page 26 those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have a complete and accurate system to track the immunization status of all facility employees affecting four employees (Employee E, Employee F, Employee G and Employee H) that work on 3 of 3 Resident care units. The findings included: On the evening of 6/7/22, the facility staff provided the survey team with a copy of the staff vaccination matrix. The as-worked schedule for 6/8/22, was requested and received. The as worked schedule was used to check that all facility employees were included on the staff vaccination matrix. This review revealed that four employees, Employee E, Employee F, Employee G and Employee H, were not listed on the staff vaccination matrix. On 6/8/22, a video call was held with the onsite survey team and surveyors E and F and the facility leadership to include the Administrator, corporate nurse consultant (CNC) and regional director of operations (RDO). During the meeting, the facility Administrator	{F 888}	F 888 1. An accurate tracking system has been put in place to effectively track the immunization status of employees. Current staff members are vaccinated and are on current tracking log. 2. Center has potential to be affected 3. Administrator or designee will educate Human Resource director/director of nursing or designee on requirement to verify and document staff vaccination status and maintain accurate vaccination tracking log. 4. Administrator or designee will conduct weekly audits to review staff vaccination status and validate accuracy of staff vaccination tracking log 5. Results of the review will be presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	

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{F 888}	Continued From page 27 confirmed that the staff vaccination log provided to the survey team was current, complete and inclusive of all facility staff and agency staff. The facility staff (Administrator, CNC and RDO) were given the facility staff names of Employees E, F, G and H and asked to locate them on the staff log. They confirmed that they were not on the listing/tracking form. There were 12 additional agency staff that were not on the log, but the facility was able to provide evidence of their vaccination status. Review of the facility policy titled, "COVID-19 Vaccination Policy", was reviewed. This policy read, "...9. Proof of full COVID-19 vaccination should be maintained for all employees in their personnel file. The center will track and securely document each staff member's vaccination status including exemptions". On 6/8/22, during the end of day meeting, the facility Administrator and CNC and RDO were made aware of the concern that the staff vaccination matrix/tracking system in use, is not complete and accurate. No additional information was received.	{F 888}		
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.	F 919		7/12/22

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F 919	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation and in the course of an investigation the facility staff failed to ensure a functioning system 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 for 1 Resident in a survey sample of 17. The findings included: For Resident # 199 the facility staff failed to maintain a functioning call bell for a quadriplegic resident. Resident # 199, had diagnoses that included quadriplegia, cerebrovascular disease, and dysphagia. Resident # 199's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/31/22, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. Resident # 199 was totally dependant on staff for all aspects of ADL care. Being quadriplegic, Resident #199 required a specialized call bell "Sip and Blow" that would enable her to use a straw like device to activate the call bell system On 6/8/22 a review of the clinical record revealed that Resident #199's specialized call bell the "Sip and Blow" was not functioning properly. A review of the progress notes revealed the following excerpt: "4/29/22 4:15 AM - Impaired call bell during shift. Continued q 2 h and PRN assessment. No	F 919	F 919 1. Resident #199 no longer resides in center 2. Current residents have the potential to be affected 3. Administrator or designee will educate all staff on requirements to maintain a functioning system whereby the resident can communicate the need for staff assistance. 4. Maintenance director or designee will complete random call bell audits to validate function to ensure resident has a method to communicate need for staff assistance. 5. Results of the review will be presented to the QAPI Committee for review and recommendation once the committee determines the problem no longer exists the review will be conducted on a random basis 6. Date of compliance 7/12/22	

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current concerns, awaiting repair. from maintenance and/or physical therapy. [Resident] call bell is special made due to Dx.[diagnosis] will continue with plan of care."

On 6/8/22 at approximately 3:00 PM, an interview was held with the corporate RN who stated that there were "frequent" rounds done on Resident #199. When asked to quantify the term "frequent" she stated "At least hourly."

The Corporate RN provided an order for hourly rounding that read:
"5/4/22 at 3:00 PM - Nurse / CNA to check on resd. [resident] to ensure needs are met r/t [related to] call bell issue and document every hour for care."

The facility provided a MAR that showed hourly rounding being signed off as completed from 5/4/22 through 5/23/22, with the exception of 5/8/22 from 3 PM - 6 PM where the signatures were left blank.

The call bell was non-functional from 4/29/22-5/4/22 with no documented evidence of interventions put in place for this Resident.

On 6/8/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

Complaint deficiency.