DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	C 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

(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 08/30/2022 through 09/01/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/30/2022 through 09/01/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. VA00054120- Substantiated without Deficiency The census in this 130 certified bed facility was 97 at the time of the survey. The survey sample consisted of 38 resident reviews.	F 000		
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.	F 561	**F561** **Corrective Action(s):** Resident #43's attending physician has been notified that facility staff facility staff failed to facilitate Resident self-determination through support of the resident's choice to spend time outside in August 2022 as was her personal preference **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The social services director/designee will complete a 100% review of all resident records to determine other residents at risk. Negative findings will be addressed at the time of discovery.	10/12/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marie Laugat LNHA — TITLE: Administrator — (X6) DATE: 9/30/22

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

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F 561	Continued From page 1 §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, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to facilitate Resident self-determination through support of Resident choice for one Resident (Resident #43) in a sample size of 38 Residents. For Resident #43, the facility staff failed to assist Resident #43 spend time outside in August 2022 as was her personal preference. The findings included: On 08/30/2022 at 8:30 A.M., Resident #43 was observed in her bed. When asked about concerns at the facility, Resident #43 stated she used to go outside sometimes but now she "cannot go outside." When asked why, Resident #43 stated she didn't know why and "would like to go outside again sometimes." On 08/31/2022, Resident #43's clinical record was reviewed. Resident #43's Minimum Data Set	F 561	**Systemic Change(s);** Facility policy and procedure was reviewed and no changes are warranted at this time. The regional nurse consultant will inservice all staff on the self-determination and resident choice. **Monitoring:** The Social Services Director is responsible for maintaining compliance. The Social Services Director/designee will complete a weekly review of residents per the Care Plan calendar to identify instances in which resident self determination was not followed through with. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date:** 10/12/22	

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F 561	Continued From page 2 with an Assessment Reference Date of 07/07/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "14" out of possible "15" indicative of intact cognition. An activity preference assessment was not completed with this quarterly review dated 07/07/2022. According to Resident #43's previous Minimum Data Set with an Assessment Reference Date of 04/08/2022 (which was coded as an annual assessment), the importance of going "outside to get fresh air when the weather is good" was coded as "1" meaning "very important." Resident #43's care plan in the electronic health record was reviewed. A problem dated 07/07/2022 entitled, "Resident (#43) has the potential for social isolation related to impaired mobility, depression, anxiety, and dementia." Interventions associated with this problem were as follows: "Assist resident to and from activities as needed. Visit with resident to determine appropriate in-room activities that may be provided. Accommodate resident's limited mobility to enable participation in activity events outside of room when possible. Reinforce attendance at activities outside of room with verbal praise. Provide in-room activities and supplies for resident. Post activity calendar in room." The care plan did not address Resident #43's personal preference of going outside at times. Resident #43's progress notes were reviewed for August 2022. There was no evidence Resident	F 561		

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F 561	Continued From page 3 #43 went outside for the month of August 2022. On 09/01/2022 at 8:25 A.M., Certified Nursing Assistant C (CNA C) was interviewed. When asked if there were any restrictions on Residents going outside, CNA C stated that Residents could go outside if they wanted to. When asked about Resident #43, CNA C stated that Resident #43 could go outside if she wanted to and would be assisted to go outside if Resident (#43) asked. On 09/01/2022 at 9:05 A.M., the Activities Director, Employee N, was interviewed. When asked about Resident #43 going outside, the Activities Director stated that it's not possible to allow Residents to go outside "due to COVID." The Activities Director then stated that "Once the facility allows me to take Residents outside, I will." When asked what activities Resident #43 participated in for August 2022, the Activities Director referred to 2 documents for Resident #43 in the Activity Binder. The list of Resident #43's Activities for August 2022 included playing Bingo (on 08/04/2022, 08/12/2022, and 08/30/2022) and drinking juice (on 08/04/2022, 08/05/2022, 08/06/2022, 08/07/2022, 08/08/2022, 08/11/2022, and 08/12/2022). There was no evidence Resident #43 went outside in August 2022 as was her personal preference. The Activities Calendar for August 2022 was reviewed. There was no evidence on the calendar any outside activities were planned. On 09/01/2022 at 10:35 A.M., the Director of Nursing and Administrator were notified of findings. The administrator provided a copy of Resident #43's updated Minimum Data Set with an Assessment Reference Date of 09/01/2022. In	F 561		

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F 561	Continued From page 4 Section F0500 Part G entitled, "How important is it to you to go outside to get fresh air when the weather is good?", it was coded as "1" meaning "very important." The Administrator also provided a copy of Resident #43's updated care plan. One intervention dated 09/01/2022 documented, "Assist Resident outside to courtyard as she desires, if all weather permits." The facility staff provided a copy of their policy entitled, "Resident Rights." In Section 1(e) it documented, "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to ... self-determination."	F 561		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657	**F657** **Corrective Action(s):** Resident #43's comprehensive care plan has been reviewed and revised to accurately reflect the resident's desire to spend time outside. Resident #59's comprehensive care plan has been reviewed and revised to accurately reflect the resident's changing goals, preferences, and needs to include changing goals, preferences and response to current interventions. **Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all care plans to identify residents at risk of having inaccurate care plans will be completed. Residents identified at risk will be corrected at time of discovery.	10/12/22

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F 657	Continued From page 5 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to revise the care plan for two Residents (Resident #43, Resident #59) in a sample size of 38 Residents. 1) For Resident #43, the facility staff failed to revise the care plan regarding Resident #43's personal preference to spend time outside. 2) For Resident #59, the facility staff failed to review and revise the care plan based on changing goals, preferences and needs of the resident and in response to current interventions. The findings included: On 08/30/2022 at 8:30 A.M., Resident #43 was observed in her bed. When asked about concerns at the facility, Resident #43 stated she used to go outside sometimes but now she "cannot go outside." When asked why, Resident #43 stated she didn't know why and "would like to go outside again sometimes." On 08/31/2022, Resident #43's clinical record was reviewed. Resident #43's Minimum Data Set with an Assessment Reference Date of 07/07/2022 was coded as a quarterly	F 657	**Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to review and revise resident care plans as resident needs change. **Monitoring:** The RCC is responsible for maintaining compliance. The RCC/designee will audit all comprehensive care plans in accordance with the MDS calendar to ensure the care plans accurately reflect the resident's current needs and condition. Any/all negative findings will be corrected at time of discovery. Detailed findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 10/12/22	

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F 657	Continued From page 6 assessment. The Brief Interview for Mental Status was coded as "14" out of possible "15" indicative of intact cognition. An activity preference assessment was not completed with this quarterly review dated 07/07/2022. According to Resident #43's previous Minimum Data Set with an Assessment Reference Date of 04/08/2022 (which was coded as an annual assessment), the importance of going "outside to get fresh air when the weather is good" was coded as "1" meaning "very important." Resident #43's care plan in the electronic health record was reviewed. A problem dated 07/07/2022 entitled, "Resident (#43) has the potential for social isolation related to impaired mobility, depression, anxiety, and dementia." Interventions associated with this problem were as follows: "Assist resident to and from activities as needed. Visit with resident to determine appropriate in-room activities that may be provided. Accommodate resident's limited mobility to enable participation in activity events outside of room when possible. Reinforce attendance at activities outside of room with verbal praise. Provide in-room activities and supplies for resident. Post activity calendar in room." The care plan did not address Resident #43's personal preference of going outside at times. Resident #43's progress notes were reviewed for August 2022. There was no evidence Resident #43 went outside for the month of August 2022.	F 657		

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F 657	Continued From page 7 On 09/01/2022 at 8:25 A.M., Certified Nursing Assistant C (CNA C) was interviewed. When asked if there were any restrictions on Residents going outside, CNA C stated that Residents could go outside if they wanted to. When asked about Resident #43, CNA C stated that Resident #43 could go outside if she wanted to and would be assisted to go outside if Resident (#43) asked. On 09/01/2022 at 9:05 A.M., the Activities Director, Employee N, was interviewed. When asked about Resident #43 going outside, the Activities Director stated that it's not possible to allow Residents to go outside "due to COVID." The Activities Director then stated that "Once the facility allows me to take Residents outside, I will." When asked what activities Resident #43 participated in for August 2022, the Activities Director referred to 2 documents for Resident #43 in the Activity Binder. The list of Resident #43's Activities for August 2022 included playing Bingo (on 08/04/2022, 08/12/2022, and 08/30/2022) and drinking juice (on 08/04/2022, 08/05/2022, 08/06/2022, 08/07/2022, 08/08/2022, 08/11/2022, and 08/12/2022). There was no evidence Resident #43 went outside in August 2022 as was her personal preference. The Activities Calendar for August 2022 was reviewed. There was no evidence on the calendar any outside activities were planned. On 09/01/2022 at 10:35 A.M., the Director of Nursing and Administrator were notified of findings. The Administrator provided a copy of Resident #43's updated Minimum Data Set with an Assessment Reference Date of 09/01/2022. In Section F0500 Part G entitled, "How important is it to you to go outside to get fresh air when the	F 657		

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F 657	Continued From page 8 weather is good?", it was coded as "1" meaning "very important." The Administrator also provided a copy of Resident #43's updated care plan. One intervention dated 09/01/2022 documented, "Assist Resident outside to courtyard as she desires, if all weather permits." The facility staff provided a copy of their policy entitled, "Activity Evaluation." Under the header "Policy Statement", it was documented, "In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities." In Section 1 it was documented, "An activity evaluation is conducted as part of the comprehensive assessment to help develop an activities plan that reflects the choices and interests of the resident." In Section 6, it was documented "The activity evaluation is used to develop an individual activities care plan separate from or as part of the comprehensive care plan that will allow the resident to participate in activities of his or her choice and interest." The facility staff provided a copy of their policy entitled, "Care Plans, Comprehensive Person-Centered." In Section 13, it was documented, "Assessments of residents are ongoing and care plans are revised as information about the residents' condition change." 2. For Resident #59, the facility staff failed to review and revise the care plan based on changing goals, preferences and needs of the	F 657		

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F 657	Continued From page 9 resident and in response to current interventions. On 8/31/22 at approximately 2:10 PM an interview was conducted with Resident #59 who stated that the facility had removed her call bell from her room and given her a hand held bell that she has to ring. She stated that she felt she had "Learned her lesson" and would like her call bell back. When asked why the facility took her call bell she stated "because I ring it too much." During an interview with the Unit Manager on 8/31/22 at approximately 3:15 PM the unit manager stated that the reason the call bell had been removed from Resident #59 was that she had attempted suicide by placing the call bell around her neck and she was found by the CNA and sent to the ER for evaluation. Upon return to the facility she was given another type of call bell without a cord. The unit manager stated this was for safety and not punitive in any way. A review of the care plan revealed that on 7/10/22 the following was written in Resident #59's care plan "7/10/22 - Q 15 min checks per orders." This was a hand written entry with no definite time frame as to when the 15 minute checks will start or end. On 8/31/22 an interview was conducted with the MDS Coordinator who stated that the care plans are reviewed and revised quarterly in the computer. Between quarterly reviews any changes are handwritten on the copy that is kept in the MDS office. When asked if the care plan	F 657		

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F 657	Continued From page 10 book stays in the MDS office she stated that it did. When asked if her office was locked over weekends and evenings she stated that it was. When asked how the staff can access the care plans she stated that they have access to the copy in the computer. When asked is that copy always up to date she stated that it was not, the "working copy" is the one with the changes and that one is located in the MDS office. When asked about the entry of 7/10/22 she stated that it was hand written in the working copy on that date. When asked how the staff would know when to start and end the 15 minute checks she stated they would have to look at the orders. A review of the Care Plan Policy read: Page 8 " The comprehensive person-centered care plan will:" "a. Include measurable objectives and time frames." On 9/1/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679	**F679** **Corrective Action(s):** Resident #43 has been reassessed by the activity director for resident specific activities to meet their physical, mental and psychosocial well-being. Resident #R4's comprehensive careplan has been reviewed and revised to reflect their current resident specific activity needs and interests with appropriate interventions to meet their activity needs.	10/12/22

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F 679	Continued From page 11 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an ongoing program to support residents in their choice of activities for one Resident (Resident #43) in a sample size of 38 Residents. For Resident #43, the facility staff failed to assist Resident #43 spend time outside in August 2022 as was her personal preference. The findings included: On 08/30/2022 at 8:30 A.M., Resident #43 was observed in her bed. When asked about concerns at the facility, Resident #43 stated she used to go outside sometimes but now she "cannot go outside." When asked why, Resident #43 stated she didn't know why and "would like to go outside again sometimes." On 08/31/2022, Resident #43's clinical record was reviewed. Resident #43's Minimum Data Set with an Assessment Reference Date of 07/07/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "14" out of possible "15" indicative of intact cognition. An activity preference assessment was not completed with this quarterly review dated 07/07/2022. According to Resident #43's previous Minimum Data Set with an Assessment Reference Date of 04/08/2022 (which was coded as an annual assessment), the importance of going "outside to get fresh air when the weather is good" was coded as "1" meaning "very important."	F 679	**Identification of Deficient Practice(s) & Corrective Action(s):** The facility conducted a 100% review of all residents to identify residents at risk. Residents identified at risk will have their activity Assessments and their care plans reviewed to determine if the resident's care plan has activities listed to meet the resident's individual activity and psychosocial needs and interests. Any changes or additional findings will be added to their resident specific care plan. **Systemic Change(s):** The current facility policy and procedure has been reviewed and no changes are warranted at this time. The Activities Director and Activity Assistants will review the Long-Term Care regulation manual for providing activities to residents which are individualized. **Monitoring:** The Activities Director is responsible for maintaining compliance. Daily audits of the activity calendar will be completed by the administrator and/or Activity Director to ensure activities are scheduled and being performed daily for residents. Activity care plans will be reviewed weekly by the by the Activity Director coinciding with the care plan calendar to ensure resident specific activities are being offered and to monitor for compliance. All negative findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion date:** 10/12/22	

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Resident #43's care plan in the electronic health record was reviewed. A problem dated 07/07/2022 entitled, "Resident (#43) has the potential for social isolation related to impaired mobility, depression, anxiety, and dementia." Interventions associated with this problem were as follows:

"Assist resident to and from activities as needed.
Visit with resident to determine appropriate in-room activities that may be provided.
Accommodate resident's limited mobility to enable participation in activity events outside of room when possible.
Reinforce attendance at activities outside of room with verbal praise.
Provide in-room activities and supplies for resident.
Post activity calendar in room."

The care plan did not address Resident #43's personal preference of going outside at times.

Resident #43's progress notes were reviewed for August 2022. There was no evidence Resident #43 went outside for the month of August 2022.

On 09/01/2022 at 8:25 A.M., Certified Nursing Assistant C (CNA C) was interviewed. When asked if there were any restrictions on Residents going outside, CNA C stated that Residents could go outside if they wanted to. When asked about Resident #43, CNA C stated that Resident #43 could go outside if she wanted to and would be assisted to go outside if Resident (#43) asked.

On 09/01/2022 at 9:05 A.M., the Activities Director, Employee N, was interviewed. When asked about Resident #43 going outside, the

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Activities Director stated that it's not possible to allow Residents to go outside "due to COVID." The Activities Director then stated that "Once the facility allows me to take Residents outside, I will." When asked what activities Resident #43 participated in for August 2022, the Activities Director referred to 2 documents for Resident #43 in the Activity Binder. The list of Resident #43's Activities for August 2022 included playing Bingo (on 08/04/2022, 08/12/2022, and 08/30/2022) and drinking juice (on 08/04/2022, 08/05/2022, 08/06/2022, 08/07/2022, 08/08/2022, 08/11/2022, and 08/12/2022). There was no evidence Resident #43 went outside in August 2022 as was her personal preference.

The Activities Calendar for August 2022 was reviewed. There was no evidence on the calendar any outside activities were planned.

On 09/01/2022 at 10:35 A.M., the Director of Nursing and Administrator were notified of findings. The administrator provided a copy of Resident #43's updated Minimum Data Set with an Assessment Reference Date of 09/01/2022. In Section F0500 Part G entitled, "How important is it to you to go outside to get fresh air when the weather is good?", it was coded as "1" meaning "very important." The Administrator also provided a copy of Resident #43's updated care plan. One intervention dated 09/01/2022 documented, "Assist Resident outside to courtyard as she desires, if all weather permits."

The facility staff provided a copy of their policy entitled, "Activity Evaluation." Under the header "Policy Statement", it was documented, "In order to promote the physical, mental and psychosocial well-being of residents, an activity evaluation is

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F 679	Continued From page 14 conducted and maintained for each resident at least quarterly and with any change of condition that could affect his/her participation in planned activities." In Section 1 it was documented, "An activity evaluation is conducted as part of the comprehensive assessment to help develop an activities plan that reflects the choices and interests of the resident."	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care according to professional standards for one Resident (Resident #38) in a sample size of 38 Residents. For Resident #38, the facility staff failed to re-valuate for leg prosthetics after a fitting for shrinkers socks was completed. The findings included: On 08/30/2022 at 8:45 A.M., Resident #38 was observed dressed, sitting on his bed covers. Resident #38 had bilateral above the knee amputations. When asked if he had any concerns about the care he received at the facility,	F 684	**F684** **Corrective Action(s):** Residents #38's attending physician was notified that the facility staff failed to re-evaluate for leg prosthetics after a fitting for shrinkers socks was completed. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON/designee will conduct a 100% audit of all resident's to identify residents who have not been re-evaluated as indicated after a significant change in condition. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding.	10/12/22

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F 684	Continued From page 15 Resident #38 stated that he wanted his prosthetic legs. When asked if he knew where they were located, Resident #38 stated that he doesn't have prosthetic legs yet, but wants to get them. On 08/31/2022, Resident #38's clinical record was reviewed. Resident #38's Minimum Data Set with an Assessment Reference Date of 07/05/2022 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. On 09/01/2022 at 8:30 A.M., Employee P, an occupational therapist, was interviewed. When asked about Resident #38's most recent dates of service for therapy, Employee P referred to Resident #38's clinical record and stated that Resident #38 was seen by physical therapy from 08/25/202 through 11/24/2020. When asked the reason for the therapy, Employee P stated the reason for the evaluation was for mobility because Resident #38 wanted leg prosthetics. On the Physical Therapy Evaluation dated 08/25/2020 under "Patient Goals" it was documented, "To be able to stand with prosthesis and get out of here." Under the section entitled, "Potential for Achieving Rehab Goals" it was documented, "Patient demonstrates good rehab potential as evidenced by ability to follow 2-step directions, attentive to tasks and active participation in skilled treatment." Employee P stated that Resident #38 currently doesn't have leg prosthetics and gets around in a wheelchair. Employee P stated that Resident #38 transfers himself to the wheelchair independently and has a functional reach of 12 inches, meaning he is not at risk for falls. Employee P then stated that on 11/04/2020, Resident #38 was scheduled for a	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician orders for residents who have experienced a change in condition resulting in the need for reevaluation. **Monitoring:** The DON will be responsible for maintaining compliance. The DON/designee will perform weekly chart audits coinciding with the care plan calendar to monitor to ensure that residents who have experienced a significant change in condition has been reevaluated as indicated. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 10/12/22	

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prosthetic assessment with an outside company for 12/04/2020. Employee P stated that Resident #38 was discharged from physical therapy services on 11/24/2020 because all of his goals were met. Employee P stated that physical therapy services would not be involved in his care again until after the prosthetic fitting occurred. When asked why Resident #38 did not have prosthetic legs currently, Employee P stated that she could not tell from the physical therapy documentation the results of the prosthetic assessment.

On 09/01/2022 at 10:35 A.M., the Administrator was notified of findings. The Administrator stated that Resident #38 was seen by outside company twice and was deemed not a good candidate for prosthetics. The Administrator stated she would provide the documents for those visits. At approximately 11:45 A.M., the Administrator provided the following:

1) A handwritten physician's order dated 07/29/2021 which documented, "Prosthetic consult for (B) [bilateral] stump shrinkers [compression socks to reduce swelling and help shape limb for prosthetic]."

2) A document entitled, "Clinical Summary" dated 07/30/2021 from a prosthetic company. The document indicated Resident #38 was seen to be evaluated for shrinker socks.

3) A document entitled, "Clinical Summary" dated 08/06/2021 from the same prosthetic company as dated 07/30/2021. The document indicated Resident #38 was successfully fitted for and provided bilateral shrinker socks.

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F 684	Continued From page 17 4) A document from the prosthetic company dated 08/06/2021 entitled, "Prescription - Letter/Certificate of Medical Necessity" under the header "Functional Capacity (from K0-K4)" documented, "K1-Ability or potential to transfer or ambulate on level surfaces with fixed cadence." Under the header "Directions for use" it was documented, "Use with therapy at this time and re-eval [re-evaluate]." There was no evidence in the documentation that Resident #38 was not a candidate for leg prosthetics. On 09/01/2022 at approximately 7:30 P.M., the Administrator stated there was no further documentation to submit.	F 684		
F 732 SS=F	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732	**F732** **Corrective Action(s)** The facility medical director has been notified that facility staff failed to post complete nursing staffing information at the beginning of each shift in a prominent place readily accessible to residents and visitors. The facility Administrator, DON, HR director, and medical records director have reviewed the requirement for posting nursing staffing information.	10/12/22

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F 732	Continued From page 18 specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to post daily staffing information for Residents, staff, and visitors to see, which has the potential to affect all Residents. The findings included: On 9/1/22 at approximately 11:00 AM, a faciltiy tour was conducted to look for daily staffing posted. Surveyor E was unable to locate it. On 9/1/22 at approximately 12:40 PM, the Director of Nursing (DON) was asked where the daily staffing is posted. The DON and Surveyor E went to the B unit and found the "Daily Unit Assignment" sheet posted in the hallway. This posting listed the date, staff's first names and their assigned shift. No census data or hours	F 732	**Identification of Deficient Practice & Corrective Action(s):** All resident may have been affected. A review of all nursing staffing sheets for the previous 90 day has been completed to identify dates sheets were not complete. Negative findings will be corrected at the time of discovery. The findings of this review will be reviewed by the Administrator and DON to aid in setting up the appropriate inservice training. **Systemic Change(s):** The facility policy and procedure for posting nursing staffing information has been reviewed and no changes are warranted at this time. The administrator, DON, HR director, medical records director, and all nursing administration have been inserviced by the regional nurse consultant regarding the requirements for posting nursing staffing information. **Monitoring:** The Administrator is responsible for maintaining compliance. The administrator and/or designee will complete 3 random weekly audits of nursing staffing postings to ensure compliance. Negative findings will be addressed at the time of discovery and disciplinary action taken as indicated. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice for 2 meetings. The QA committee will determine, based on findings of the audits, when the audits may be discontinued. **Completion Date:** 10/12/22	

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F 732	Continued From page 19 worked was noted. The DON and Surveyor E then went to the A unit. The "Daily Unit Assignment" was posted in the chart room, which was located behind the nursing station. On 9/1/22, the Director of Nursing (DON) was interviewed. The DON stated the scheduler posts the daily staffing and on the weekends posts for the entire weekend on Friday. When asked what the purpose of posting the daily staffing is, the DON said, "For the staff to know where to go since we have two sides". On 9/1/22, the facility Administrator was asked where the staff posting is posted. She said, "I will have to check, is it not posted out by the time clock". Surveyor E went and made an observation of the postings around employee time clock and didn't see a posting of daily staffing. On 9/1/22, the facilty staffing coordinator, Employee H was asked where she posts the daily staffing. She stated, "On B unit across from the station, on A unit in the chart room. I know families are supposed to have access but A side doesn't really have any where to post it". On 9/1/22 at approximatey 12:55 PM, the faciltiy Administrator approached Surveyor E and asked if the posting in the lobby had been seen. Surveyor E and the Administrator went to the lobby and behind the reception desk in a case/shadow box, there was a posting that was not ligible. It was above eye level and at a distance that the text could not be read.	F 732		

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F 732	Continued From page 20 On 9/1/22 at 1:30 PM, upon the survey team's return from lunch, Surveyor E pointed out the daily staff posting behind the receptionist. Surveyor E asked Surveyor D if she could read it and Surveyor D said, "No". On 9/1/22 at 1:35 PM, an interview was conducted with Employee J, the business office assistant and receiptionist. The facility lobby had a door that was locked, which seperates the lobby from the Resident care areas and units. Facility staff have to enter a code to unlock the door for access to be gained to the Resident care unit and back to the lobby from the unit. When asked if Residents have access to the lobby, Employee J said they do not, a staff member would have to unlock the door for them to access the lobby. A review of the facility policy titled, "Posting Direct Care Daily Staffing Numbers" was conducted. This policy read, "1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format". On 9/1/22, during an end of day meeting with the facility Administrator, Assistant Administrator, DON, and corporate staff were made aware of the above findings. No further information was provided.	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

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F 812	Continued From page 21 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to distribute food in accordance with professional standards for food service safety. Specifically, the facility staff failed to ensure a safe holding temperatures for 2 out of 2 milk containers on 08/31/2022 for the lunch tray line. The findings included: On 08/31/2022 at 11:00 A.M., this surveyor observed Employee K, a cook, obtain tray line temperatures. The cold beverages for the tray line were on cart shelves by the tray line. Employee K selected a carton of milk to check the holding temperature. The temperature was 50.8 degrees Fahrenheit. Employee K then selected another milk off the cart and checked the temperature. The temperature was 47.2	F 812	**F812** **Corrective Action(s):** The facility medical director has been notified that the facility staff failed to ensure a safe holding temperatures for 2 out of 2 milk containers on 08/31/2022 for the lunch tray line. The affected milk was discarded during the survey. **Identification of Deficient Practices & Corrective Action(s):** The food service manager will inservice dietary staff on the appropriate method of setting up cold beverages in ice filled containers while awaiting placement on trays. The inservice will also include the proper procedure for monitoring cold beverage temperatures during each tray line setup. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician and/or Dietary manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions. **Monitoring:** The Dietary Manager is responsible for maintaining compliance. The Food service manager/designee will complete random reviews of food temp documentation and cold beverage temperature checks no less than 3 times weekly to monitor for compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 10/12/22	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

(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 812	Continued From page 22 degrees Fahrenheit. The cook then stated the milk on the cart would be taken away. The Dietary Manager was informed of findings and stated that the milk should be on ice while serving on the tray line. On 08/31/2022, the facility staff provided a copy of their policy entitled, "Food Production." In Section D(b)(1) entitled, "Milk Production", an excerpt documented, "During service, place on ice to maintain temperature below 41 degrees Fahrenheit." On 08/31/2022 at approximately 6:00 P.M., the administrator and Director of Nursing were notified of findings.	F 812		
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	F 886	**F886** **Corrective Action(s):** The facility medical director was notified that the facility staff failed to test Residents for COVID-19 on one unit in accordance with The Centers for Disease Control and Prevention guidance. The facility medical director was notified that the facility staff failed to conduct routine testing of staff who were not up to date with COVID immunizations for 6 staff (Staff #1, #2, #4, #5, #6, and #10) in a sample of 8 staff reviewed for COVID testing. The facility medical director has been notified that the facility staff failed t0 conduct outbreak testing of staff regardless of their vaccination status during the facility's COVID outbreak which ended 8/30/22.	10/12/22

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F 886	Continued From page 23 suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §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	F 886	**Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected. A 100% review of all residents who were on A-unit during the 8/19/22 exposure incident will be completed to identify residents who did not receive required testing. Negative findings will be addressed at the time of discovery and the facility Medical Director will be notified. The facility's infection preventionist and all licensed nursing staff have been inserviced by the regional nurse consultant regarding the current CDC Guidance for testing of residents for COVID 19. Additionally, a 100% review of all staff who are not up to date with COVID 19 immunization will be completed to identify other staff who did not receive required testing in the past 90 days. Negative findings will be addressed at the time of discovery and the facility Medical Director will be notified. **Systemic Change(s):** The facility COVID-19 testing policy has been reviewed and no changes are warranted at this time. All facility staff have been re-inserviced on the current COVID-19 testing policy. **Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete monthly QA audits to monitor for compliance.	10/12/22

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F 886	Continued From page 24 efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to test Residents for COVID-19 in on one (A-unit) of two units accordance with The Centers for Disease Control and Prevention guidance. The findings included: Review of the CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" updated on 02/02/2022, was reviewed. An excerpt of the document read, "Asymptomatic residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but generally not earlier than 24 hours after exposure) and, if negative, again 5-7 days after the exposure. On 08/31/2022 at approximately 5:00 P.M., the facility staff provided a copy of their staff line listing. According to the line listing, Staff #17, a nurse, had symptom onset (cough, temperature greater than 100 degrees Fahrenheit, chills/shaking, new malaise, dizziness, sore throat, and body aches) on 08/19/2022 and tested positive for COVID-19 on 08/19/2022. On 09/01/2022, the facility staff provided an as worked schedule for 08/18/2022. According to the schedule, Staff #17 was the only nurse assigned on the "A" unit to care for Residents from 11:00	F 886	Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date:** 10/12/22	

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F 886	Continued From page 25 P.M. (08/18/2022) to 7:00 A.M. (08/19/2022). On 09/01/2022 at 10:45 A.M., the Infection Preventionist (Employee D) was interviewed. When asked about the timeline for the current outbreak, the Infection Preventionist stated that they were no longer in outbreak. The Infection Preventionist explained that a Resident tested positive on 08/02/2022 and their policy is that outbreak is considered to extend 28 days after a Resident tests positive. The Infection Preventionist stated that Residents would be tested twice a week for the 28 days. This surveyor and the Infection Preventionist reviewed the facility's testing logs. According to the testing logs, Residents were tested on 08/02/2022, 08/09/2022, 08/16/2022, 08/22/2022, 08/23/2022, and 08/26/2022. There was no evidence Residents exposed to Staff #17 on 08/19/2022 were tested until 3 days after exposure. On 09/01/2022, the Administrator was notified of findings. 2. The facility staff failed to conduct routine testing of staff who were not up to date with COVID immunizations for 6 staff (Staff #1, #2, #4, #5, #6, and #10) in a sample of 8 staff reviewed for COVID testing. On 8/31/22, a review was conducted of the staff vaccination matrix and a sample of 11 employees was selected. On 8/31/22 at 2:14 PM, Surveyor E met with the Infection Preventionist (IP) and the QA (Quality Assurance) Nurse to review staff COVID testing.	F 886		

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F 886	Continued From page 26 The following testing dates were noted and confirmed by the IP nurse. The hire dates, work status and time card/punches were obtained from Employee F, Human Resources Manager. 2a. Staff #1 had testing occurrences of 8/9/22 and 8/11/22. Staff 1 was hired 3/2/22, and worked on an as needed basis. Staff #1 was noted on the staff vaccination matrix as being partially vaccinated. Review of the vaccination information Human Resources had on file revealed Staff #1 received one dose of a multi-dose, Moderna COVID vaccine on 2/22/22. Staff #1 worked 8/18 and 8/24, without having any testing completed. 2b. Staff #2 had no evidence of any testing conducted in July or August, 2022. Staff #2 was hired 5/20/22, and worked full time. Staff #2 was noted as having been granted a non-medical exemption from vaccination, which was approved on 5/24/22. 2c. Staff #4 was tested 7/4/22, 7/12/22, 7/15/22, 7/19/22, and 7/22/22. There was no testing occurrences for Staff #4 after 7/22/22. Staff #4 worked 6 additional shifts following 7/22, without any testing. 2d. Staff #5, was noted on the staff vaccination matrix as being partially vaccinated. Staff #5 was tested only twice in July, on 7/19 and 7/27. In August she was tested twice weekly from 8/1/22-8/17/22. Following the test on 8/17/22, the other testing occurrences were 8/23/22 and 8/30/22. She had not been tested twice weekly in July or for the last two weeks in August. Review of the time card revealed Staff #5 worked 10 shifts from 8/17-8/31.	F 886		

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F 886	Continued From page 27 2e. Staff #6, was noted on the staff vaccination matrix as having had been granted a non-medical exemption from immunization. Staff #6 was not tested twice weekly. Her testing occurrences for July and August were as follows: 7/19/22, 7/22/22, 7/23/22, 8/2/22, 8/4/22, 8/8/22, 8/11/22, 8/16/22, 8/18/22, 8/22/22, and 8/29/22. When Surveyor E asked if there was any testing between, 7/23/22-8/2/22, the IP said, "No". 2f. Staff #10, was noted on the staff vaccination matrix as being partially vaccinated. Review of the testing for Staff #10 revealed that the facility staff had her marked as being boosted, therefore she was not conducting routine testing. She was not tested from July 20, 2022 until Aug. 21. Once they started testing Staff #10, she did not have twice weekly testing. She was tested 8/21/22, 8/26/22, and 8/31/22. Review of the time card for Staff #10 revealed she worked 17 days in July and 22 days in Aug. During the interview, Staff #10 identified as working at that time, she was called into the office and confirmed that she is not boosted for COVID-19. The Infection Preventionist was made aware that the staff who were not up-to-date were not being tested twice weekly. She confirmed the findings. 3. The facility staff failed to conduct outbreak testing of staff, regardless of their vaccination status. On 8/31/22 and again on 9/1/22, Surveyor E met with the facility Infection Preventionist (IP). The IP confirmed they had been in a COVID outbreak until 8/30/22. When staff testing records for August were reviewed, the IP stated that staff	F 886		

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F 886	Continued From page 28	F 886		

who are up-to-date do not have to be tested unless they are symptomatic. When asked if they are tested during an outbreak, the IP said, "No".

The testing records revealed no evidence of any staff who are up-to-date with COVID immunizations receiving any COVID testing.

On 9/1/22 at approximately 5:45 PM, the Regional Director of Clinical Services (RDCS) stated, "Per CMS definition, it says 1 staff or 1 Resident is an outbreak, but VDH (Virginia Department of Health) tells us often no, so we let VDH make the determination if we are in outbreak or not". The RDCS was asked which guidance they follow if there is a discrepancy between the two. The RDCS said, "We follow VDH because they are in the area and are experts in their area".

Review of the facility policy titled, "Coronavirus (COVID-19)" with a revision date of 5/10/22, was conducted. This policy read, "... Routine testing of staff that are not up to date with all recommended vaccinations will be based on the extent of the virus in the community. Facilities should use their community transmission level as the trigger for staff testing frequency. Reports of COVID-19 level of community transmission are available on the CDC COVID-19 Integrated County View site: https://covid.cdc.gov/covid-data-tracker/#county-view (9.14.2021) see Covid 19 Testing Policy..."

The facility policy titled, "COVID-19 Testing" was reviewed. This policy read, "...Testing Triggered by an Outbreak Investigation/Testing of Staff and Residents During an Outbreak Investigation: A

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F 886	Continued From page 29 new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident triggers an outbreak investigation. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin. Facilities have the option to perform outbreak testing through two approaches, 1) contact tracing or 2) broad-based (e.g. facility-wide) testing. If the facility has the ability to identify close contacts of the individual with COVID-19, they could choose to conduct focused testing based on known close contacts. If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility). Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission. When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection. A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach	F 886		

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F 886	Continued From page 30 should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below for alternative approaches to individual contact tracing. Alternative, broad-based approach: If close contacts cannot be determined, the facility should investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility)..." On 9/1/22, during an end of day meeting the facility Administrator and Director of Nursing were made aware of the above findings. No additional information was provided.	F 886		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures	F 888	**F888** **Corrective Action(s):** The facility medical director has been notified that the facility staff facility staff failed to have an accurate system to track the COVID immunization status of one employee Staff #5 and permitted her to work after being eligible to receive the second dose, which she didn't receive timely **Identification of Deficient Practice(s) and Corrective Action(s):** The infection preventionist/designee will complete a 100% of all staff records to identify those at risk. Any staff member found to not be fully vaccinated or exempted will be furloughed until vaccination/exemption is complete per the facility's policy.	10/12/22

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F 888	Continued From page 31 must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in 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	F 888	**Systemic Change(s):** The facility COVID-19 Vaccination Policy has been reviewed and no changes are warranted at this time. All facility staff have been re-inserviced on the current COVID-19 Vaccination Policy. **Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete monthly QA audits to monitor for compliance. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date:** 10/12/22	

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F 888	Continued From page 32 its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (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	F 888		

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F 888	Continued From page 33 recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to have an accurate system to track the immunization status of all facility employees affecting one employee (Staff #5) in a sample of 11 employees reviewed, and the facility staff permitted one staff member (Staff #5) who was not fully immunized to continue to work; the facility staff's vaccination rate was 99.5%	F 888		

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	495300	A. BUILDING _____ B. WING _____	C 09/01/2022

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F 888	Continued From page 34 The findings included: The facility staff failed to have an accurate system to track the COVID immunization status of one employee Staff #5 and permitted her to work after being eligible to receive the second dose, which she didn't receive timely. On 8/30/22, the facility staff provided the survey team with a copy of the staff vaccination matrix and a document titled, "COVID-19 Vaccination Record Log for Staff", which included dates of vaccination. These two documents were reviewed and a sample of 11 employees were selected for review. The staff vaccination matrix revealed the following: Staff #5 was listed as being partially vaccinated. The COVID-19 vaccination record log for staff, revealed that Staff #5 was listed as having received one dose on 6/28/22. On 8/31/22 at 2:14 PM, an interview was conducted with the Infection Preventionist (IP) Nurse. She stated that she oversees the COVID testing of Residents and staff but that Human Resources (HR) maintains the staff vaccination cards and staff vaccination matrix. The IP and Employee E, the Quality Assurance (QA) nurse confirmed that second doses of COVID vaccinations are given 30 days from the first dose. On the afternoon of 8/31/22, Surveyor E met with Employee F, the HR Director. The HR director looked through employee files and found the following: Staff #5's information on file indicated	F 888		

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she received one dose of a multi-dose vaccine series on 6/28/22. Staff #5 was hired 7/13/22.

During this interview, the HR director said, "I do recruiting and onboarding. If they don't have the vaccine then they have to file for an exemption prior to hire. They bring their vaccination card when they come in for the drug test or orientation, they can't start without at least one [dose]. We had one or two that only had one dose and I put them on the COVID tracker. I put new hires on there and I send an email to the Administrator every week as to who was hired, terminated, received the booster, etc. I put the information on the tracker but I don't follow-up".

On 8/31/22 at 4:24 PM, an interview was conducted with Employee E. Employee E was asked about COVID vaccine requirements for staff. Employee E said, "They are required to have their first shot before hired and second when eligible".

On 8/31/22 at 4:56 PM, during an end of day meeting, the facility Administrator and Corporate staff were made aware that Staff #5 was noted as being partially vaccinated, is eligible to receive the second dose, and has continued to work. The facility staff indicated they would look into this.

On 9/1/22 at 10:53 AM, Surveyor E met with the facility Infection Preventionist and QA nurse. They were both shown Staff #5's information on the "COVID-19 Vaccination Record Log for Staff" that the facility provided. It indicated Staff #5 received 1 dose of a primary series on 6/28/22, and they were asked when she would be eligible for the second dose. The QA nurse said, "7/26/22". They were then shown Staff #5's time card, which

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revealed she had worked 7/26/22, 7/30/22, 7/31/22, 8/2/22, 8/3/22, 8/5/22, 8/8/22, 8/9/22, 8/11/22, 8/14/22, daily from 8/17/22-8/23/22, 8/25/22, 8/28/22, and 8/30/22. When asked if this is a problem, they both [the IP and QA nurse] stated, "Yes".

On the morning of 9/1/22, the facility Administrator provided Surveyor E with a document from CDC that read, "Stay Up to Date with COVID-19 Vaccines Including Boosters". This document had a revision date of 8/23/22. The Administrator pointed out that it indicated the 2nd dose of the primary series for the Moderna is due 4-8 weeks after the first dose and stated that Staff #5 was within the 8 weeks of her first dose.

Surveyor E then showed the Administrator a document from CDC that read, "Stay Up to Date with Your Vaccines" dated 1/16/22, that indicated Moderna vaccines are to be "given 4 weeks (28 days) apart".

On 9/1/22 at 11:02 AM, the Administrator provided Surveyor E with a copy of Staff #5's vaccination card that showed a second dose of the primary vaccination series was completed 8/15/22. The document had a printed date of 9/1/22, 10:50 AM. The Administrator was asked about this and she said, "She [Staff #5] just sent it to HR this morning.

On 9/1/22, the HR Director, Employee F, confirmed that Staff #5 had emailed her a photo of her COVID immunization card this morning and prior to receiving this at 10:50 AM, she was not aware that Staff #5 had been immunized.

The facility staff's vaccination rate was 99.5%.

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F 888	Continued From page 37 A review was conducted of the facility policy titled, "Covid-19 Vaccine Policy & Forms" with a revision date of 5/10/22. This policy read, "... Guidelines: 1. It is required that all affected individuals working within the center receive a COVID-19 vaccination as a condition of employment or access to the center unless a valid medical or religious exemption is granted. All affected individuals are expected to either receive the 2-shot series or a single dose of a one shot COVID-19 vaccine or obtain an approved exemption from the vaccination requirement. 5. New affected individuals are required to receive COVID-19 vaccination or provide proof of vaccination or provide adequate documentation of exemption at the time of hire or entry to the center. New applicants or affected individuals who have not provided documentation of compliance (or have failed to secure an approved exemption or immunization), will be listed as 'pending' hire and will not participate in the new Team member orientation program. Newly affected individuals who have not provided documentation of compliance (or have failed to secure an approved exemption or immunization) will not be allowed to enter the facility. a. New team member applicants will be given seven (7) business days from the date of the employment health screening to provide adequate documentation of exemption or vaccination before the facility rescinds the offer of employment; during this (7) day period the new applicant will not be allowed to work without proof of vaccination status or documentation of exemption. If documentation is not received, the facility Human Resources will advise the applicant	F 888		

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they are not cleared for hire and may result in rescinding the offer of employment.

b. Newly affected individuals who receive the initial dose of COVID -19 vaccine on day one of entering the facility and complete the medical exemption form under "other" stating they have initial dose and will wear Personal Protection Equipment, PPE of a N95 face mask until full vaccination status of 2 weeks after final vaccine will be allowed to enter facility and work.

6.Team members on leave of absence who return are required to be in compliance with this policy upon return and must provide documentation of policy compliance (approved exemption or immunization) prior to the scheduled return to work date. If no documentation is provided to the facility Human Resource office at the time of the return-to-work visit, the team member will be advised that he/she is not cleared to return to work until he/she is in compliance with this policy..."

CMS (Centers for Medicare and Medicaid Services) issued notice in the QSO Memo titled, "Ref: QSO-22-09-ALL, DATE: January 14, 2022". This notice read, "...CMS expects all providers' and suppliers' staff to have received the appropriate number of doses by the timeframes specified in the QSO-22-07 unless exempted as required by law, or delayed as recommended by CDC. Facility staff vaccination rates under 100% constitute non- compliance under the rule...Within 90 days and thereafter following issuance of this memorandum, facilities failing to maintain compliance with the 100% standard may be subject to enforcement action..."

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F 888	Continued From page 39 On 9/1/22, during the end of day meeting, the facility staff were made aware of the above findings. No additional information was received.	F 888		