STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE 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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/11/22 through 7/14/22. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 037 SS=B	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E 037	1. 1. The facility recognizes that all new and existing staff were not fully trained in emergency preparedness policies/procedures. 2. 2. All residents in the facility have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Executive Director/Human Resource Coordinator of staff that require emergency preparedness training. 3. 3. All staff will be re-educated by the Executive Director/Director of Clinical Services related to emergency preparedness policies/ procedures.	8/25/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/02/2022

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E 037	Continued From page 1 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and	E 037	The Executive Director/Human Resource Coordinator will review weekly all new hires and ensure they have received the proper emergency preparedness training. Additionally monthly the Human Resource Coordinator will provide a list of upcoming annual evaluations and the Executive Director/Human Resource Coordinator will ensure they receive emergency preparedness training along with their evaluation as indicated. 4. 4. The Executive Director/Human to conduct quality monitoring of new hire emergency preparedness education and annual evaluation emergency preparedness education, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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E 037	Continued From page 2	E 037		

procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training.	E 037		

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E 037	Continued From page 4	E 037		

(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and review of the facility's Emergency Preparedness Plan, the facility staff failed to ensure all new and existing staff were trained in their emergency preparedness policies and procedures.

The findings included:

On 7/12/22 at approximately 4:30 PM, during the course of reviewing the facility's Emergency Preparedness Plan (EPP) with the Facility Administrator and the Regional Administrator, staff training records and/or onboarding records were requested for a randomly selected sample of 9 active facility staff members which included 3 nurses (RN C, LPN F, LPN G), 3 certified nursing assistants (CNA C, CNA D, CNA L), the Business Office Manager (BOM-Employee W), the receptionist (Employee V), and a dietary assistant

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E 037	Continued From page 5 (Employee X). The Facility Administrator provided a copy of computer based training records for the receptionist and BOM, however he stated there were no training records or onboarding records available for the remainder of the staff sample. Review of the 2 staff training records submitted revealed no evidence of facility-specific emergency preparedness procedures. On 7/13/22 at approximately 11:50 AM, the Facility Administrator and the Regional Administrator were updated concerning the lack of required documentation for facility training in emergency preparedness procedures for staff members. The Facility Administrator stated, "There are no records for our Emergency Management training, I cannot say that it [emergency preparedness training] was provided directly to the staff members". The Facility Administrator and the Regional Administrator confirmed that the "emergency procedures" module denoted on the computer based training transcripts is generalized and does not provide facility-specific training or guidance. No further information was provided.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted 07/05/22 through 07/08/22 which resulted in a standard survey 07/11/22 through 07/14/22. An extended survey was conducted 07/14/2022. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Three complaints were investigated during the survey.	F 000		

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F 000	Continued From page 6 VA00055551- Substantiated with deficiency VA00055078- Substantiated with deficiency VA00053968- Substantiated with deficiency The census in this 174 certified bed facility was 143 at the time of the survey. The survey sample consisted of 48 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550	1. Resident #142 was provided clothing by the facility 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Social Service Director to determine that all residents have clothing available to them that fit and appropriate for the season.	8/25/2022

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F 550	Continued From page 7 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to maintain dignity for one Resident (Resident #142) in a sample size of 48 Residents. Specifically, the facility staff did not assist Resident #142 to obtain clothes/get dressed for approximately 2 months. The findings included: On 07/11/2022 at 2:35 P.M., Resident #142 was observed lying in bed wearing a hospital gown. When asked if it was their preference to be in bed in a hospital gown at this time of day, Resident #142 stated they would like to be dressed but they do not have clothes to wear. Resident #142 indicated that out of respect for other Residents, they really want to wear pants. When asked if the facility staff have assisted with getting clothes, Resident #142 stated that some clothes were ordered but were too small so other clothes needed to be ordered. Resident #142 stated it has been a few months since then. Resident #142 stated they have not received any clothes	F 550	3. All staff will be re-educated by the Social Service Director/Assistant related to Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required. In the AM meeting, the Social Service Director and Director of Clinical Services will review new admits focusing on their inventory sheets to ensure they have available appropriate clothing for fit and season. 4. The Social Service Director/Assistant to conduct quality monitoring of available appropriate clothing weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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yet.

On 07/12/2022, Resident #142's clinical record was reviewed. Resident #142's most recent Minimum Data Set with an Assessment Reference Date of 07/01/2022 was coded as an annual assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition.

On 07/13/2022 at approximately 10:30 A.M., Certified Nursing Assistant N (CNA N) was interviewed. CNA N verified they care for Resident #142 on a regular basis. When asked about Resident #142's clothes, CNA N stated the social worker brought him clothes a few months ago but they were too small so they took the clothes back. CNA N confirmed Resident #142 does not have clothes to wear.

On 07/13/2022 at approximately 10:35 A.M., Employee T, a social worker, was interviewed. When asked how long she worked at the facility, the social worker stated she worked for a sister facility and was only filling in because the previous social worker quit. When informed that Resident #142 had no clothes and asked about the expectation for assisting Residents to obtain clothes, the social worker indicated that something should be done to assist (Resident #142) obtain clothes.

On 07/13/2022 at approximately 5:00 P.M., the Administrator was notified.

O 07/14/2022 at 2:45 P.M., the corporate nurse entered the conference room and stated that the facility staff were going to get Resident #142 some pants today.

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F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to promote self determination through support of resident choice, for Resident # 84 in a survey sample of 48 Residents. The findings included:	F 561	1. Resident #84 was educated regarding resident rights and their ability to choose their bed times. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Social Service Director/Assistant of all residents regarding resident rights and choosing their bed time. 3. All staff will be re-educated by the Social Service Director/Assistant related to resident rights and choices including bed times. Mock surveyor rounds will be reviewed in am meeting to determine if any residents voice concerns regarding not being able to make choices. 4. The Executive Director/Social Services Director to conduct quality monitoring of resident interviews on choices, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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For Resident # 84 the facility staff told the Resident he must go to bed between 9:00 PM and 10:00 PM.

On 7/11/22 at approximately 2:00 PM Resident # 84 was interviewed about his stay at the facility and he stated "They told me I have to go to bed between 9:00 and 10:00 o'clock. I am not a child, I am a grown man I don't need a bedtime."

On 7/12/22 at 4 PM an interview was conducted with CNA B, (a staff member working 3-11 shift) who stated "We try to get the Residents in bed by 10:00 PM so that the night shift doesn't have to get them to bed. We have more staff on 3-11 than nights so we try to make sure everyone is in bed, in a gown by 10:00." When asked what is done if a Resident refuses to go to bed, CNA B said, "Well we try at 9:00 and then give them more time like until 9:30. Then at 9:30 we remind them we will be back at 10:00 to get them in bed. They usually don't fuss if you say it like that."

On 7/12/22 an interview was conducted with RN A who stated "The Residents have the right to go to bed when they want to however the CNA's like to get them changed into night clothes by 10:00 PM." When asked why that was she stated "They don't want nights to complain that people were left up. I guess because nights has less staff."

On 7/13/22 during end of day meeting with facility acting Administrator was informed of this practice and asked his opinion on Resident going to bed at specific times. The Acting Administrator stated that the Residents have the right to stay up as late as they want and get up at the time they want

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F 561	Continued From page 11 to. He stated that he would use this as a "learning opportunity for his staff." On 7/14/22 during the end of day meeting the Acting Administrator was made aware of concerns and no further information was provided.	F 561		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for	F 563	1. Resident #127 and her family will be educated to resident rights and the ability to receive visitors. LPN F and employee S were re-educated on the facility's policy for access and visitation. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Social Services Director/Assistant of residents with a BIMS score of 8 or higher regarding resident rights and their ability to have visitors/visitation policy. 3. 3.All staff will be re-educated by the Social Services Director/Assistant related to The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time;	8/25/2022

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	495327	A. BUILDING _____ B. WING _____	C 07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

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F 563	Continued From page 12 the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to allow a Resident to have visitors at the time of their choosing, for one Resident (#127) in a survey sample of 48 Residents. The findings included: For Resident #127, the facility staff had her daughter removed from the facility for visiting beyond visiting hours. On 7/12/22, during a clinical record review a nursing note was noted that read, "Late Entry: Note Text: Daughter [name redacted] c/o [complained of] Nurse called security previous night and walked sister out of building for staying past visiting hours. Reassured daughter that family was welcomed to visit with patient, as long as they wished to without being loud and interfering with other residents care. Daughter very appreciative and patient is currently alone in room. No further complaints voiced at this time. Patient resting comfortably in bed with eyes closed. No distress noted at this time". This entry was made on 7/10/22, by Employee C, the Assistant Director of Nursing (ADON) and noted as a late entry for 7/5/22. Resident #127 was unable to be interviewed regarding the incident. On 7/12/22, during the morning, the Regional Administrator and the facility Administrator were asked about the above nursing note entry and both said they had no knowledge of the incident	F 563	The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. Mock surveyor rounds will be reviewed in am meeting to determine if any Residents voice concerns over visitation. 4. 4. The Executive Director/Social Service Director to conduct quality monitoring of resident visitation weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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F 563	Continued From page 13	F 563		

and would have to look into it.

On 7/12/22 at 2:16 PM, an interview was conducted with Employee C, the writer of the progress note. Employee C was asked about the progress note and events of Resident #127's daughter being removed. Employee C said, [Resident #127's name redacted] daughter had approached me and said the other daughter was escorted out by security". Employee C said she was not able to find out who had escorted the family member out but, "I did interview the nurse who called security and the nurse reported they were visiting after visiting hours had ended and she wanted them out of the building. I reached out to [Regional Administrator name redacted] and told him and he said we can't be uptight about visiting hours due to the business we are in, unless they are being noisy or disturbing resident care. The nurse said they weren't causing problems and in this case [Resident name redacted] was alone in the room".

On 7/13/22 at 3:15 PM, an interview was conducted with LPN F. LPN F was asked about the facility security and she said, "We have someone at the desk that monitors entry and enforces visiting hours". When asked what time visiting hours were, she said "usually 8 AM to 8 PM". LPN F was asked to discuss the events regarding Resident #127's family being removed. LPN F said, "All I asked was that security go knock on the door and let them know that visiting hours were over". LPN F was asked who the security person was and she gave Employee S's name. LPN F went on to say that she wasn't working that unit and was just helping out another nurse, therefore she didn't observe when Resident #127's family left the facility.

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F 563	Continued From page 14	F 563		

LPN F was asked what her understanding of visiting rights are. LPN F said, "The only time family can extend or stay beyond visiting hours is if the resident is actively dying and she [Resident #127] wasn't in that condition and I'm not aware of her having any special privileges". LPN F was asked if it is her current understanding of when visitors are permitted. LPN F said, "Visiting hours are 8 AM to 8 PM". LPN F was asked if Resident #127's family was causing any problems or disturbances on the night the family was asked to leave. LPN F said, "No, there were no issues".

LPN F was asked if she had received any training regarding Resident Rights. LPN F said, "Yes". When asked what the nature of that training included with regards to visitation she said "If there is a situation such as the Resident's condition changes and they are dying, they have the right to have visitors then". LPN F was asked if it was ever discussed that Residents have the right to receive visitors at any time, LPN F said, "They only time we have that is if a change in condition and they are actively dying, I was told the visiting hours are 8 AM to 8 PM".

A review of the facility policy titled, "Access and Visitation" was conducted. This policy read, "The resident has the right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. ...2. The center will provide immediate access to a resident by immediate family and other relative of the resident, subject to the resident's right to deny or withdraw consent at the time".

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F 563	Continued From page 15 On 7/13/22, the facility Administrator was asked to provide any Resident Rights training LPN F had since her hire on 1/2/2018. The facility Administrator reported they did not have any evidence to submit. On 7/13/22, during an end of day meeting the facility Administrator and Assistant Director of Nursing and Corporate staff were made aware of the above findings. No further information was provided.	F 563		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	1. 1. Resident #50 will have his paper towel holder replaced. Resident #111 will have their floors cleaned and moped. The shower room on the 400 unit will have the shower head fixed, ensure hot water was available in all used stalls, the floors/baseplates will be cleaned, the sinks will be cleaned and fixed and the shower handles will be fixed. 2. 2. All residents residing on unit 400 that use the shower rooms have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Executive Director/Maintenance Director of all shower rooms regarding their functioning and cleanliness. 3. 3. All staff will be re-educated by the Social Service Director/Executive Director related to Safe, Clean, Comfortable, Home-like Environment.	8/25/2022

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F 584	Continued From page 16 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview, the facility staff failed to provide a clean, comfortable, and homelike environment for Residents on one unit (the 400 unit) out of 4 units. Specifically, observations of the 400 unit shower room and Resident rooms included the following: 1) The shower room had no hot water from 2 out of 3 shower heads 2) One shower head was detached from the hose and inoperable so the water temperature could not even be tested. 3) The shower room sink had a leaky faucet and there were rust stains in the sink basin. 4) There were rust spots on the floor in various places in the shower room and black spots on the floor in one of the shower stalls. 5) There was a dry, white, crusty substance covering the entire base plate of the shower handle in one of the three shower stalls.	F 584	The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide— a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; Clean bed and bath linens that are in good condition; Private closet space in each resident room, as specified in Adequate and comfortable lighting levels in all areas; Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and for the maintenance of comfortable sound levels. Mock surveyor rounds will be reviewed in AM meeting to discuss status of shower rooms and resident rooms focusing on function and cleanliness. 4. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of shower rooms and resident rooms, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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F 584	Continued From page 17	F 584		

6) For Resident #50, the paper towel dispenser in the bathroom was on the bathroom floor
7) For Resident #111 and in Resident room #413, the floors were sticky to walk upon, stained, scuffed, and had debris on the floor.

The findings included:

On 07/11/2022 at approximately 12:55 P.M., Resident #110 was interviewed. When asked about any concerns identified, Resident #110 stated the only concern was that the shower room (on the 400 unit) was "a mess."

On 07/11/2022 at approximately 1:25 P.M., the shower room on the 400 unit was observed. This surveyor observed that one of three shower heads were detached/inoperable; the sink was leaking and had rust in the basin; there were rust spots on the floor in various areas and black spots on the floor in one of the shower stalls; and there was a dry, white, crusty substance covering the entire base plate of the shower handle in one of the shower stalls.

On 07/11/2022 at 3:45 P.M., Resident #50 was interviewed. When asked about concerns, Resident #50 stated the showers (on the 400 unit) were not working. Resident #50 was unable to say how long the showers weren't working. Also, Resident #50 indicated he told staff that the paper towel dispenser was off the wall in their room bathroom. This surveyor observed the paper towel dispenser on the bathroom floor up against the wall.

On 07/11/2022 at approximately 3:55 P.M., this surveyor and Certified Nurse Assistant M (CNA M) observed the shower room on the 400 hall.

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F 584	Continued From page 18	F 584		

When asked about the broken shower head, CNA M stated that it wasn't like that on Friday (3 days ago). When asked to test the water temperature, CNA M turned on the water for one of the shower stalls and let the water run for approximately 3 minutes. The water temperature did not rise above 80 degrees according to the temperature gauge on the wall. The water was tepid to touch. When asked about the rust and black spots on the floor, CNA M stated, "They need to clean up in here."

On 07/11/2022 at approximately 4:10 P.M., this surveyor and the unit manager for the 400 hall, Licensed Practical Nurse H (LPN H) observed the shower room. When asked to test the water temperature for the third shower stall, LPN H turned on the water and let it run. After approximately 3 minutes, LPN H stated the water was not heating up. LPN H also stated that staff usually just use the other 2 showers.

On 07/12/2022 at approximately 9:10 A.M., the paper towel dispenser in Resident #50's bathroom was still on the bathroom floor as observed on 07/11/2022.

On 07/12/2022 at approximately 9:15 A.M., Resident #111 and two family members were interviewed. When asked about concerns, one of Resident #111's family members stated housekeeping staff have not been mopping the floor and the floor appears dirty. This surveyor observed the floor in Resident #111's room to have debris on the surface, dried spill stains, and sticky to walk upon.

On 07/13/2022 at approximately 8:50 A.M., Employee U, a housekeeper, was interviewed.

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F 584	Continued From page 19 Employee U verified she works on the 400 hall. When asked about her process for cleaning Resident rooms, Employee U stated she sweeps and mops each Resident room daily, among other things. When asked about Resident #111's room, Employee U stated she had not gotten to that room yet today. Employee U verified she did clean Room 413 already today. This surveyor and Employee U observed Room 413. There were particles of debris on floor (looking unswept) and a coin on the floor in the center of the room. There were dried spill stains and the floor was sticky to walk upon. When asked about the floor being sticky, Employee U stated she didn't notice the floor was sticky. On 07/13/2022 at 3:30 P.M., three maintenance employees (Employee K, (Maintenance Director) Employee F, and Employee G) were interviewed. When asked about Resident #50's paper towel dispenser, Employee F stated he saw it in the sink this morning and will be fixing it. When asked about the shower head in the 400 hall shower room, Employee K stated they just found out about the shower head yesterday and fixed it. On 07/13/2022 at approximately 5:00 P.M., the administrator was notified of findings.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		

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F 609	Continued From page 20 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 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. §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. This REQUIREMENT is not met as evidenced by: Based on interview, facility record review and clinical record review the facility staff failed to report allegations of abuse to the State Agency (VDH Office of Licensure and Certification) for 1 Resident (# 64) in a survey sample of 48 Residents. The findings included: For Resident #64 the facility staff failed to report allegation of sexual abuse by a CNA. On 7/11/22 during review of FRI's (Facility Reported Incidents) for this facility it was discovered that on 8/27/21 APS (Adult Protective Services) reported to the OLC an allegation of	F 609	1. 1.Abuse/neglect reporting timeframes will be reviewed with the Executive Director/Director of Clinical Services by the Regional Director of Clinical Services to ensure that all incidents are reported timely 2. 2.All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Regional Director of Clinical Services/designee to identify any issues with facility reporting processes. 3. 3.Regional Director of Nursing will educate the Executive Director/Director of Nursing on regulatory guidelines for reporting abuse and neglect. The Executive Director/Director of Clinical Services will notify Regional Director of Clinical Services with incidents that may require reporting for timeline tracking purposes. 4. The Regional Director of Nursing/ designee to conduct quality monitoring of all Facility Reported Incident submissions, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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F 609	Continued From page 21 sexual abuse of Resident # 64 that they were investigating. The alleged abuse occurred on 8/21/21 by a CNA, employee O. The report from APS states that the local Police were notified, APS was notified and that the Resident was taken to the hospital for an examination. On 7/12/22 at approximately 1:00 PM the facility was asked to see any and all FRI's for 2021. Employee Q submitted the "FRI Book" for the surveyors to examine. The "FRI Book" did not contain any FRI's for alleged sexual abuse of Resident #64. The acting Administrator and the Regional Administrator searched the records and could not find the FRI. The Regional Administrator stated that he talked to the former DON who stated that she remembers doing the investigation but does not know where the paperwork would be. The facility was given an additional 2 days until end of survey to find the documents however none were found. On 7/14/22 during the end of day meeting the Interim Administrator was made aware and no further information was provided.	F 609		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F 645		

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F 645	Continued From page 22 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645	1. The facility recognizes that the PASARR for resident #45 was not located. 2. All newly admitted residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Social Services Director/Designee of current facility residents to ensure that have a PASSAR/UAI completed. 3. Admission Coordinator will be re-educated by the Executive Director/Social Service Director related to Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. A nursing facility must not admit, on or after January 1, 1989, any new residents with: Mental disorder, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and If the individual requires such level of services, whether the individual requires specialized services; or Intellectual disability, unless the State intellectual disability or developmental disability authority has determined prior to admission— That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. Exceptions.	8/25/2022

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F 645	Continued From page 23 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on electronic health record (EHR) review the facility failed ensure the preadmission screening (PASARR) evaluation for an individual with a mental disorder was conducted for one resident (Resident #45) in a sample of 48. The findings include: On 07/13/22 at approximately 4:30 p.m., while conducting EHR review observed that Resident #45 did not have a PASARR on record. Administrator was made known that the PASARR for Resident #41 could not be located.	F 645	The preadmission screening program need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. The State may choose not to apply the preadmission screening program to the admission to a nursing facility of an individual- Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, Who requires nursing facility services for the condition for which the individual received care in the hospital, and Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. Definition. An individual is considered to have a mental disorder if the individual has a serious mental disorder. An individual is considered to have an intellectual disability if the individual has an intellectual disability or is a person with a related condition. The Admissions Coordinator will discuss pending admission in the AM meeting and the Executive Director/Social Service Director will verify that a PASSAR is present if indicated prior to admission. 4. The Executive Director/Social Services Director to conduct quality monitoring of new admission PASSARs, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care	F 655		

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F 655	Continued From page 24 Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting	F 655	1. The facility recognizes the baseline care plan for resident #127 was not completed. The resident's comprehensive care plan will be reviewed and updated as indicated. 2. All new admissions have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Minimum Data Set Coordinator/Assistant of all new admissions since 8/4/2022 to ensure baseline care plan was completed as indicated. 3. All licensed nurses will be re-educated by the Minimum Data Set Coordinator/Assistant/ Director of Clinical Services related to Comprehensive Person-Centered Care Planning Baseline Care Plans The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must— be developed within 48 hours of a resident's admission. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to—Initial goals based on admission orders. Physician orders. Dietary orders. Therapy services. Social services. PASARR recommendation, if applicable. The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan — Is developed within 48 hours of the resident's admission. The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: The initial goals of the resident. A summary of the resident's medications and dietary instructions. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. Any updated information based on the details of the comprehensive care plan, as necessary.	8/25/2022

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F 655	Continued From page 25 on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop a resident-centered baseline care plan that met professional standards of quality care for one resident (Resident #127) in a sample of 48 Residents. The findings included: For Resident #127, the facility staff failed to develop a baseline care plan to direct the Residents care upon admission. On 7/11/22 and 7/12/22, a clinical record review was conducted. This review revealed the following: 1. Resident #127, was admitted to the facility on 6/22/22. 2. There was no evidence of a baseline care plan being developed. 3. The comprehensive care plan was not initiated until 6/30/22. On 7/12/22, the facility Administrator was asked to provide Resident #127's baseline care plan. On 7/12/22, the facility Administrator advised the survey team that a base line care plan for Resident #127 was not available. On 7/13/22, the facility's Corporate Clinical Consultant confirmed that a base line care plan for Resident #127 was not located and not available.	F 655	Interdisciplinary team to review new admissions daily in AM Meeting to ensure baseline care plan is completed within 48 hours of admission with documentation in the medical record. 4. The Minimum Data Set Coordinator/ Assistant to conduct quality monitoring of all new admissions, weekly x 6 weeks to ensure that the base line care plan has been completed as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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On 7/13/22 at 11:31 AM, an interview was conducted with Employee P, the MDS (care plan) Nurse. Employee P was asked when and who initiates baseline care plans. Employee P said, "The nursing staff initiate the baseline care plan within 24 hours of a patient being admitted". Employee P was asked, what is the purpose of the baseline care plan? Employee P said, "To let the staff know how to properly care for the patient and things to look out for".

During the above interview with Employee P, she was asked, what are the risks if a care plan is not developed or doesn't include items? Employee P said, "If it is not on the care plan, the patient may not be cared for properly".

The facility staff provided a copy of their Policy titled, "Plans of Care." The policy was received and reviewed. It read, "Develop and implement an Individualized Person-Centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed".

On 07/13/2022 at approximately 10:45 AM, the Administrator and Assistant Director of Nursing (DON), Corporate Clinical Consultant, and Regional Administrator were notified of the findings.

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F 655	Continued From page 27 No further information was provided.	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to review and revise care plans for 6 Residents (Resident #127, 93, 4, 49, 75, and 34) in a survey sample of 48 Residents.	F 657	1. Resident #127 will have their care plan updated to reflect their wound. Resident #93 will have their care plan updated to reflect their weight gain. Resident #4 will have their care plan updated to reflect their fall. Resident $49 will have their care plan updated to reflect their weight loss. Resident #75 will have their care plan updated to reflect their change in wound care/treatments. Resident #34 will have their care plan updated to reflect their need for eyeglasses. 2. All residents with wounds, falls, weight change or need for eye glasses are at risk to be impacted by the alleged deficient practice. A quality review will be conducted by the DCS/ designee of care plans since July 1, 2022 for residents with wounds, falls, weight change and eyeglasses to ensure care plan addressing these items was accurate as indicated.	8/25/2022

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F 657	Continued From page 28 The findings included: 1. For Resident #127 the facility staff failed to revise the care plan to include an unstageable wound (a wound where the wound bed is not able to be visualized and therefore the extent of the wound cannot be determined) that required debridement. On 7/11/22 and 7/12/22, a clinical record review was conducted. This review revealed that on 6/30/22, the nurse practitioner ordered for a wound consult and would culture. On 7/8/2022, Resident #127 was seen by a wound specialist and a surgical debridement procedure was performed at the bedside on the unstageable sacral wound. Review of the care plan for Resident #127 revealed that the sacral wound had not been addressed on the care plan. 2. For Resident #93, the facility staff failed to review and revise the nutritional care plan to capture an 82 lb. weight gain. On 7/12/22, the clinical record for Resident #93 was reviewed. This review revealed the following with regards to weights. On 1/3/22, Resident #93 weighed 251.1 lbs. On 3/28/22, Resident #93 weighed 333.2 lbs. There were entries into the clinical record from the dietician requesting the physician be consulted for the significant weight gain. Review of the nutritional care plan for Resident	F 657	3. Minimum Data Set Coordinator/Assistant, Social Services Director/Assistant, Dietary Manager and Wound nurse re-educated by the Director of Clinical Services/Assistant related to Comprehensive Care Plans. A comprehensive care plan must be— Developed within 7 days after completion of the comprehensive assessment. Prepared by an interdisciplinary team, that includes but is not limited to-- The attending physician. A registered nurse with responsibility for the resident. A nurse aide with responsibility for the resident. A member of food and nutrition services staff. To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Interdisciplinary team to review 24 hour report to capture resident changes during AM Meeting to ensure resident's care plan is updated in a timely manner to reflect their current status. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of 10 resident care plans, weekly x 6 weeks ensure changes to the plan of care are updated in a timely and accurate manner . The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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#93 revealed that a nutritional care plan was implemented on 11/3/2021. All of the interventions on the care plan were dated 11/3/2021, and the significant weight gain had not been addressed on the care plan.

3. For Resident #4, who had a fall on 5/29/22, the facility staff failed to review and revise the fall care plan since 1/10/22.

On 7/12/22, during a clinical record review the nursing notes revealed an entry on 5/29/22, which indicated Resident #4 was found on the floor beside her bed. This was an unwitnessed fall.

Review of the care plan revealed she had been identified as a fall risk and a fall care plan initiated on 3/5/2019. Review of the interventions revealed the most recent intervention was entered into the fall care plan on 7/15/2021. The care plan was not reviewed or revised following the fall on 5/29/22, to implement any interventions to prevent a reoccurrence.

On 7/13/22, the facility Administrator was made aware of the findings and confirmed that the care plan had not been revised following the fall and had not been revised quarterly with the assessments as required. The Administrator indicated they would update the care plan that day.

On 7/13/22 at 11:31 AM, an interview was conducted with Employee P, the care plan nurse. Employee P stated that the comprehensive care plan is developed when a Resident has their admission assessment and with each subsequent

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assessment or change in condition that warrants a change in treatment. When asked what the purpose of the care plan is, Employee P said, "It guides the daily care". When asked who uses the care plan, she said, "The nursing staff". When asked if a Resident has a change such as a significant weight change or develops a wound or has a fall when the care plan would be reviewed and revised, she said, "It would go on the care plan the day of occurrence, the same day". Employee P went on to say, "If it is not on the care plan the patient may not be cared for properly".

During the above interview with Employee P, she accessed the clinical chart for Resident #127 and #93 and confirmed the above findings. When asked if these are items that should warrant a revision of the care plan, Employee P said, "Absolutely".

Review of the facility policy titled "Plan of Care" was conducted. This policy read, "...Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each OBRA MDS assessment (except discharge assessments), and as needed. The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being".

On 7/13/22, the facility Administrator and Corporate Clinical Consultant were made aware of the above findings for Residents #127, #93, and #4.

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No further information was received.

4. Resident #49 experienced an 18.91% weight loss over a 3 month time period (January 2022 through April 2022) and the care plan was not revised to include goals and interventions addressing the significant weight loss.

On 07/11/2022 at 1:25 P.M., Resident #49 was observed in her bed. Resident #49 appeared small-framed and thin.

On 07/12/2022, Resident #49's clinical record was reviewed. According to the weight flow chart, Resident #49 was weighed twice since 01/13/2022. Resident #49 weighed 110 pounds on 01/13/2022 and 89.2 pounds on 04/18/2022 which represented an 18.91% weight loss in 3 months.

The nursing progress notes around 04/18/2022 were reviewed. There were no progress notes addressing the significant weight loss.

The following excerpts of a provider progress note dated 04/19/2022 documented the following: " ...currently tolerating a regular diet, dysphagia pureed texture, nectar thickened fluid consistency and has had a stable weight." "Weight: 89.2 pounds. Height: 62 inches."

The dietary progress notes were reviewed. There was one dietary note written since 04/18/2022. A dietary note dated 06/01/2022 at 12:16 P.M. documented, "Note Text: Weight Note:
Weight loss noted. Additional weights requested

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in order to establish new baseline. BMI 16.3 [underweight]. On a pureed diet with nectar thick liquids and fortified foods eating variably 0-100%. Recommend MD consult r/t [related to] weight loss and possible benefit from appetite stimulant and add Med Pass 120mL TID [three times a day]."

The physician's orders were reviewed. There were no orders for an appetite stimulant or Med Pass (or any similar supplement).

Resident #49's care plan was reviewed. There was no focus addressing actual significant weight loss as recorded on the weight flow sheet on 04/18/2022.

On 07/13/2022 at 2:00 P.M., Employee R, the nurse practitioner was interviewed. When asked about the process for tracking weights, the nurse practitioner stated that there are dietary and weight meetings and usually with weight changes, the nurses "would let me know." When asked if she was aware of Resident #49's significant weight loss, the nurse practitioner stated that "No one brought it to my attention" and "They [nurses] have to let me know." When asked what she would've ordered if she was aware of the weight loss, the nurse practitioner stated she would've ordered Ensure with every meal, weekly weights, a dietary referral for food preference assessment and possibly look at labs.

On 07/13/2022, the facility staff provided a copy of their policy entitled, "Plans of Care." In the Section entitled, "Procedure" paragraph 4, an excerpt documented, "Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the

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resident and in response to current interventions .....as needed."

5. For Resident #75 the facility staff failed to review and revise the care plan to include changes in wounds and wound treatments.

On 7/12/22 during clinical record review it was discovered that Resident # 75's Care Plan was not updated to include the sacral wound that was labeled "Moisture Associated Dermatitis."

On 7/12/22 at approximately 3:00 PM an interview was conducted with Employee N who was asked when the care plan should be updated and she stated that at least quarterly but also PRN as changes occur. When asked should wounds or skin breakdown be included she stated that they should. When asked who can update the care plan she stated that Nursing staff have access to the care plans.

On 7/14/22 during the end of day meeting the Interim Administrator was made aware of the concerns and no further information was provided.

6. For Resident #34 the facility staff did not review and revise the care plan include Resident #34's need to wear eyeglasses.

On 7/6/22 at approximately 1:45 PM an interview was conducted with Resident #34 who explained

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F 657	Continued From page 34 that he needed eyeglasses and had not had his vision checked in some time. He stated he was not aware of the exact date he last had an eye exam but he knew it was more than a year ago. Resident #34 stated that he had his eyes examined and the doctor recommended a certain type of eyeglasses. On 7/12/22 at approximately 1:50 PM Employee T was interviewed and she stated that Resident #34 has not had an eye exam since 2016 and it the Resident was correct in saying that he did require eyeglasses and that his care plan was not updated to include that information. On 7/14/22 during the end of day meeting the Interim Administrator was made aware of the concerns and no further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility documentation review and clinical record review, the facility staff failed to follow the nursing standards of practice, for two Residents (Resident #106 & #127) in a survey sample of 48 Residents. The findings included: 1. For Resident #106, the facility staff failed to	F 658	1. Residents #106 had their weight obtained as ordered and resident #127 had their wound culture obtained as ordered. 2. All residents with orders for daily weights and wound cultures have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Unit Managers of residents with daily weight and wound culture orders to ensure they are being obtained as indicated.	8/25/2022

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F 658	Continued From page 35 follow physician orders and obtain weekly weights as ordered by the physician. On 7/11/22 and 7/12/22, a clinical record review was conducted of Resident #106's clinical chart. This review revealed an active physician orders which read, "Weekly weights" with an effective date of 2/16/2021. Review of Resident #106's weights revealed a weight had not been obtained since 4/29/22. On 7/13/22 at 11:04 AM, an interview was conducted with the Nurse Practitioner (NP)/Employee R. The NP was asked what her expectations are when she writes or gives an order regarding a Resident. The NP said, "To execute it as soon as possible or as soon as available, at least within 24 hours". When asked what is the importance of monitoring someone's weight? The NP said, "The majority I monitor is if they had significant weight loss, I will also order med pass, ensure or something to increase their appetite because we want to make sure they don't diminish their protein or calorie malnutrition". The NP was asked specifically about the monitoring of Resident #106's weight on a weekly basis. The NP said, "He has bilateral lymphedema, I have him on diuretics and he has kidney disease so I want to make sure if he has a significant weight change I am notified and can work on plan B". The NP was asked if she was aware that the despite the order for weekly weights that the facility staff had not recorded a weight on this Resident since 4/29/22. The NP said she was not aware and added, "They used to have meetings and would discuss Residents	F 658	3. All license nurses will be re-educated by the Director of Clinical Services/Assistant related to Comprehensive Plans of Care and ensuring that orders are completed as required. The services provided or arranged by the facility, as outlined by the comprehensive care plan, must— Meet professional standards of quality. The Interdisciplinary team will review new physician orders in the AM meeting to determine any new daily weight orders and/or wound culture orders for follow up and tracking purposes. 4. The Executive Director/Director of Clinical Services/designee to conduct quality monitoring of daily weights and wound culture weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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with weight changes and would give me a list but they haven't been having those meetings in some time now".

2. For Resident #127, the facility staff failed to obtain a wound culture as ordered by the physician.

On 7/11/22 and 7/12/22, a clinical record review was conducted of Resident #127's chart. This review revealed that on 6/30/22, an order was entered that said to obtain a wound culture from the sacral wound and wound specialist consult. Further review revealed that the wound culture had not been obtained as of the time of review.

On 7/12/22, the Corporate Clinical Consultant/Employee N was asked to access Resident #127's chart and confirmed the order for a wound culture. Employee N stated she would need to look into if it was obtained.

On 7/13/22 at 10:44 AM, a video call was held between Surveyor F and the Corporate Clinical Consultant, facility Administrator, and Regional Administrator. Employee N confirmed, "We did not get that [referring to the wound culture ordered on 6/30/22], we spoke with the NP and got a new order yesterday and they will be obtaining that culture today if they didn't get it last night".

On 7/13/22 at 11:04 AM, an interview was conducted with the Nurse Practitioner (NP)/Employee R. The NP was asked about Resident #127's wound. The NP said, "It was brought to my attention when it was bad, that's

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F 658	Continued From page 37	F 658		

why I consulted a wound specialist and ordered a wound culture". When asked if she was aware that the wound culture was not obtained as ordered, the NP said, "I was not aware until they told me yesterday that they didn't get it".

The facility Administrator confirmed that the facility follows "Potter & Perry" for their standards of nursing practice.

Review of "Potter & Perry Fundamentals of Nursing" eighth edition was conducted. On page 302, Box 23-2 "Common Negligent Acts" it read, "Failure to notify the health care provider of problems, failure to follow orders, failure to follow the six rights of medication administration, .. failure to follow policy and procedures"...

Review of the facility policy titled, "Physician Orders" was conducted. This policy read, "A Nurse may accept a telephone order from the Physician, Physician Assistant or Nurse Practitioner (as permitted by state law). The order will be repeated back to the physician, PA or ARNP for his/her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMar/eTAR). For pharmacy orders, the nurse will notify the pharmacy per pharmacy policy by telephoning, faxing or completing the order electronically. The ordering physician or physician extender will review and confirm orders. Confirmation of routine orders requires that the physician sign and date the order as soon as practicable after it is provided to maintain an accurate medical record."

On 7/13/22, during an end of day meeting the facility Administrator, Assistant Director of

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F 658	Continued From page 38 Nursing and Corporate staff were made aware of the findings. No further information was provided.	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, facility documentation review and in the course of a complaint investigation, the facility staff failed for one of 48 sampled residents (#75) to ensure the Resident received ordered wound physician visits, care, and failed to identify a pressure wound to the heel before it reached an advanced stage. This is harm. The Findings Include: Resident # 75 was admitted to the facility on 5/23/22, her diagnoses included, quadriplegia, diabetes type 2, and pressure ulcers.	F 686	1. Resident #75 will have a skin assessment and measurement of all wounds with documentation in the medical record to include a treatment order for all wounds as indicated by the medical team. 2. All residents with wounds have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Wound nurse of all wounds in house to ensure supporting documentation and treatment is in place. 3. All licensed nurses re-educated by the Director of Clinical Services/Assistant related to Skin Integrity, wound program and documentation expectations of wounds including Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that— A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Interdisciplinary team will review all new wounds in the AM clinical meeting to ensure proper documentation/treatment order in the medical record. Interdisciplinary team will review all in house wounds weekly to ensure that proper documentation and treatment orders are in place and appropriate.	8/25/2022

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F 686	Continued From page 39 Resident # 75's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/29/22, coded the Resident as follows: Section G - Resident #75 was coded as requiring #3- Extensive Assistance of #3 - 2 Person Physical Assistance for bed mobility and dressing. For transfers and toileting she was coded as requiring #4 -Total Assistance (requiring a mechanical lift) and #3 - 2 Person Physical Assistance Walking was coded as #8 -Activity did not occur. Resident required a wheelchair for locomotion on and off the unit. Section H - Coded Resident #75 as having and indwelling catheter and being "always incontinent" Section M - Coded Resident #75 as at risk for developing pressure ulcers. Excerpts from the admission note read as follows: "Resident was admitted to the hospital R/T [related to] abuse / neglect. History of diabetes type 2, neurogenic bladder, has Foley catheter in place, depression, quadriplegic spinal paralysis, ... , abrasion to great toe and left foot. Turn every 2 hours, resident needs air mattress. Resident is incontinent." Resident #75 was seen by the wound physician on 5/25/22 for "Initial Wound Evaluation and Management." The document did not list any wounds to the heel and included the following: "Follow up evaluation by wound care specialist within seven days with further interventions as indicated." Resident #75 was seen again by the wound	F 686	4. The Director of Clinical Services/Assistant to conduct quality monitoring of wounds and their documentation and treatment orders, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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physician on 6/1/22 (7 days later) and no wounds to the heel were documented.

The next time Resident #75 was seen by the wound physician was on 7/8/22 (over 1 month since the last visit) and the following wound was documented: "Unstageable Left Heel - Wound size - 6 cm X 8.5 cm X unmeasurable"

There were no other entries in the Resident's clinical record concerning the wound to the heel.

On 7/6/22 an observation of Resident #75's wound was made by Surveyor B. The following was noted: Wound to Left heel and side of foot - 9cm X 10.5cm, open with black necrotic tissue, yellow slough. and active bleeding at the time of observation.

A review of the Resident's care plan revealed the following: "Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate Date Initiated: 06/02/2022"

The "Nutrition Evaluation Annual and Significant Change" was completed by the dietician on 5/27/22 with recommendations for "vitamins and Prostat for wound healing."

On 7/12/22 a review of the clinical record revealed that these recommendations were never implemented.

On 7/13/22 at approximately 1:50 PM, the Nurse Practitioner (NP) was interviewed and asked if she was aware that the RD had put in a recommendation for "Pro-Stat for wound healing." The NP stated that she was not aware. The NP

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stated they have not been having the "meetings" where the DON would bring those things to my attention."

On 7/14/22 at approximately 945 am, an interview with the Corporate RN was conducted. The Cooperate RN stated that she had looked in the records and could not find consistent documentation of the progression of Resident #75's wound and could not locate consistent accurate weekly skin assessments. She stated that she had only been in the facility a couple of days and did not know what happened to the documentation and did not know why the Resident was only seen once in June.

A review of the policies and procedures document "WC - 130 Pressure Injury Record" revealed the following:

"Policy: To document the president of skin impairment/new skin impairment related to pressure when first observed and weekly thereafter until the side is resolved. One site will be recorded per page."

"Procedure:"
"1. Residents will have a pressure injury record completed for each skin impairment that is related to pressure.
2. Mark the pressure area on the body description identifying the site
3. Enter the date.
4. Enter the stage of the pressure injury.
5. Enter the size of the pressure injury - length X width X depth in centimeters
6. Enter the tissue type in color.
7. Enter the wound edges and drainage
8. Enter the peri-wound information.

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F 686	Continued From page 42 9. Licensed nurse to sign the appropriate area." On 7/14/22 the Interim Administrator was made aware and no further information was provided.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to supervise one Resident during meal time to ensure safety (Resident #49) in a sample size of 48 Residents. Specifically, Resident #49 was observed eating her lunch in an unsafe position presenting a potential choking hazard on 07/11/2022. The findings included: On 07/11/2022 at 1:25 P.M., Resident #49 was observed in her bed eating lunch. The head of the bed was elevated approximately 45 degrees but Resident #49's upper back was in the fold of the bed where the head of the bed begins to rise. Resident #49's head was at the level of the tray table with the lunch tray on it. Resident #49 was not seated upright to safely consume food without the risk of choking. There was no staff in the room. At approximately 1:28 P.M., this surveyor and Certified Nurse Assistant H (CNA H)	F 689	1. Resident #49 was immediately repositioned in the bed. 2. All residents who eat in their bed have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Unit Managers of all residents who chose to eat in their beds. 3. All nursing staff (Licensed nurses and CNAs) will be re-educated by the Director of Clinical Services/Assistant related to Accidents/ Supervision. The facility must ensure that – The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents including bed positioning with meals. The interdisciplinary team will review those residents who chose to eat in bed weekly and ensure that proper bed positioning is present and documentation is evident in the medical record. 4. The Director of Clinical Services/ Assistant to conduct quality monitoring of proper bed positioning for those residents that chose to eat in their beds, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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observed (from the hall) Resident #49 eating their lunch. When asked if any concerns were identified, CNA H stated that the room floor looked dirty. When asked if there were any concerns related to positioning, CNA H stated yes and entered Resident #49's room. CNA H talked with Resident #49 about repositioning. Resident #49 stated, "No" and continued to eat. CNA H explained it wasn't safe to eat in that position and Resident #49 was agreeable when CNA H elevated the head of the bed to approximately 60 degrees and repositioned Resident #49 to a seated upright position. CNA H then exited the room and explained to this surveyor that they repositioned (Resident #49) so that (Resident #49) "won't choke."

On 07/12/2022, Resident #49's clinical record was reviewed. Resident #49's most recent Minimum Data Set with an Assessment Reference Date of 05/13/2022 was coded as a quarterly assessment. Resident #49's Brief Interview for Mental Status was coded as "4" out of possible "15" indicative of severe cognitive impairment. Functional status for eating was coded as "1" meaning requiring supervision-oversight, encouragement, or cueing for eating.

Resident #49's physician's orders were reviewed. An active order dated 03/24/2021 documented, "Regular diet Dysphagia pureed texture, nectar thickened fluids consistency, fortified foods."

Resident #49's care plan was reviewed. A focus with a revision date of 10/20/2021 entitled, "At risk for nutrition risk r/t [related to] anxiety, HLD [hyperlipidemia], GERD [gastroesophageal reflux disease], constipation, dysphagia [difficulty swallowing], nausea, vitamin D defiency [sic],

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F 689	Continued From page 44 dementia, schizophrenia, hx [history] of low weight. On mechanically altered diet and thickened liquids." An intervention for this focus included but was not limited to the following: - "Monitor/document/report PRN any s/sx of worsening dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals." On 07/13/2022 at approximately 11:15 A.M., Certified Nursing Assistant H (CNA H) was interviewed. When asked about Resident #49's appetite, CNA H stated (Resident #49 "eats well" and usually eats about 50% of her food and drinks all of her fluids. When asked about swallowing difficulties, CNA H stated (Resident #49) does not have any problems with swallowing. On 07/13/2022 at approximately 5:00 P.M., the Administrator was notified of findings.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		

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F 692	Continued From page 45 desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to identify, monitor, and treat significant weight loss for one Resident (Resident #49) in a sample size of 48 Residents. Specifically, Resident #49 experienced an 18.91% weight loss over a 3 month time period (January 2022 through April 2022). The findings included: On 07/11/2022 at 1:25 P.M., Resident #49 was observed in her bed eating lunch. Resident #49 appeared small-framed and thin. On 07/12/2022, Resident #49's clinical record was reviewed. According to the weight flow chart, Resident #49 was weighed twice since 01/13/2022. Resident #49 weighed 110 pounds on 01/13/2022 and 89.2 pounds on 04/18/2022 which represented an 18.91% weight loss in 3 months. The nursing progress notes around 04/18/2022 were reviewed. There were no progress notes addressing the significant weight loss nor	F 692	1. Resident #4 will be reviewed by the medical team and Registered Dietician and interventions implemented as indicated. 2. All residents are at risk to be impacted by the alleged deficient practice. A quality review will be conducted by the Registered Dietician of residents with weight changes to ensure proper follow up and review by the medical team. 3. All nursing staff (licensed nurses and CNAs) will be re-educated by the Director of Clinical Services/Assistant related to assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident — Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; Is offered sufficient fluid intake to maintain proper hydration and health; Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. The Interdisciplinary team will review weight changes on a weekly basis to determine that appropriate tracking and interventions are in place to maintain proper hydration and nutrition. The Registered Dietician will meet (via phone or in person) with the Director of Clinical Services/ Assistant weekly to review weight change recommendations. 4. The Director of Clinical Services/Assistant to conduct quality monitoring of weights and interventions, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	8/25/2022

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notification of provider or responsible party.

The following excerpts of a provider progress note dated 04/19/2022 documented the following: " ...currently tolerating a regular diet, dysphagia pureed texture, nectar thickened fluid consistency and has had a stable weight." "Weight: 89.2 pounds. Height: 62 inches."

The dietary progress notes were reviewed. There was one dietary note written since 04/18/2022. A dietary note dated 06/01/2022 at 12:16 P.M. documented, "Note Text: Weight Note:
Weight loss noted. Additional weights requested in order to establish new baseline. BMI 16.3 [underweight]. On a pureed diet with nectar thick liquids and fortified foods eating variably 0-100%. Recommend MD consult r/t [related to] weight loss and possible benefit from appetite stimulant and add Med Pass 120mL TID [three times a day]."

The physician's orders were reviewed. There were no orders for an appetite stimulant or Med Pass (or any similar supplement).

Resident #49's care plan was reviewed. There was no focus addressing actual significant weight loss as recorded on the weight flow sheet on 04/18/2022. A focus with a revision date of 10/20/2021 entitled, "At risk for nutrition risk r/t [related to] anxiety, HLD [hyperlipidemia], GERD [gastroesophageal reflux disease], constipation, dysphagia [difficulty swallowing], nausea, vitamin D defiency [sic], dementia, schizophrenia, hx [history] of low weight. On mechanically altered diet and thickened liquids."

Interventions for this focus included but were not

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limited to the following:
- "Monitor/document/report PRN any s/sx of worsening dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals."

- "Weight monitoring as ordered and as indicated."

On 07/13/2022 at approximately 11:15 A.M., Certified Nursing Assistant H (CNA H) was interviewed. When asked about Resident #49's appetite, CNA H stated (Resident #49 "eats well" and usually eats about 50% of her food and drinks all of her fluids. When asked about swallowing difficulties, CNA H stated (Resident #49) does not have any problems with swallowing.

On 07/13/2022 at approximately 11:20 A.M., the unit manager for the 400 hall was interviewed. When asked about the process for obtaining weights, the unit manager stated monthly weights are divided by shifts. The expectation is that staff will record the weights on paper and then give the paper to her to put in her book. The unit manager stated she would then enter the weight values into each clinical record. When asked about Resident #49's most recent weight, the unit manager stated that the staff on the previous evening shift did all the weights but the unit manager was unable to locate the sheet of paper with the weights on it. When asked about the policy for obtaining weights, the unit manager stated that an order is needed to obtain weights but by policy, everyone gets weighed monthly. When asked about the process for ordering the

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registered dietitian recommendations, the unit manager stated that the nurses will let the physician/provider know what the dietitian recommended and either the nurse or the provider will enter the orders into the clinical record. When asked about Resident #49's weight, the unit manager referred to the clinical record and stated Resident #49's last weight was 89.2 pounds on 04/18/2022. The unit manager then stated "I don't see where we were monitoring weights [for Resident #49]. When asked about the orders for the appetite stimulant and Med Pass as recommended by the dietitian, the unit manager stated she did not see an order for the appetite stimulant and Med Pass has been on back order from the manufacturer. When asked if there were other options similar to Med Pass, the unit manager stated it could be substituted with Ensure. A current weight for Resident #49 was requested.

On 07/13/2022 at approximately 11:35 A.M., this surveyor observed Certified Nursing Assistant M (CNA M) obtain Resident #49's weight on the standing scale. Resident #49 weighed 91.8 pounds.

On 07/13/2022 at 2:00 P.M., the nurse practitioner was interviewed. When asked about the process for tracking weights, the nurse practitioner stated that there are dietary and weight meetings and usually with weight changes, the nurses "would let me know." When asked if she was aware of Resident #49's significant weight loss, the nurse practitioner stated that "No one brought it to my attention" and "They [nurses] have to let me know." The nurse practitioner also indicated the dietary meetings have not been happening for about a year. When asked if she

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F 692	Continued From page 49 has access to weight values and dietitian notes in the clinical record, the nurse practitioner stated that she could look at them "But it's a lot." When asked what she would've ordered if she was aware of the weight loss, the nurse practitioner stated she would've ordered Ensure with every meal, weekly weights, a dietary referral for food preference assessment and possibly look at labs. On 07/13/2022, the facility staff provided a copy of their policy entitled, "Weighing the Resident." Under the header, "Policy", it was documented, "Residents will be weighed unless ordered otherwise by the physician: Admission/readmission x 3 days [for three days]; weekly x [for] 4 weeks; monthly thereafter; as needed." Under the header "Procedure" an excerpt of the last paragraph documented, "Record weight and alert nurse to any significant change. Nurse to notify the physician of any significant weight change." On 07/13/2022 at approximately 5:00 P.M., the Administrator was notified of findings.	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 725		

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F 725	Continued From page 50 at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed to ensure sufficient nursing staff to provide nursing and related services to meet the resident's needs safely, timely, and in a manner that promotes each residents rights, physical, mental, and psychosocial well being. The Findings included: On 7-5-22 Staffing schedules were requested for the week, and were reviewed each day. A tour of the entire building to ascertain all staff currently providing care to the Residents and working during the shift was conducted on 7-5-22. The census on this day was 143 Residents. There was no Infection Preventionist (IP), nor Director of Nursing (DON), and no MDS (Minimum Data Set)/care plan Coordinator present.	F 725	1. The facility will employ and dispatch sufficient staff to maintain the highest practicable well-being of the residents. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant of nursing staff for the upcoming week beginning 8/4/2022 to ensure sufficient nursing support personnel scheduled. 3. Staffing Coordinator and Director of Clinical Services re-educated by the Executive Director related to Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Sufficient Staff. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph of this section, licensed nurses; and other nursing personnel, including but not limited to nurse aides. Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. The Staffing Coordinator/Director of Clinical Services will report in the AM meeting staffing patterns for the upcoming week to discuss any staffing concerns with plans for addressing. The Executive Director will report to the Regional Administrator any anticipated staffing concerns following AM meeting or upon discovery.	8/25/2022

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F 725	Continued From page 51 Nursing staff were interviewed during initial tour and asked who the Administrator, DON, IP, and MDS Coordinators were for the building. All answered that none of those positions were filled and that Employee Q was the only one they had seen, and that had been seldom as he only came a couple times per week because his facility and home were hours away from this facility. There was an Assistant Director of Nursing present (ADON) on 7-5-22 who stated she was very new to the role and facility, and had worked there less than a month, and was "getting to know the residents and facility." She continued to say that she was "not acting as the Director of Nursing in an interim capacity." She stated that there was no Director of Nursing at that time. The Social Worker was also interviewed on 7-5-22, and stated it was her last week to work, as she was working out her notice, and that she had resigned her position with the facility. The Social Worker stated there was no DON, no MDS Coordinator, and no IP. She stated they all left about the same time which was "Weeks ago." The Area Ombudsman came to the conference room on 7-5-22 to talk with surveyors about her concerns of no administrative personnel in the building, and restated that there was no DON, nor IP in the building for weeks, as she had visited several times for resident advocacy issues regarding staff guidance and lack of leadership, and found no one in charge to discuss the incidents with. Employee Q indicated there was no DON, nor IP at the time of survey, however, that a sister facility	F 725	4. The Executive Director/Human Resource Coordinator to conduct quality monitoring of sufficient staffing numbers, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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was going to share a DON next week, and an MDS Coordinator was already being shared as there also was not an MDS Coordinator for the facility. He went on to state that the IP position was going to be filled temporarily by the Corporate IP professional until an IP could be hired.

On 7-5-22 (7:00 a.m., to 3:00 p.m., shift) during entrance to the survey there were 3 CNA's (Certified Nursing Assistants) for all resident care on the 4 wings in the facility, for 143 Residents. There were also 5 "Residential Aides" who the CNA's stated may only pass water, meal trays, and get supplies, as they are not trained and certified to provide physical care to a Resident. Staffing for that shift indicated that each CNA would be responsible for the care of 47.6 Residents in one 7.5 hour shift with one 30 minute staff meal break.

This allows 9.45 minutes for each resident to receive care.

Resident interviews were conducted individually and in a resident council group meeting during the course of the survey. The interviews revealed complaints from the residents regarding staffing. Those complaints voiced consisted of; "Wait too long for call bells to be answered", "not enough staff to get a shower.", "My bed gets wet because no one will come take me to the bathroom." "there is not enough staff to take care of us."

On 7-13-22 and 7-14-22 at the end of day debrief, the Regional Administrator and newly started facility Administrator, were made aware of the findings. No further information was submitted by the facility.

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F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed to ensure a Registered Nurse (RN) Director of Nursing (DON) was present and overseeing resident care, and staff competencies on a full time basis. The Findings included: On 7-5-22 Staffing schedules were requested for the week, and were reviewed each day. A tour of the entire building to ascertain all staff currently providing care to the Residents and working during the shift was conducted on 7-5-22. The census on this day was 143 Residents. There was no Director of Nursing (DON) present. Nursing staff were interviewed during initial tour and asked who the Administrator, DON, IP, and MDS Coordinators were for the building. All	F 727	1. The facility employs a full time interim Director of Clinical Services. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. Executive Director was educated by the Regional Director of Clinical Services/designee that the facility must designate an RN to serve as the Director of Clinical Services on a full time basis. The Executive Director will notify the Regional Director of Clinical Services with any vacancy in the Director of Clinical Services position and plans for replacement for tracking purposes. 4. The Regional Director of Clinical Services/designee to conduct quality monitoring of full time Director of Clinical Services status weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee	8/25/2022

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answered that none of those positions were filled and that Employee Q was the only one they had seen, and that had been seldom as he only came a couple times per week because his facility and home were hours away from this facility.

There was an Assistant Director of Nursing present (ADON) on 7-5-22 who stated she was very new to the role and facility, and had worked there less than a month, and was "getting to know the residents and facility." She continued to say that she was "not acting as the Director of Nursing in an interim capacity." She stated that there was no Director of Nursing at that time, nor Administrator, but that the "Administrator of a sister building was helping out a couple days a week." The ADON directed surveyors to talk with the Social Worker "who can tell you more, I just don't know".

The Social Worker was also interviewed on 7-5-22. The Social Worker stated there was no DON. She stated they left "Weeks ago."

The Area Ombudsman came to the conference room on 7-5-22 to talk with surveyors about her concerns of no administrative personnel in the building, and restated that there was no full time DON in the building for weeks, as she had visited several times for resident advocacy issues regarding staff guidance and lack of leadership, and found no one in charge to discuss the incidents with.

Human resources records, and state agency records were reviewed and no documentation had been sent from the facility notifying of the loss nor reassignment of the DON position.

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F 727	Continued From page 55 Employee Q indicated there was no DON, at the time of survey, however, that a sister facility was going to share a DON next week. On 7-13-22 and 7-14-22 at the end of day debrief, the Regional Administrator and newly started facility Administrator, were made aware of the findings. No further information was submitted by the facility.	F 727		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed to ensure competent nursing staff to provide nursing and related services to meet the resident's needs for 4 of five record reviews. The Facility failed to provide performance competency reviews to ensuring skilled and competently trained staff, able to provide for Resident care needs. The Findings included: On 7-5-22 Staffing schedules were requested for the week, and were reviewed each day. A tour of	F 730	1. The facility recognizes that not all Certified Nursing Assistants had received their annual evaluation and review of competencies. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by Human Resource Coordinator of employee files to determine performance evaluations/competencies out of compliance. Employees that were due for annual evaluations since 6/1/2022 will have an evaluation, education/competency review completed. 3. Human Resources Coordinator will re-educate Executive Director and Department Heads about ensuring performance evaluations/ competencies are completed after 90 day introductory period and annual, according to regulations. By the 5th of each month the Human Resources Coordinator will provide a list of evaluations due for the month to department heads to ensure evaluations and competencies are reviewed and updated as indicated. 4. The Human Resource Coordinator/ assistant to conduct quality monitoring of 10 employee files, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	8/25/2022

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the entire building to ascertain all staff currently providing care to the Residents and working during the shift was conducted on 7-5-22. The census on this day was 143 Residents. There was no Administrator, no Infection Preventionist (IP), nor Director of Nursing (DON), and no MDS (Minimum Data Set)/care plan Coordinator present.

Staff members (2 LPN's, and all 3 CNA's) were asked during initial tour if they had received training and had annual competencies evaluated. All responded they could not remember any training other than a recent first CNA licensing course, and "long ago" abuse training that they had ever received. They were asked who provided training and evaluations, and all responded "I don't know, some are on the computer."

A sample of 5 employee records was requested for performance competency and education review. The review of nursing staff documentation revealed the lack of required training for baseline staff. Competencies were not completed to assess ability to care for the residents.

CNA (B) - all education or competencies.
CNA (P) - Abuse education only.
CNA (H) - all education or competencies.
CNA (Q) - all education or competencies.

On 7-14-22 the Administrator stated "We have no more education/documentation to provide.

On 7-13-22 and 7-14-22 at the end of day debrief, the Regional Administrator and newly started facility Administrator, were made aware of the

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F 730	Continued From page 57 findings. No further information was submitted by the facility.	F 730		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility record review and clinical record review the facility staff failed to provide medically related social services to maintain highest practicable well-being for 1 Resident (#34) in a survey sample of 48 Residents. The findings included: For Resident #34 the facility staff failed to provide needed prescription eye glasses to enable Resident # 34 to pursue reading and other leisure activities that require adequate vision. On 7/6/22 at approximately 1:45 PM an interview was conducted with Resident #34 who explained that he needed eyeglasses and had not had his vision checked in some time. He stated he was not aware of the exact date he last had an eye exam but he knew it was more than a year ago. Resident #34 stated that he had his eyes examined and the doctor recommended a certain type of eyeglasses and the facility staff told him "They are too expensive we won't buy them." On 7/12/22 at approximately 11:00 AM an interview was conducted with Employee T (a	F 745	1. Resident #34 was seen by the eye doctor on 7/26/2022 2. All residents requiring the use of eye glasses has the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Social Service Director/Assistant of residents needing eyeglasses to ensure their availability. 3. Social Service Director/Assistant will be re-educated by the Executive Director related to ensuring medically related social services provided including vision related follow up. The Interdisciplinary team will review the 24 hour report and new admissions in the AM meeting to capture new vision issues or any order dealing with vision services and provide the Social Service Director/Assistant a list for follow up. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of medically related social services focusing on vision services, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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F 745	Continued From page 58 Social Worker) who stated that she was not from this building she had been called from a sister facility to assist because the Social Worker assigned to the building was no longer employed by the company. She stated she would research and find out what happened with obtaining Resident #34's glasses. On 7/12/22 at approximately 1:50 PM Employee T returned to inform this Surveyor that Resident #34 has not had an eye exam since 2016 and it the Resident was correct in saying that the facility did not purchase his glasses. They were not covered under his insurance (Medicaid). When asked what is usually done in cases like this Employee T stated we usually get the bill and submit it to the Business Office Manager to do a MAP adjustment. There is no reason the Resident should be without his glasses. Employee T stated she had arranged for Resident #34 to be seen by the eye doctor on July 26th 2022 when they are scheduled to come to the building. She further stated that they will get his eyeglasses ordered once the eye exam is done. On 7/14/22, during the end of day meeting, the Interim Administrator was made aware of the concerns and no further information was provided.	F 745		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		

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F 761	Continued From page 59 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to properly store drugs on two medication carts in a sample of four medication carts. The findings included: On 7/13/22 at approximately 11:04 a.m. while conducting a review of medication cart(S) observed the following: 1. On Unit 1 the medication cart was reviewed with LPN F. The following medications routes were commingled in the up left corner pocket of drawer one: topical patches (catapres), transdermal (rivastigmine), suppositories (bisacodyl), oral medications (alendronate).	F 761	1. The carts on unit 1 and 2 were organized with the storage of the medications placed in proper divided compartments. LPN F and RN D will be re-educated by the Director of Clinical Services/Assistant regarding proper medication storage in the medication carts. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by Director of Clinical Services/Unit Managers of medication carts focusing on medication storage. 3. All licensed nurses will be re-educated by the Director of Clinical Services/Assistant related to medication storage and the medication cart. The Regional Director of Clinical Services will conduct a quality audit of the medications carts monthly focusing on storage to assess for staff compliance. 4. The Director of Clinical Services/Unit Managers to conduct quality monitoring of medication carts focusing on storage, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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F 761	Continued From page 60 LPN F acknowledged that medications of various route are to be stored with dividers separating each medication route. However, the aforementioned medications were not stored in such a manner. 2. On Unit 2 the medication cart was reviewed with RN D. The following medication route were commingled: injectable (single dose of medroxyprogesterone syringe with needle), multi-dose vial (medroxyprogesterone), and oral medications (aspirin, Motrin). RN D acknowledged that medications of various route are to be stored with dividers separating each medication route. However, the aforementioned medications were not stored in such a manner. The facility's medication storage policy states: "Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals."	F 761		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 802		

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F 802	Continued From page 61 §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility record review and in the course of a complaint investigation, the facility staff failed to employ sufficient staff to carry out the functions of the food and nutrition services for the facility as a whole. The findings included: For the facility, on 6/21/22 the facility staff failed to ensure the proper number of staff including a cook as well as dietary aids to prepare and serve dinner. On 7/5/22 at approximately 1:00 PM the Social Worker was interviewed and she stated that she was aware of the incident involving having to order pizza for Residents. She stated that she was present at the time. She stated that the Acting Administrator was called in and he called a sister facility to get a kitchen staff member to prepare the puree foods and he then ordered pizza for the Residents who could eat regular consistency. On 7/7/22 at approximately 9:00 AM an interview was conducted with Resident # 34 who stated "Oh yeah last month we had pizza from a	F 802	1. The facility recognizes that dietary support has been less than sufficient. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Executive Director/Human Resource Coordinator of dietary staff for the upcoming week beginning 8/4/2022 to ensure sufficient dietary support personnel scheduled. 3. Dietary manager will be re-educated by the Executive Director/Human Resource Coordinator related to providing sufficient dietary staffing. The Dietary manager will report in the AM meeting staffing patterns for the upcoming week to discuss any staffing concerns with plans for addressing. The Executive Director will report to the Regional Administrator any anticipated staffing concerns following AM meeting or upon discovery. 4. The Executive Director/Human Resource Coordinator to conduct quality monitoring of dietary staffing, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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restaurant because they didn't have enough staff to cook."

On 7/7/22 at approximately 9:15 AM an interview was conducted with Resident # 83 who stated that the kitchen staff had not shown up for work on 6/21/22 and that the facility ordered pizza. She also stated that she felt one slice of pizza, a cookie and some juice was not sufficient.

On 7/7/22 at approximately 10:15 AM, an interview was conducted with Employee Q (the Regional Administrator) who stated that on 6/21/22 he was called by the facility staff to inform him that only 2 dietary staff had shown up for work, no cook had shown up. The the Regional Administrator stated that he called the contracted Dietary District Manager (Employee D) and told him, "We have to get these folks fed." He stated that he also called the cook from the sister facility to this facility to prepare the puree diet for the residents that could not eat regular a consistency. For the Residents that could have a regular consistency he ordered pizza from a local restaurant.

On 7/7/22 at approximately 2:00 PM an interview was conducted Employee D who was asked if they were experiencing staffing challenges he stated that they had enough staff and that dietary was contracted through an agency, however that day in particular the cook just did not show up for work.

On 7/7/22 at approximately 10:45 AM, Employee J (the Cook from the sister facility) was interviewed and he stated that on 6/21/22 he did receive a call asking him to come to this facility to prepare puree foods for those who could not eat

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F 802	Continued From page 63	F 802		

pizza. When asked what he prepared he stated they were given pureed herb chicken, pureed mixed veggies, mashed potatoes and applesauce.

A review of the employee file for Dietary Manager Employee X revealed that on 6/30/22 the dietary manager was given an " Employee Corrective Action" write excerpts are as follows:

"To date you have established a pattern of failure to meet performance expectation, and the following issues were identified:"
"Failed to maintain proper staffing levels. Your non aggressive approach towards recruiting has put [facility name redacted] in critical staffing mode. After reviewing ICISMS your last employee ad posted on 5/30/22 this should be accessed/updated.

"Has not provided leadership, support and guidance to ensure that food quality standards, safety guidelines and customer service expectations are met. Numerous complaints regarding plate presentation, and cold food. Utilizing paper service ware for meal service has negatively impacted the unit financially and residents overall satisfaction."

"Additionally our client feels you lack the commitment to improve your performance and the performance of your staff and has noted several concerns including frequently no staff, missed and late meals. During the week of June 23, 2022 the entire staff was out on 3-11, requiring facility staff to work the line and call out for pizza. This is not only a regulatory issue but a safety concern."

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F 802	Continued From page 64 The Employee signed the document on 7-5-22. On 7/14/22 during the end of day meeting the Acting Administrator was made aware of the concerns and no further information was provided.	F 802		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility	F 803	1. The facility recognizes that residents received items different from the planned menu. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Executive Director/Director of Clinical Services of the dietary provided meals against the planned menu beginning 8/4/2022. 3. Dietary manager re-educated by the Executive Director/Director of Clinical Services related to residents receiving planned menu items. The dietary manager will review in am meeting the menu for the upcoming week to ensure compliance and will discuss any barriers at this time with plans for addressing. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of planned menu vs. resident trays, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	8/25/2022

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documentation and during the course of a complaint investigation the facility staff failed to follow the menus for the facility in general and for Resident #34.

The findings included:

For the facility in general, it was reported in an anonymous complaint that the facility did not follow the menus and ordered pizza for Residents on 6/21/22, also during survey it was noted that Resident #34 received turkey sandwich instead of what was on his meal ticket and had some food items missing from his lunch tray.

On 7/5/22 at approximately 1:00 PM the Social Worker was interviewed and she stated that she was aware of the incident involving having to order pizza for Residents. She stated that the allegation was true and that she was present at the time. She stated that the Acting Administrator was called in and he called a sister facility to get a kitchen staff member to prepare the puree foods and he then ordered pizza for the Residents who could eat regular consistency.

On 7/7/22 at approximately 9:00 AM an interview was conducted with Resident # 34 who stated "Oh yeah last month we had pizza from a restaurant because they didn't have enough staff to cook."

On 7/7/22 at approximately 9:15 AM an interview was conducted with Resident # 83 who stated that she felt one slice of pizza, a cookie and some juice was not sufficient

On 7/7/22 at approximately 10:15 an interview was conducted with Employee Q (Regional

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F 803	Continued From page 66	F 803		

Administrator) who stated that on 6/21/22 he was called by the facility staff to inform him that only 2 dietary staff had shown up for work, no cook had shown up. Employee Q stated that he called employee D (the Regional Dietary Manager) and told him "We have to get these folks fed." He stated that he also called Employee J, the cook from the sister facility in close proximity, and that employee J the facility to prepare the puree diet for the residents that could not eat regular consistency, and he ordered pizza from a local restaurant for those with regular consistency diets.

On 7/7/22 at approximately 10:45 Employee J, the Cook from the sister facility was interviewed and he stated that on 6/21/22 he did receive a call asking him to come to this facility to prepare puree foods for those who could not eat pizza. When asked what he prepared he stated they were given pureed herb chicken, pureed mixed veggies, mashed potatoes and applesauce..

On 7/11/22 at approximately 1:00 PM while speaking with Resident #34 the CNA came in to bring his lunch tray. The CNA knocked on the door announced herself and set the tray on the table asked the Resident if he needed anything else and then left the room. Resident # 34 looked at his tray and said " Why do they give me turkey sandwiches when I don't eat the fake turkey roll they serve I only eat real turkey carved from a turkey not the deli meat."

A review of the Resident's lunch ticket revealed that Resident #34 was supposed to receive herbed chicken breast, sauteed spinach with garlic, whipped sweet potatoes, dinner roll and margarine, pineapple tidbits and coffee and 16 oz

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F 803	Continued From page 67 whole milk. The tray contained 8 oz whole milk, no coffee, no herbed chicken. The vegetable, the potato, the pineapple and the dinner roll were all on the tray along with the cold turkey sandwich. The Resident asked the CNA to please ask the kitchen for a Tomato Sandwich with mayonnaise which was provided at 1:30 PM. On 7/11/22 at approximately 3:00 PM an interview was conducted with Employee X (the Dietary Manager) who stated that Resident #34 has an extensive list of likes and dislikes. She stated it is hard to know what he likes and it can vary from day to day. A review of the dietary preferences did reveal that the Resident does not like turkey sandwiches. During the end of day meeting on 7/13/22 the Interim Administrator was made aware and no further information was provided.	F 803		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation the facility was not administered in a	F 835		

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F 835	Continued From page 68 manner that enabled it to use it's resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This has the potential to affect all residents. The Directors and Officers of the facility's parent company knew of the absence of leadership in the facility, as the Regional Administrator had been tasked with assisting in the capacity of Administrator for 2 buildings and they did not act to allocate effective full time leadership to the facility. The findings included; On 7-5-22 Staffing schedules were requested for the week, and were reviewed each day. A tour of the entire building to ascertain all staff currently providing care to the Residents and working during the shift was conducted on 7-5-22. The census on this day was 143 Residents. There was no Administrator, no Infection Preventionist (IP), nor Director of Nursing (DON), and no MDS (Minimum Data Set)/care plan Coordinator present. Nursing staff were interviewed during initial tour and asked who the Administrator, DON, IP, and MDS Coordinators were for the building. All answered that none of those positions were filled and that Employee Q (name) was the only one they had seen, and that had been seldom as he only came a couple times per week because his facility and home were hours away from this facility. There was an Assistant Director of Nursing present (ADON) on 7-5-22 who stated she was	F 835	1. The Executive Director began employment on 8/1/2022. A full time Social Service Director has been hired . A full time Minimum Data Set Coordinator has been hired. The Director of Clinical Services position is currently being interviewed for. The facility has identified an RN that will serve as the Infection Preventionist and will complete the Infection Preventionist training. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Regional Administrator of open administrative positions. 3. The Executive Director was re-educated by the Regional Administrator related to the regulations surround the allocation of resources to ensure the highest practicable well-being for all residents. The Executive Director will report all open administrative positions and the plan to recruit/ replace on a weekly basis to the Regional Administrator. 4. The Regional Administrator to conduct quality monitoring of open administrative positions, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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very new to the role and facility, and had worked there less than a month, and was "getting to know the residents and facility." She continued to say that she was "not acting as the Director of Nursing in an interim capacity." She stated that there was no Director of Nursing at that time, nor Administrator, but that the "Administrator of a sister building was helping out a couple days a week." The ADON directed surveyors to talk with the Social Worker "who can tell you more, I just don't know".

The Social Worker was also interviewed on 7-5-22, and stated it was her last week to work, as she was working out her notice, and that she had resigned her position with the facility. The Social Worker stated there was no Administrator, no DON, no MDS Coordinator, and no IP. She stated they all left about the same time which was "Weeks ago."

The Area Ombudsman came to the conference room on 7-5-22 to talk with surveyors about her concerns of no administrative personnel in the building, and restated that there was no full time Administrator, DON, nor IP in the building for weeks, as she had visited several times for resident advocacy issues regarding staff guidance and lack of leadership, and found no one in charge to discuss the incidents with.

Human resources records, and state agency records were reviewed and documented that the Administrator of record (Employee Administrator) had started immediately after the resignation of the former Administrator (before 6-14-22), as the previous Administrator was documented as having become the Administrator of record at another facility. This was incorrect. Interviews

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with the facility staff, ADON, Social Worker, and Ombudsman, as well as the Regional Administrator (Employee Q) confirmed that the Administrator of record had not yet been in the facility and was on "vacation until 8-1-22, when he would join the facility on a full time basis."

Employee Q stated that there had been several Administrators assisting during this time, however, all of the other interviews stated no one with the exception of employee Q had acted as an Administrator since the former Administrator left. Employee Q stated he was the Administrator of record for a sister facility 2 hours from this facility, and came a few days a week to help since there previous Administrator left.

Employee Q indicated there was no DON, nor IP at the time of survey, however, that a sister facility was going to share a DON next week, and an MDS Coordinator was already being shared as there also was not an MDS Coordinator for the facility. He went on to state that the IP position was going to be filled temporarily by the Corporate IP professional until an IP could be hired.

On 7-7-22 an interview was requested with the Social Worker. Employee Q stated that the Social worker was "as of yesterday no longer employed by the facility". When surveyors asked why the termination and early departure as the Social Worker had self scheduled for 2 more days, no answer was given.

On 7-11-22 the Administrator of record entered the position, building, and survey.

On 7-12-22 The social worker from a sister facility

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F 835	Continued From page 71 (Employee T) was present during survey, and upon interview stated she was joining the facility from a sister facility to "help out for 2 or 3 days a week" until a replacement could be found. She was asked if she was familiar with the resident population and she stated "no, and stated that she was "fairly new with the sister facility as well." The former Social Worker had given a 2 week notice of resignation, yet no replacement had been obtained, and she was not allowed to work out her notice. The sharing of Social workers between facilities with 120 beds is not permitted by federal regulation. Both facilities had greater than 120 beds. From 7-6-22 through 7-14-22 at the time of survey exit, the facility had no full time Social Worker. In conclusion, the lack of sufficient and competent staffing, and leadership, resulted in the outcome of a "Substandard Level of Care" finding. Extensive other deficiency findings were cited and an extended survey ensued for multiple system failures which impacted the delivery of care and services to the resident population in a negative manner. On 7-13-22 and 7-14-22 at the end of day debrief, the Regional Administrator and newly started facility Administrator, were made aware of the findings. No further information was submitted by the facility.	F 835		
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		

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F 842	Continued From page 72 (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	1. Resident #75's medical record will be reviewed and updated as indicated regarding their catheter status. 2. All residents with catheters have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Unit Managers of resident with catheters to ensure documentation in the medical record was accurate. 3. All licensed nurses were re-educated by the Director of Clinical Services/Assistant related to catheter documentation. The Interdisciplinary team will review the 24 hour documentation and physician orders in the AM clinical meeting to capture any changes with catheters and ensure that documentation surrounding catheters is accurate. 4. The Director of Clinical Services/Assistant to conduct quality monitoring of catheter documentation, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	8/25/2022

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§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 observation, interview, clinical record review and facility documentation the facility staff failed to maintain accurate clinical records for 2 Residents (#'s 75) in a survey sample of 48 Residents.

The findings included:

For Resident # 75 the facility staff failed to maintain accurate and consistent information on catheter.

On 7/6/22 at approximately 11:45 AM an interview

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F 842	Continued From page 74	F 842		

was conducted with Resident #75 when asked if she has had her catheter since admission. The resident stated she had gotten the catheter at the hospital prior to admission. Observation was made of Resident with Foley Catheter in privacy bag attached to wheelchair.

On 7/6/22 during clinical record review it was noted that Resident #75 has had an indwelling catheter since admission for a diagnosis of neurogenic bladder. Excerpts from skilled nurses notes are as follows:

5/24/22 at 402 AM"Catheter is not noted"
5/25/22 at 2:31 PM "Catheter is in dwelling
5/25/22 at 7:05 PM "Catheter not noted"
5/25/22 at 9:30 PM "Catheter not noted"
5/26/22 at 3:30 AM "Catheter not noted"
5/26/22 at 10:36 AM "Catheter is indwelling"
5/26/22 at 6:36 PM "Catheter not noted"
5/27/22 at 6:43 AM "Catheter not noted"
5/27/22 at 12:43 PM "Catheter not noted"
5/28/22 at 12:39 PM "Catheter not noted"
5/28/22 at 11:40 PM "Catheter is indwelling"
5/29/22 at 2:40 AM "Catheter in dwelling draining yellow urine no signs or symptoms of infection noted"

This documentation continues on through June and July as well with some shifts and nurses writing "Catheter not noted," and others writing "Catheter is indwelling."

On 7/11/22 at 10:00 AM an interview was conducted with RN B who stated that Resident #75 has had an indwelling Foley Catheter since admission. When asked about the documentation she stated that it was inaccurate

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F 842	Continued From page 75 On the morning of 7/12/22 during clinical record review of Resident # 75 it was discovered that the Resident had been admitted with wounds from the hospital. The Residents weekly skin assessments had not been accurately completed, and there were only 2 notes by the wound physician in spite of the fact that the wound physician clearly wrote in the notes that Resident #75 was to be seen weekly by the wound physician. On 7/14/22 after requesting all wound documentation and a timeline of progression of wounds Employee N stated that since she had only been there for 2 days she had not been able to locate the former wound nurse's notes or tracking. She stated that since the wound nurse quit, the DON and the ADON had only been employed for a short time, she did not feel the documentation was consistent with regards to wound care. On 7/14/22 during the end of day meeting the Interim Administrator was made aware of concerns and no further information was provided,	F 842		
F 850 SS=F	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2) §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special	F 850		

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F 850	Continued From page 76 education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and in the course of a complaint investigation, the facility failed to ensure employment of a qualified Social worker on a full time basis. This has the potential to affect all residents. This is Substandard Quality of Care. The Facility failed to provide a full time Social worker for the second week of survey, and planned to use another facility's Social worker to "help out 2-3 days per week." The Findings included: The Social Worker was interviewed on 7-5-22, and stated it was her last week to work, as she was working out her notice, and that she had resigned her position with the facility. On 7-7-22 an interview was requested with the Social Worker. Employee Q stated that the Social worker was "as of yesterday no longer employed by the facility". When surveyors asked why the termination and early departure as the Social Worker had self scheduled for 2 more days, no answer was given. On 7-12-22 The social worker (Employee T) from a sister facility, which had greater than 120 beds, was present during survey, and upon interview	F 850	1. A full time Social Service Director has been hired. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. The Executive Director was re-educated by the Regional Administrator related to ensuring the facility maintains the employment of a full time, qualified social worker. 4. The Regional Administrator to conduct quality monitoring to ensure a full time qualified social worker is in place, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	8/25/2022

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F 850	Continued From page 77 stated she was joining the facility from a sister facility to "help out for 2 or 3 days a week" until a replacement could be found. She was asked if she was familiar with the resident population and she stated "no, and stated that she was "fairly new with the sister facility as well." The former Social Worker had given a 2 week notice of resignation, yet no replacement had been obtained, and she was not allowed to work out her notice. From 7-6-22 through 7-14-22 at the time of survey exit, the facility had no full time Social Worker. On 7-13-22 and 7-14-22 at the end of day debrief, the Regional Administrator and newly started facility Administrator, were made aware of the findings. No further information was submitted by the facility.	F 850		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	and update their infection control line listing as indicated to include those infections that developed in May, June, and July. The facility will maintain an Infection Control program consistent with guidance from the CDC and in accordance with the Covid-19 Pandemic Plan. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant, of infections and antibiotic, antimicrobial use during the months of May, June and July and reviewed these with the medical team to determine if there is any needed medical follow up.	8/25/2022

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F 880	Continued From page 78 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	3. Director of Clinical Services/Assistant/Unit Managers will be re-educated by the Regional Director of Clinical Services related to Infection Control, The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted and following accepted national standards; Written standards, policies, and procedures for the program, which must include, but are not limited to: A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; When and to whom possible incidents of communicable disease or infections should be reported; Standard and transmission-based precautions to be followed to prevent spread of infections; When and how isolation should be used for a resident; including but not limited to: The type and duration of the isolation, depending upon the infectious agent or organism involved, and A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease;	

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F 880	Continued From page 79 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility documentation review, and clinical record review, the facility staff failed to maintain an infection prevention and control program for the prevention, identifying, reporting, and investigating infections. The findings included: 1. The facility staff failed to maintain an infection prevention and control program to include infection surveillance, infection investigation and system to prevent the development and transmission of communicable diseases within the facility. On 7/12/22 at 8:09 AM, the facility administration was asked to provide the survey team with evidence of infection surveillance logs/line listing (for COVID and non-COVID infections) Jan-July 2022. On 7/12/22 at approximately 11 AM, a video call was conducted with the facility interim Infection Preventionist (IP)/Employee N, who was also the Corporate Clinical Consultant. During this video	F 880	and The hand hygiene procedures to be followed by staff involved in direct resident contact. A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. All Licensed nurses will be educated by the Director of Clinical Services/Assistant to the symptom tracking tool and their expectation to use each shift to track resident/staff symptoms that may require follow up. Which will be completed by 8/12/2022 All licensed nurses will be educated by the Director of Clinical Services/Assistant to the infection surveillance logs and their expectation to use each shift to track resident/staff infections. Which will be completed by 8/12/2022 The Infection Preventionist and nursing leadership will be educated on maintaining infection surveillance logs. This education will be provided by the Regional Director of Clinical services and competency will be validated by the Medical Director-this will be completed by 8/12/2022.	

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F 880	Continued From page 80 call the IP was asked to show evidence of the infection line listing and she said, "I'm having difficulty finding it". When asked about their COVID infections and recent outbreaks, Employee N had difficulty providing details on when and who had tested positive for COVID-19. On 7/12/22 at 4:20 PM, another video call was held with the IP and Surveyor F. Also present was the facility Administrator and Regional Administrator. The IP stated, "I found the binder and they did not keep it current, we are in the process of doing June's now, we are trying to catch it up". For the infection line listing, the IP showed Surveyor F that the line listing ended on 5/20/22. The facility staff confirmed that they had COVID cases in June as well as July and were currently in outbreak but that the infections were not currently being tracked/surveilled, investigated, etc. The IP confirmed that the previous IP had left around June 23-26, and she assumed the role of interim IP on 6/26/22. The IP further confirmed that prior to her arrival at the facility this week (week of survey) she had been "overseeing from a distance", and was not aware that infection surveillance, tracking, etc. had not been maintained. When asked what is the purpose and importance of infection line listings and surveillance, etc. the IP said, "We need to be keeping a line listing so we can track and trend and identify if we have an issue. Ideally Monday through Friday when they go through the orders during clinical meeting they should be discussing infections and adding to the line listing. In June it wasn't done. We are having to run a report of antibiotics and	F 880	The Interdisciplinary team will review physician orders, 24 hour documentation and lab reports in the AM clinical meeting to capture any new infection or antibiotic/antimicrobial use for incorporation into the facility line listing for accurate follow up. The Infection Preventionist/designee will review the symptom tracking log and infection surveillance for compliance and follow up daily and PRN 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of infection control line listing, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	8/25/2022

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F 880	Continued From page 81	F 880		

treatments prescribed in June to try to catch it up. We should be investigating infections, if you are trying to catch it up at the end of the month you are missing the boat, it is a living document".

A review of the facility policy titled, "Policies and Practices- Infection Control", was conducted. This policy read, "...2. The objectives of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility..."

The facility policy titled, "Monitoring Compliance with Infection Control" was received and reviewed. This policy stated, "Routine monitoring and surveillance of the workplace are conducted to determine compliance with infection prevention and control policies and practices. 1. The infection preventionist or designee monitors the compliance and effectiveness of our infection prevention and control policies and practices. 2. Monitoring includes regular surveillance of adherence to hand hygiene practices and availability of hand hygiene supplies, and the availability of personal protective equipment and its appropriate use..."

The policy titled, "Surveillance for Infections" was received and reviewed. This policy read, "1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections... Gathering Surveillance Data: 1. The infection preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data...5. In addition to collecting data on the incidence of infections, the

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F 880	Continued From page 82 surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted..." On 7/12/22 and again on 7/13/22, the facility Administrator, Corporate Clinical Consultant/IP, and Regional Administrator were made aware of the findings that they did not have an ongoing infection prevention program. No further information was provided.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to maintain an ongoing antibiotic stewardship program to monitor the use of antibiotics which had the ability to impact numerous Residents throughout the facility on all nursing units/resident care units. The findings included: On 7/12/22 at 8:09 AM, a request was made for the facility administration to provide the survey	F 881	1. The facility will review and update the antibiotic surveillance tracking as indicated per facility policy/procedures. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant of antibiotic use for the months of May, June and July and will be reviewed with the medical team for follow as needed. These medications will also be logged on the antibiotic surveillance tracking as indicated. 3. Director of Clinical Services/Assistant/Unit Managers/wound nurse will be re-educated by the Regional Director of Clinical Services/designee related to Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. The Interdisciplinary team will review physician orders, 24 hour documentation and lab reports in the AM clinical meeting to capture any new infection or antibiotic/antifungal use for incorporation into the antibiotic surveillance tracking for accurate follow up.	8/25/2022

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F 881	Continued From page 83	F 881	4. The Director of Clinical Services/Regional Director of Clinical Services to conduct quality monitoring of antibiotic surveillance tracking, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

team with, "the Antibiotic surveillance tracking from Jan-July, 2022".

On 7/12/22 at approximately 11 AM, a video call was conducted with the facility interim Infection Preventionist (IP)/Employee N, who was also the Corporate Clinical Consultant. The IP stated, "I have gone through the binders and can't find antibiotic surveillance, I will keep looking for it". The IP was asked to provide the infection line listing, which was noted in the facility policy. The IP again said, "I'm having difficulty finding it".

On 7/12/22 at 4:20 PM, another video call was held with the IP. She stated, "I did locate the binder and they did not do antibiotic surveillance/infection investigations for June, we are in the process of catching it up". When asked what the purpose of an antibiotic stewardship program is and the importance, the IP said, "We need to keep a line listing so we can track and trend and identify if we have an issue. We need to look at antibiotics, are we prescribing in the right way, is the treatment appropriate and make sure we don't have poor practices- we review in QA (quality assurance) and with the doctors, you don't want to prescribe unnecessarily- there are a lot of purposes for keeping a log. If you try to catch up at the end of the month you are missing the boat".

Review of the facility policy titled, "Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes", was conducted. This policy read, "1. As part of the facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. 2. The IP, or designee, will review antibiotic

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F 881	Continued From page 84 utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics.... 3. At the conclusion of the review, the provider will be notified of the review findings. 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form..." On 7/12/22 and again on 7/13/22, the facility Administrator, Corporate Clinical Consultant/IP, and Regional Administrator were made aware that the facility had failed to provide evidence of an ongoing antibiotic stewardship program. No further information was provided.	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control.	F 882	1. The facility has identified an RN that will serve as the Infection Preventionist and will complete the Infection Preventionist course. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. Executive Director and Director of Clinical Services will be re-educated by the Regional Director of Clinical Services related to Infection Preventionist and all subparts will be implemented beginning November 28, 2019. The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	8/25/2022

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F 882	Continued From page 85 §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review, the facility staff failed to have a designated individual to serve as the Infection Preventionist (IP) which has the potential to affect all 143 Residents residing in the facility. The findings included: On 7/5/2022, the Regional Administrator reported to the survey team that the Infection Preventionist for the facility had quit. He (the Regional Administrator) said they were going to get the Corporate Clinical Consultant (nurse consultant) to fill in, but she was on vacation that week. On 7/11/22, the facility's interim Administrator and Regional Administrator stated that Employee N/Corporate Clinical Consultant is serving as the facilities interim Infection Preventionist. On 7/12/22 at 10:10 AM, an interview was conducted with Employee N/the Corporate Clinical Consultant/interim Infection Preventionist. Employee N stated, "This was not one of my assigned buildings, I just took it over the first of June. [Previous Infection Preventionist name redacted] was here then, she left about 3 weeks ago. The Assistant Director of Clinical Services (also known as the Assistant Director of Nursing)	F 882	; be qualified by education, training, experience or certification; Work at least part-time at the facility; and Have completed specialized training in infection prevention and control. IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. The Executive Director will report to the Regional Administrator and Regional Director of Clinical Services with any new vacancy in the Infection Preventionist role with plans to recruit and replace. 4. The Executive Director/Regional Administrator to conduct quality monitoring of Infection Preventionist position status weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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doesn't have a lot of experience in infection control and hasn't done the training yet, but she will become the infection preventionist".
Employee N was asked if she works at the facility on a full-time or part-time basis and she said, "No, I've just been overseeing it from a distance. I was here two days in June to on-board a new DCS (director of clinical services/director of nursing) but she is gone now. Week before last I was in another facility who was in survey and I was on vacation last week, so yesterday I would have been here anyway".

Review of the facility's job description for the Infection Preventionist revealed the following as "Duties and Responsibilities": ..."2. Oversight of the IPCP to include:
a. Preventing, identifying, controlling, reporting and investigating infections and communicable diseases for all residents, staff and visitors of the centers following local, state and national guidelines as well as recognized best practices.
b. Education, enforcement and reinforcement of the written standards of the program as outlined in the Infection Control Policies and Procedures and as directed by the center Infection Control Program Risk Assessment.
c. Maintain a system of surveillance to identify and prevent spread of infections to other persons within the center.
d. Appropriately report communicable disease to the local, state and federal authorities as directed by regulation and law.
e. Identify, enforce, observe, and reinforce appropriate transmission based and standard precautions within the center.
f. Monitor the appropriate use of isolation within the center to reduce the risk of spread based on the organism and type of infection using the least

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F 882	Continued From page 87	F 882		

restrictive measures possible to maintain the resident's highest level of practicable well-being.....
5. Record, track and trend surveillance and investigation of infections; and actions taken to prevent and control spread of infections and report to center QAPI committee
6. Conduct, record and report on outbreak investigations and the actions taken to mitigate spread of infection.
7. Oversee the center antibiotic stewardship program and monitor resident and physician/extenders use of antibiotics
8. Track and trend organisms within the center based on lab reporting. Report any trending to Medical Director, Director of Nursing and QAPI committee."

The Centers for Disease Control and Prevention (CDC) gives the following recommendations in their document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes: It read, "...Infection Prevention and Control Program. Assign One or More Individuals with Training in Infection Prevention and Control to Provide On-Site Management of the IPC Program. This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the IPC risk assessment". Accessed online 7/13/22, at web address: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

During the course of the survey it was determined

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F 882	Continued From page 88 that the facility's lack of an infection preventionist resulted in the facility not tracking or surveilling for infections, investigating infections, conducting outbreak investigations, or implementing the antibiotic stewardship program. The facility was in an active COVID outbreak and continued to identify new COVID cases during the survey. On 7/13/22, during a meeting with the facility interim Administrator, Corporate Clinical Consultant and Regional Administrator, they were made aware of the above findings. No further information was received prior to the end of survey at 5:45 PM, on 7/14/22.	F 882		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883	1. Resident #121 will be offered the pneumonia vaccine and will be offered a flu vaccine when flu season opens. Resident #23 will be offered a flu vaccine when flu season opens. Resident #140 will be offered the pneumonia vaccine and will be offered a flu vaccine when flu season opens. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant of resident's current vaccination status regarding flu and pneumococcal vaccines. 3. All licensed nurses were re-educated by the Director of Clinical Services/Assistant related to Influenza and pneumococcal immunizations Influenza. The facility must develop policies and procedures to ensure that- Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	8/25/2022

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F 883	Continued From page 89 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to implement their immunization policy and ensure each Resident is offered influenza and	F 883	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; The resident or the resident's representative has the opportunity to refuse immunization; and The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. Pneumococcal disease. The facility must develop policies and procedures to ensure that- Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; The resident or the resident's representative has the opportunity to refuse immunization; and The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. The Interdisciplinary team will review new admissions in AM meeting and review their vaccination status. During this time they will ensure that consents/declinations and orders are obtained and vaccination provided as indicated with supporting documentation in the medical record.	

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F 883	Continued From page 90 pneumococcal immunization, for 3 Resident (Resident #121, 23, 140), in a sample of 5 Residents reviewed for immunizations. The findings included: On 7/11/22 and 7/12/22, clinical record reviews were conducted for the sampled Residents with regards to immunization for flu and pneumonia. This review revealed the following: 1. Resident #121 had been admitted to the facility on 5/26/22. On the immunization tab of the electronic health record (EHR) it read, "No immunizations found". Review of the misc. (miscellaneous) tab, assessment tab, and progress notes revealed no evidence of vaccine administration or offering of such. There was a document scanned into the EHR on the misc. tab that was titled, "COVID vaccines no record". This document was reviewed and contained immunization information accessed from VIIS (Virginia Immunization Information System) which revealed Resident #121 had not received any doses of the flu or pneumonia immunizations. Review of the Medication Administration Records (MAR) revealed no evidence of the flu or pneumonia immunization being provided to Resident #121. 2. Resident #23 had been admitted to the facility on 2/10/22, during flu season. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the flu vaccine status of Resident #23. Physician orders revealed an order that read, "Flu vaccine annually". Review of the misc. (miscellaneous) tab, assessment tab, and	F 883	4. The Executive Director/Director of Clinical Services to conduct quality monitoring of vaccination compliance, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	

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F 883	Continued From page 91	F 883		

progress notes revealed no evidence of vaccine administration or offering of such. Review of the "admission agreement" that had been scanned into the EHR under the miscellaneous tab revealed that Resident #23 had consented to receive the flu vaccine. Review of the Medication Administration Records (MAR) revealed no evidence of the flu immunization being provided to Resident #23.

3. Resident #140 had been admitted to the facility on 2/21/22, which was during flu season. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the pneumonia or flu vaccine status of Resident #140. Review of the misc. (miscellaneous) tab, assessment tab, and progress notes revealed no evidence of vaccine administration or offering of such. Review of the "admission agreement" that had been scanned into the EHR under the miscellaneous tab revealed that Resident #140 had consented to receive the flu vaccine. Review of the Medication Administration Records (MAR) revealed no evidence of the flu or pneumonia immunization being provided to Resident #140.

On 7/12/22, an interview was conducted with Employee N, the Infection Preventionist (IP)/Corporate Clinical Consultant. The IP was asked to explain the process when a Resident is admitted, with regards to immunizations. The IP said, "When a Resident is admitted we should get their immunization status, ideally we should document in [name of the EHR software redacted], sometimes we have to go back and research and the nurse doesn't always enter it. During flu season we get authorization when they

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F 883	Continued From page 92	F 883		

come in, see their pneumonia status and if eligible we offer it to them".

Employee N was asked where all of the immunization information such as education and offering of a vaccine get documented. Employee N said, "The consent should be scanned into the miscellaneous file and additionally 1 or 2 things happen, we scan the vaccine information sheet and check the box on the immunization tab that they were educated".

During the above interview with the IP/Employee N, she was asked to access the EHR for Resident #121. She observed and confirmed the immunization tab had no data recorded. She reviewed the misc. tab and nursing notes and confirmed there was no information in the EHR. Employee N then accessed Resident #23 and #140's EHR and confirmed the above findings that no information was available to indicate they had been educated on or offered the immunizations.

Review of the facility policy titled, "Pneumococcal Vaccine" was conducted. This policy read, "...1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission..."

The facility policy titled, "Influenza, Prevention

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F 883	Continued From page 93 and Control of Seasonal" was reviewed. This policy was noted to read, "...Vaccination. 1. The Infection Preventionist organizes and oversees an annual influenza vaccine campaign. 2. All residents and staff are offered the vaccine unless there is a medical contraindication..." On 7/12/22 and again on 7/13/22, the facility interim Administrator, Assistant Director of Nursing and Infection Preventionist/Corporate Clinical Consultant were made aware of the above findings. No further information was provided prior to the conclusion of the survey on 7/14/22. Complaint related deficiency.	F 883		
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents,	F 885	1. The facility will provide notification to residents/RPs with covid-19 positive cases or with the development of 3 respiratory cases within 72 hours as indicated. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will conducted by the Executive Director/Social Service Director of notification of residents/RPs for covid-19 positive cases or 3 cases of respiratory symptoms within 72 hours from 8/4/2022 forward. 3. Executive Director and Social Service Director will be re-educated by the Regional Administrator related to the facility must— Electronically report information about COVID-19 in a standardized format specified by the Secretary. This report must include but is not limited to-- Suspected and confirmed COVID-19 infections among residents and staff, including residents previously treated for COVID-19;	8/25/2022

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F 885	Continued From page 94 their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to notify Residents and families when new cases of COVID-19 were identified in the facility, affecting all 143 Residents residing in the facility. The findings included: On 7/12/22 at 8:09 A.M., a request for "Evidence of Resident and family notifications of COVID cases and the weekly communication for May, June and July" was made. On 7/12/22 at 10:40 AM, the facility provided the survey team with evidence of automated calls being made to Resident's families on 6/10/22, for notification of a COVID case identified on 6/9/22. On 7/12/22 at approximately 11 AM, during a video call with the Corporate Clinical Consultant/Interim Infection Preventionist (IP). The IP identified that on 5/30, 6/6, 6/13, and 6/20 the facility was in outbreak. She also stated that on 7/4/22, a Resident tested positive for COVID-19, which placed the facility back into an outbreak status. On 7/13/22, the facility staff provided an infection surveillance log with the last entry being 5/20/22, where a staff member tested positive for	F 885	Total deaths and COVID-19 deaths among residents and staff; Personal protective equipment and hand hygiene supplies in the facility; Ventilator capacity and supplies in the facility; Resident beds and census; Access to COVID-19 testing while the resident is in the facility; Staffing shortages; and Other information specified by the Secretary. Provide the information specified in paragraph of this section at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention's National Healthcare Safety Network. This information will be posted publicly by CMS to support protecting the health and safety of residents, personnel, and the general public. Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— Not include personally identifiable information; Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. The Interdisciplinary team will notify the Executive Director/Social Service Director with each new positive covid-19 case or 3 respiratory symptom cases that require reporting to residents/RPs. They will then verify that notification has been initiated per the regulation.	

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F 885	Continued From page 95 COVID-19. The facility was in an active COVID outbreak and continued to identify new COVID cases during the survey. On 7/13/22 at 10:44 AM, the facility administration was made aware that evidence of Resident and family notification for the identification of COVID cases in May and July was still outstanding. They stated, "That is all I can show, we have no other documentation". Review of the facility policy titled, "COVID-19 - Pandemic Plan" with a revision date of 3/11/22, was conducted. This policy read, "...35. Residents and resident representatives will be notified: * By 5pm the next calendar day following the occurrence of either a single confirmed infection of COVID-19 OR three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other; * Cumulative update weekly OR by 5pm the next calendar day following the subsequent occurrence of each confirmed infection of COVID-19 or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other * Notification must include: mitigating actions implemented to prevent or reduce the risk for transmission, and changes in normal operations at the facility but not include personally identifiable information..." On 7/13/2022, the interim administrator, Corporate Clinical Consultant/Infection Preventionist and Regional Administrator were made aware of the above findings.	F 885	4. The Regional Administrator to conduct quality monitoring of notification of positive covid-19 cases or respiratory symptom cases to residents/ RPs, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/ Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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F 885	Continued From page 96 No further information was submitted prior to the end of survey at 5:45 PM on 7/14/22.	F 885		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this 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;	F 886	1. The facility will conduct Covid-19 testing in accordance with CDC guidance. The facility will also test residents/staff who present with covid-19 symptoms as indicated. RN B was educated verbally by the Regional Director of Clinical Services on 7/11/2022 regarding testing requirements and what to do if she could not locate testing supplies. Resident #83 was tested on 7/11/2022. Residents: #46, 23 and 92 will be tested in accordance with CDC guidance. Employees: K, CNA J, RN C, LPN C, C, L, CNA K, LPN E and M will be tested in accordance with CDC guidance. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant of the most recent testing episode in the facility to determine testing as required. Additionally a quality review will be conducted of admissions beginning 8/4/2022 in the AM meeting to determine testing as required. A quality review will be completed by the Director of Clinical Services/Assistant of the 24 hour documentation in the AM meeting beginning on 8/4/2022 to determine if any residents presented with any symptoms that warranted covid-19 testing. 3. Licensed nurses will be re-educated by the Director of Clinical services/Assistant related to 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:	8/25/2022

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F 886	Continued From page 97 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: 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 4 Residents (Residents #46, #23, #92, and #83) in a sample of 5 Residents reviewed for testing and for 9 staff (Employee K, CNA J, RN C, LPN C, Employee C, Employee L, CNA K, LPN E, and Employee M) in a sample of 9 employees reviewed for COVID	F 886	Conduct testing based on parameters set forth by the Secretary, including but not limited to: Testing frequency; The identification of any individual specified in this paragraph diagnosed with COVID19 in the facility; The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; The response time for test results; and Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; For each instance of testing: Document that testing was completed and the results of each staff test; and Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. 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. Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. 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. During testing the clinical team will validate that residents requiring testing were completed by utilizing a resident census and comparing test results against census.	

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F 886	Continued From page 98 testing. The findings included: 1. For Residents #46, #23, and #92, the facility staff failed to conduct COVID-19 testing upon their admission to the facility. On 7/11/22 and 7/12/22, a clinical record review was conducted and revealed the following: 1a. Resident #46 was readmitted to the facility on 5/6/22. Resident #46 was not tested for COVID until 5/9/22. 1b. Resident #23 had been readmitted to the facility on 6/26/22. The first instance of COVID testing for Resident #23 following readmission was 7/4/2022. Resident #23 had been tested in the hospital on 6/17/22. 1c. Resident #92 was admitted to the facility on 6/4/22. There was no evidence in the clinical chart of Resident #92 that he/she had been tested for COVID-19 at the facility until 7/4/22. On 7/12/22, a video call was conducted with the facility Interim Infection Preventionist (IP)/Employee N. When asked about COVID testing of admissions, she stated, "When admitted they are tested upon admission then again on day 5-7". When asked if they accept testing conducted at the hospital in lieu of being tested in the facility upon admission, the IP said, "No, we shouldn't be, if it is a few days old then we can't accept the hospital test". The IP confirmed that the facility has a pandemic plan which is based upon CDC guidance, which they follow.	F 886	During testing the clinical team will validate that staff requiring testing were completed by utilizing a staff roster/exemption tracking log and test results against lists. The Interdisciplinary Team will review the 24 hour documentation in the AM meeting to determine if any resident presents with covid-19 symptoms that may require testing. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of testing logs, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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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". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

The facility policy titled, "COVID-19 - Pandemic Plan" with a revision date of 3/11/22, was reviewed. This policy read, "...13. New admissions/re-admissions: Newly admitted or re-admitted residents, regardless of their vaccination status will have a series of two viral COVID-19 test, immediately and if negative, again in 5-7 days after admission. Residents not up to date with all recommended COVID-19 vaccines (even those with a negative test upon admission) will be quarantined for 10 days (if they do not develop symptoms). Quarantine may be shortened to 7 days if the resident does not develop symptoms AND a viral test for COVID-19 is negative. The specimen will be collected and tested within 48 hours before planned discontinuation of TBP".

2. The facility staff failed to conduct COVID-19 testing of Resident #83, who reported COVID symptoms.

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On 7/11/22 at 2:45 PM, Surveyor B was informed by Resident #83 that she has had cold symptoms since Friday, 7/8/22. During the interactions Surveyor B observed Resident #83's voice was hoarse and it hard for the Resident to talk. Resident #83 reported that she did not get COVID tested yet and she was concerned since she was supposed to be leaving on Friday (7/15/22). Resident #83 reported that the Nurse on duty (RN B) told her she did not have a test (COVID test) over the weekend and therefore could not perform the test.

On 7/11/22 at 3:00 PM, Surveyor B interviewed Employee N, the Interim Infection Preventionist (IP) who stated that she was unaware there was someone in the building that had COVID-like symptoms since Friday that had not been tested.

On 7/11/22 at 3:15 PM, Employee N reported back to Surveyor B that she had spoken to the Resident and the nurse (RN B) and that the nurse stated she could not find a test in the med room but did not call the supervisor or search elsewhere for the test.

On 7/12/22, a video call was conducted with Employee N/ the Interim IP. She was asked about Resident #83's report of COVID symptoms and she confirmed that the facility has an abundance of COVID tests and should have been tested when she/he reported symptoms. The IP stated that Resident #83 had now been tested. The IP confirmed that the facility has a pandemic plan which is based upon CDC guidance, which they follow.

Review of the CDC document entitled, "Interim Infection Prevention and Control

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Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, and was reviewed. This document read, "...Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible...". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

The facility policy titled, "COVID-19 - Pandemic Plan" with a revision date of 3/11/22, was reviewed. This policy read, "...6. Testing: Symptomatic testing: Test staff or residents who have signs or symptoms of COVID-19 (regardless of their vaccination status) i. Staff experiencing signs or symptoms should be excluded from work pending results. If COVID-19 test is positive refer to the Employee Health section of this plan
ii. Residents experiencing signs or symptoms are placed on transmission-based precautions pending test results.
Note: Follow CDC Guidance on interpretation of Antigen testing- If the patient is asymptomatic and the antigen test is positive confirm with PCR If the patient is symptomatic and the antigen is negative confirm with a PCR...".

3. The facility staff failed to conduct routine and outbreak testing of for 9 staff (Employee K, CNA J, RN C, LPN C, Employee C, Employee L, CNA K, LPN E, and Employee M) who were not vaccinated and/or up to date with COVID vaccines.

On 7/11/22 and 7/12/22, the facility submitted

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staff vaccination matrix was reviewed and a sample of employees was selected for review.

On 7/12/22, a video call was held with the Interim Infection Preventionist/Employee N. Employee N was given each of the employee's names and asked to provide evidence of COVID testing for the months of May, June and July.

Employee N reported the following as testing occurrences/dates: 5/23/22- routine testing, 5/30/22- outbreak testing, 6/6/22- outbreak testing, 6/13/22- outbreak testing, 6/20/22- outbreak testing, 6/27/22- routine testing, 7/4/22- outbreak testing, and 7/11/22- outbreak testing. Review of the facility submitted tracking of community transmission rates revealed the community rate of transmission had been high for the months of May, June and July. There was no evidence of routine testing for staff not up-to-date being conducted twice weekly as per the CDC recommendations and facility policy.

The findings were as follows for the specific staff members:

3a. Employee K, who was noted as having a religious exemption had evidence of COVID testing on 5/23/22, 6/27/22, and 7/11/22. Employee K's name was highlighted on the 7/4/22, listing of staff as having been tested but the facility staff had no evidence of Employee K's test results for that date of testing.

Employee K was missing testing occurrences on 5/30/22, 6/6/22, 6/13/22, 6/20/22, and 7/4/22.

3b. CNA J, was noted as having had a religious

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exemption. Testing occurrences were noted as: 5/23/22, 6/20/22, 6/27/22, and 7/11/22. CNA J's name was highlighted on the 7/4/22, listing of staff as having been tested but the facility staff had no evidence of CNA J's test results for that date of testing.

CNA J was missing testing occurrences on: 5/30/22, 6/6/22, 6/13/22, and 7/4/22.

3c. RN C, was noted as having had a religious exemption. Testing occurrences were noted as: 5/23/22, 6/20/22, 6/27/22, and 7/11/22. RN C's name was highlighted on the 7/4/22, listing of staff as having been tested but the facility staff had no evidence of RN C's test results for that date of testing.

RN C was missing testing on the following dates: 5/30/22, 6/6/22, 6/13/22, and 7/4/22.

3d. LPN C, was noted as having had a religious exemption. Testing occurrences were noted as: 5/23/22, 6/20/22, and 7/11/22. The Infection Preventionist reported that LPN C was on vacation the week of 7/4/22.

LPN C was missing testing on the following dates: 5/30/22, 6/6/22, 6/13/22, and 7/4/22.

3e. Employee C, who was not up-to-date with COVID vaccines was noted as having been tested for COVID-19 on 6/20/22, 7/4/22, and 7/11/22.

Employee C was missing testing on the following

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dates: 5/23/22, 5/30/22, 6/6/22, and 6/13/22.

3f. Employee L, who was not up-to-date with COVID vaccination, was noted to have COVID testing occurrences on the following dates: 6/20/22, 7/4/22, and 7/11/22.

Employee L was missing testing on the following dates: 5/23/22, 5/30/22, 6/6/22, 6/13/22, and 6/27/22.

3g. CNA K, who was not up to date with COVID immunizations, was tested on 6/20/22, 7/4/22, and 7/11/22.

CNA K was missing testing on the following dates: 5/23/22, 5/30/22, 6/6/22, 6/13/22, and 6/27/22.

3h. LPN E, who was not up to date with COVID immunizations was tested on: 6/20/22, 7/4/22, and 7/11/22.

LPN E was missing testing on the following dates: 5/23/22, 5/30/22, 6/6/22, 6/13/22, and 6/27/22.

3i. Employee M who was not up to date with COVID immunizations, was tested on: 7/4/22 and 7/11/22.

Employee M was missing testing on the following dates: 5/23/22, 5/30/22, 6/6/22, 6/13/22, 6/20/22, and 6/27/22.

On 7/12/22, during a video call with the facility

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Infection Preventionist she confirmed that there were multiple testing occurrences missing for staff as noted above. When the Surveyor notified the IP there was not evidence of twice a week testing for routine testing when not in outbreak, the IP said, "That's a fair statement to say".

On 7/12/22 at 4:20 PM, the facility Infection Preventionist stated she had found some additional testing information and provided evidence of LPN E, Employee C, LPN C, and CNA K being tested on 6/27/22. She stated she had no further information to provide.

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, "...In nursing homes, HCP who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, these HCP should have a viral test twice a week..." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

The facility policy titled, "COVID-19 - Pandemic Plan" with a revision date of 3/11/22, was reviewed. This policy read, "...6. Testing:...Outbreak Investigation: A single new case of COVID-19 infection in any staff or a nursing home -onset COVID-19 infection in a resident should be evaluated as a potential outbreak A resident admitted to a center with COVID-19 does not constitute a center outbreak.

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F 886	Continued From page 106 Testing should begin immediately, and the center can perform outbreak investigation using either, contact tracing or broad-base (e.g. facility -wide) testing (unless otherwise directed by the local health department)...Expanded Screening Testing of Asymptomatic Staff: Test all staff who are not up to date with the recommended COVID-19 vaccine doses based on the extent of the virus in the community, using the community transmission level available from the CDC. i. Centers should begin testing based on the community transmission level reported for the past week. ii. Center should monitor their community transmission level every other week and adjust the frequency of testing accordingly. Level of COVID-19 Community Transmission Minimum Testing Frequency, Staff Not Up to Date with ALL Recommended Vaccine Doses ONLY Low (blue)-Not Recommended; Moderate (yellow)- Once a Week; Substantial (orange)- Twice a week; High (red)- Twice a Week..." On 7/12/22 and again on 7/13/22, the facility Administrator, Assistant Director of Nursing, Corporate Clinical Consultant and Regional Administrator were made aware of the above findings. The Administrator confirmed the facility "should be" following CDC guidance. 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	F 887		

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F 887	Continued From page 107 facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (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	F 887	1. Resident #121 will be offered the covid-19 vaccine. Resident #23 will be offered additional information on the Jansen vaccine they received. Resident #140 will be offered the covid-19 vaccine. Resident #92 will be offered the covid-19 booster. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant of residents needing the covid-19 vaccine and/or booster. 3. All licensed nurses will be re-educated by the Director of Clinical Services related to The LTC facility must develop and implement policies and procedures to ensure all the following: 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; Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;	8/25/2022

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F 887	Continued From page 108 (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to offer COVID vaccination(s) to four Residents (Resident #121, 23, 140 and 92), in a sample of 5 Residents reviewed for immunizations. The findings included: 1. The facility staff failed to provide evidence that Resident #121 was offered, educated and provided/or declined COVID vaccination. Review of the facility submitted listing of Resident's COVID vaccination status revealed Resident #121 was not vaccinated for COVID-19. On 7/11/22 and 7/12/22, a clinical record review for Resident #121 was conducted. This review revealed the following: Resident #121 had been	F 887	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; 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. The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and Each dose of COVID-19 vaccine administered to the resident, or If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and The COVID-19 vaccine status of staff and related information as indicated by NHSN. The COVID-19 vaccine status of residents and staff, including total numbers of residents and staff, numbers of residents and staff vaccinated, numbers of each dose of COVID19 vaccine received, and COVID-19 vaccination adverse events; and Therapeutics administered to residents for treatment of COVID-19.	

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F 887	Continued From page 109 admitted to the facility on 5/26/22. On the immunization tab of the electronic health record (EHR) it read, "No immunizations found". Review of the misc. (miscellaneous) tab, assessment tab, and progress notes revealed no evidence of vaccine administration or offering of such. There was a document scanned into the EHR on the misc. tab that was titled, "COVID vaccines no record". This document was reviewed and contained immunization information accessed from VIIS (Virginia Immunization Information System) which revealed Resident #121 had not received any doses of the COVID vaccine. The progress notes for Resident #121 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 #121 being offered or educated on the benefit of immunization for COVID. Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #121. 2. The facility staff failed to provide evidence that Resident #23 was educated about the COVID vaccination. Review of the facility provided listing of Resident's vaccination status revealed Resident #23 had received one dose of the Janssen COVID vaccine on 2/9/22. On 7/11/22 and 7/12/22, a clinical record review for Resident #23 was conducted. This review	F 887	The Interdisciplinary team will review in AM clinical meeting any new admission And verify their covid-19 vaccination status. They will determine if a vaccine/booster is needed and obtain consent/declination as indicated. They will verify that with each vaccine/booster or declination that the medical record is updated with educational information provided 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of admission vaccination status and education with medical record documentation weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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revealed the following: Resident #23 was admitted to the facility on 2/10/22, with a readmission on 6/26/22. On the immunization tab of the electronic health record (EHR) there was documentation that Resident #23 received one dose of the COVID vaccine on 2/9/22.

All of the progress notes for Resident #23 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 #23 being offered or educated on the benefit of immunization for COVID.

Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #23.

3. The facility staff failed to provide evidence that Resident #140 was offered, educated and provided/or declined COVID vaccination.

On 7/11/22 and 7/12/22, a clinical record review for Resident #140 was conducted. This review revealed the following: Resident #20 was admitted to the facility on 6/11/22. On the immunization tab of the electronic health record (EHR) there was no documentation with regards to the COVID vaccine status of Resident #20.

All of the progress notes for Resident #140 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 #140 being offered or educated on the benefit of immunization for

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COVID.

Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #140.

4. The facility staff failed to provide evidence that Resident #92 was offered, educated and provided/or declined COVID booster vaccination.

On 7/11/22 and 7/12/22, a clinical record review for Resident #92 was conducted. This review revealed the following: Resident #20 was admitted to the facility on 6/20/22. On the immunization tab of the electronic health record (EHR) there was documentation that Resident #92 had received the primary vaccination series for COVID on 7/30/21 and 8/27/21, and was eligible for a vaccine booster.

All of the progress notes for Resident #92 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 #92 being offered or educated on the benefit of a COVID booster.

Review of the Medication Administration Records (MAR) and Treatment Administration Records (TAR), revealed no evidence of the COVID immunization being provided to Resident #140.

On 7/12/22, a video call was held with the Interim Infection Preventionist (IP)/Employee N. The IP confirmed that Resident immunizations are documented on the immunization tab of the electronic health record of each Resident. She

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stated that "Anyone we admit we have to know their COVID vaccination status and we offer immunizations and boosters if needed".

During the above video call Employee N accessed the EHR for each of the Residents (Resident #121, 23, 140 and 92) and confirmed that she saw no evidence within the clinical record of the Residents being offered COVID immunizations and/or booster doses.

Review of the facility policy titled, "COVID-19 Pandemic Plan" was conducted. This policy read, "...COVID-19 Vaccine. Residents, employees/contractors/community members will be offered the COVID-19 vaccine when vaccine supplies are available to the center...Vaccine emergency use authorization fact sheet will be provided and reviewed with the resident/resident representative, employee and community member (including the risk/benefit and potential side effects), Consent (including the screening questions) will be obtained, Monitor for allergic reaction post administration for 15 minutes up to 30 minutes for those with previous reaction to vaccines (per the CDC)
Residents: Obtain physician order, Document in the medical record, Monitor the resident for 72 hours post vaccine and document in the medical record..."

The facility policy titled, "COVID-19 Vaccination-Residents" was reviewed. This policy read, "1. COVID-19 vaccinations will be offered to residents per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or the individual refuses to receive the vaccine. 2. Residents/representatives

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will be educated on the COVID-19 vaccine they are offered, in a manner they can understand..." This policy went on to read, "...Documenting COVID-19 Vaccine. 5. Review the COVID-19 consent with the resident/resident representative or community member a) obtain signature indicating acceptance or declination...b) file the consent form in resident electronic health record. 6. Documentation includes but is not limited to: Residents (in the electronic health record) a) Whether the resident/representative consented or declined the vaccine..."

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 7/13/22, at web address: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631030153017

On 7/13/22, during an end of day meeting held, the interim facility Administrator, Assistant Director of Nursing, Corporate Clinical Consultant and Regional Administrator were made aware of concerns regarding COVID immunizations for Residents noted above.

No further information was provided.

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F 887	Continued From page 114 Complaint related deficiency.	F 887		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (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	F 888	1. Employees K, Y, G, CNA F, CNA G, CNA H, CNA J, LPN C, LPN, J and RN C will have their exemption forms reviewed and completed in their entirety as indicated. Additionally they will be provided with mitigation strategies for unvaccinated staff. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Executive Director/Human Resource Coordinator of all covid-19 exemption forms for completion. 3. The Executive Director/Human Resource Coordinator will be re-educated by the Regional Administrator/designee related to 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	8/25/2022

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F 888	Continued From page 115 facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely 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	F 888	multi-dose vaccine. 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: Facility employees; Licensed practitioners; Students, trainees, and volunteers; and Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. The policies and procedures of this section do not apply to the following facility staff: 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 of this section; and Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph of this section. The policies and procedures must include, at a minimum, the following components: A process for ensuring all staff specified in paragraph 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 2 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	

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F 888	Continued From page 116 who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of 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:	F 888	A process for ensuring that all staff specified in paragraph of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; 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; A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph of this section; 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; A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; 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; 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: All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical	

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F 888	Continued From page 117 §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to complete exemption documents for 10 of 10 exemptions requested by staff (Employee K, Employee Y, Employee G, CNA J, CNA F, CNA H, CNA G, LPN C, LPN J, and RN C) The findings included: On 7-6-22, the facility staff was requested to provide the survey team with a copy of the staff vaccination matrix and as worked schedule. The as worked schedule was used to check that all facility employees were included on the staff vaccination matrix. On 7-8-22 after several revisions to omissions of staff, between the schedule and the matrix, a final copy was received. The final copy included all exemption forms (10) that had been requested by the staff. None of the (10) exemption documents were complete, to include; Dates, signatures, approved or denied status for the requested exemptions, and mitigation strategies to be adhered to by unvaccinated staff. On 7-8-22 at 2:00 p.m., a conference call was placed with the onsite survey team and the	F 888	contraindications; 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 Contingency plans for staff who are not fully vaccinated for COVID-19. All staff vaccination exemption forms will be presented to the Executive Director/Human Resource Coordinator for verification of completion. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of new exemption forms, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.	

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F 888	Continued From page 118	F 888		

Regional Administrator, who was the only leadership in the building.

During that meeting, the facility Administrator confirmed that the staff vaccination log provided to the survey team was current, complete and inclusive of all facility staff and agency staff. The Regional Administrator was asked why the exemption forms were incomplete and the staff who had applied for, but were not yet approved for exemptions, were unvaccinated, and actively working on the floors. He was asked what mitigating precautions the staff who were unvaccinated were required to follow to protect the resident population from contracting COVID-19. The Regional Administrator stated he was unsure, however, he would look into it.

On 7-8-22 at 3:00 p.m., The Regional Administrator was asked for the staff vaccination and exemption policy, and it was supplied. The Regional Administrator confirmed that the exemption forms were incomplete, and the documents would be corrected immediately, and unvaccinated staff made aware of the need to wear N-95 respirator masks, and CDC required weekly testing.

Review of the facility policy titled, "COVID-19 Vaccinations", was reviewed. This policy read, "...2. "Personnel will submit their request for religious exemption on the company's form to the location executive, or their designee, at the individual's primary work location." 3. " Care center employees....who regularly work in, or provide services to, the care center will submit appropriate...proof of an approved exemption to the Infection Preventionist or their designee by the regulatory deadline." "All documentation will

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F 888	Continued From page 119 be maintained confidentially and in compliance with applicable record keeping requirements." The facility was experiencing an active outbreak of COVID-19, however, no hospitalizations as a result of the outbreak had occurred. On 7-8-22, during the end of day meeting, the Regional Administrator was made aware of the concern that the staff vaccination exemptions policy and tracking system in use, was not implemented and not complete and accurate. No additional information was received during the course of the survey, and by the time of exit on 7-14-22.	F 888		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based in observation, interview, facility documentation and clinical record review the facility staff failed to maintain patient care equipment for 1 Resident #34 in a survey sample of 48 Residents. The findings included: For Resident #34 the facility staff failed to ensure the proper working order of his CPAP machine. On 7/13/22 at approximately 9:00 AM an interview was conducted with Resident #34 who stated "I didn't sleep at all last night, this CPAP	F 908	1. Resident #34's C-pap was replaced on 7/14/2022. 2. All residents with C-PAPs or Bi-PAPs have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant of C-PAPs and Bi-PAPs in house to ensure proper working order. 3. All licensed nurses will be re-educated by the Director of Clinical Services/Assistant related to maintaining resident equipment in a safe operating condition.	8/25/2022

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F 908	Continued From page 120	F 908	The Unit Managers will inspect their C-PAPs and Bi-PAPs on a weekly basis and report any issues to the Director of Clinical Services and the respiratory therapy provider for follow up.	

was worse than ever. It doesn't work right and I was up all night." When asked if the Resident had told the staff he stated "We don't have a DON we don't have a Social Worker we don't have an Administrator. I told all of them a bunch of times before they quit and nothing was done. Now I have told the nurses but half of them don't care and the other half are agency staff, what are they going to do."

After leaving the Resident's room this surveyor went to the ADON's office and reported the concerns of the Resident and how he stated that he has complained repeatedly about this issue. The ADON stated she would check on it.

On the afternoon of 7/13/22 the following note was entered in Resident #34's chart:

"7/13/22 at 1:07 PM - Nursing Progress Note: Patient stated he felt C-Pap not working well. On assessment lung sounds clear to auscultations. No cyanosis noted on fingers and toes. No SOB observed at this time. Respirations even, non-labored. Chest expansion even bilaterally. RT [Respiratory Therapist] notified and will arrive later today and access machine. MD notified with none/o [orders] at this time. Patient resting in bed with eyes open. HOB elevated"

On the morning of 7/14/22 the Corporate RN brought this surveyor a copy of the shipping receipt for a new CPAP machine and stated, "The Respiratory Therapist would be in to set it up this afternoon when it arrives."

On 7/14/22 at approximately 2:00 PM during an interview with Resident #34 the Resident stated "Thank you so much for your help in getting my

4. The Executive Director/Director of Clinical Services to conduct quality monitoring of C-PAP and Bi-PAP inspections, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/ designee.

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F 908	Continued From page 121 CPAP. The Respiratory Therapist is coming today to set it up. I know it's been months since it has worked right and now I can get a good night's sleep with a new machine." On 7/14/22 the Administrator was made aware of the concerns and no further information was provided.	F 908		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation the facility staff failed to ensure the bed frame and the mattress are compatible, for 1 Resident # 34 in a survey sample of 48 Residents. The findings included: For Resident #34 the facility staff failed to supply the appropriate sized mattress for the bariatric bed Resident #34 was using. On 7/11/22 at approximately 12:30 AM Resident #34 was interviewed and he stated that the bed he has is uncomfortable and that he had to order feather pillows from [name of company redacted] to put under his back and bottom because the	F 909	1. Resident #34's bed/mattress compatibility was corrected. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Maintenance Director/Assistant of bed frame/ mattress compatibility. 3. The Maintenance Director was re-educated by the Executive Director/Director of Clinical Services related to ensuring that bed frames, mattresses and or rails are compatible. The Interdisciplinary team will review in the AM meeting of any issues with beds requiring new mattresses or rails and the Maintenance Director will validate compatibility. 4. The ED/DCS/designee to conduct quality monitoring of bed/mattress compatibility, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

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F 909	Continued From page 122	F 909		

mattress was not comfortable. In visualizing the mattress there was a 3 inch gap on either side of the mattress where it did not meet the edge of the bed frame or the top rails. When asked about this the Resident stated he has always had this problem with the mattress not being wide enough, and stated "I have complained a number of times but nothing is done about it."

On the afternoon of 7/11/22 during clinical record review it was discovered that Resident # 34 has resided at the facility since 7/23/15 and has a current BIMS (Brief Interview of Mental Status) score of 15 out of 15, indicating no cognitive impairment. The Resident is extensive assistance for all aspects of ADL care to include turning and positioning, this Resident cannot ambulate without a wheelchair and requires staff assistance for mobility.

On 7/11/22 at approximately 1:45 PM, the Maintenance Director was interviewed about Resident # 34's bed. The Maintenance Director was asked if this was the appropriate sized mattress for this bed. He indicated that there are 2 size bariatric mattresses and that he felt this mattress was appropriate for this bed. The manufacture instructions and recommendations for the bed were requested at this time.

On the morning of 7/12/22 the Corporate RN notified this surveyor that Maintenance had put "wedges" in the bed. Upon visualization of the bed it was noted that wedges were placed between the mattress and the top rails of the bed however there was still a 3 inch gap on either side of the bed from the end of the wedge to the foot of the bed (from end of top rail to foot of bed). When asked, Resident #34 stated he was not

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F 909	Continued From page 123 happy with the wedges because it was uneven, not the same depth as the mattress. After observing the bed, once again the manufacture instructions and recommendations for the bed were requested. On 7/13/22 The Corporate RN stated the Maintenance Director could not find the manufacture instructions and were indeed ordering a new bed for Resident #34. On 7/14/22 the Administrator was made aware of the concerns and no further information was provided.	F 909		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and facility documentation review, the facility staff failed to ensure a working call light for one Resident (Resident #91) in a sample size of 48 Residents. Resident #91's call light was not working for a number of days in June and July 2022. The findings included:	F 919	1. Resident #91's call light was repaired on 7/12/2022. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Maintenance Director/designee of call light functioning in the facility. 3. Maintenance Director was re-educated by the Executive Director related to ensuring the communication system in the facility was operating correctly and to follow up with grievances timely. The Executive Director will review open grievances involving maintenance and or call light concerns daily in am meeting for follow up and resolution. The Interdisciplinary Team will review the 24 hour documentation in the AM to capture any issues noted with call lights. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of grievance resolution and call light system functioning, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

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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 919	Continued From page 124 On 07/11/2022 at approximately 12:05 P.M., Resident #91 was observed lying in her bed. When asked if there were any concerns about the care received at the facility, Resident #91 stated that the call light has not been working. Resident #91 indicated staff was notified about it. This surveyor observed Resident #91 press the button on the call light several times and the light and sound were not activated. On 07/11/2022 at approximately 12:15 P.M., the Regional Administrator was notified Resident #91's call light was not working. The Regional Administrator stated he would let maintenance staff know. On 07/12/2022 at 9:30 A.M., Resident #91 was interviewed. Resident #91 stated that the call light was now working. On 07/12/2022, a grievance for Resident #91 was reviewed. The grievance, dated 06/21/2022 indicated that Resident #91's call light was not working. According to the grievance document, the grievance was not addressed/resolved.	F 919		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 943		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495327	A. BUILDING _____ B. WING _____	C 07/14/2022

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ENVOY OF WESTOVER HILLS	4403 FOREST HILL AVENUE RICHMOND, VA 23225

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F 943	Continued From page 125 §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility failed to ensure completion of staff abuse training for 3 of 5 sampled records The Findings included: On 7-5-22 Staffing schedules were requested for the week, and were reviewed each day. A tour of the entire building to ascertain all staff currently providing care to the Residents and working during the shift was conducted on 7-5-22. The census on this day was 143 Residents. There was no Administrator, no Infection Preventionist (IP), nor Director of Nursing (DON), and no MDS (Minimum Data Set)/care plan Coordinator present. Staff members (2 LPN's, and all 3 CNA's) were asked during initial tour if they had received training and had annual competencies evaluated. All responded they could not remember any training other than a recent first CNA licensing course, and "long ago" abuse training that they had ever received. They were asked who provided training and evaluations, and all responded "I don't know, some are on the computer."	F 943	1. CNA B, CNA H and CNA Q will be provided abuse education. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Human Resource Coordinator/Assistant of employee files focusing on abuse training documentation. 3. The Human Resource Coordinator and Social Service Director were re-educated by the Executive Director/Director of Clinical Services related to ensuring all staff have staff abuse training as indicated. In the AM meeting, the Human Resource Coordinator will review new hires for the upcoming week and will coordinate with the Social Service Director for abuse training. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of abuse training, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	8/25/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 943	Continued From page 126 A sample of 5 employee records was requested for performance competency and education review which is required upon hire and at least annually. Competencies were not completed for the following: CNA (B) - No education on abuse documented. CNA (H) - No education on abuse documented. CNA (Q) - No education on abuse documented. On 7-14-22 the Administrator stated "We have no more education/documentation to provide. On 7-13-22 and 7-14-22 at the end of day debrief, the Regional Administrator and newly started facility Administrator, were made aware of the findings. They stated at that time there were no more education documents for those staff on record. No further information was submitted by the facility.	F 943		