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

PRINTED 11/03/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495425		10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE REHAB CENTER AT BRISTOL	301 VILLAGE CIRCLE BRISTOL, VA 24201

(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	E 000		
	An unannounced Emergency Preparedness survey was conducted 10/24/2022 through 10/26/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 10/24/2 through 10/26/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 70 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 3 closed record reviews.			
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.	F 584		

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

Lori Martin — Executive Director — 11/11/22

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 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, and facility document review the facility staff to ensure a clean, comfortable, homelike environment for 1 of 2 floors, and one of 19 residents, Resident #36. The findings included: 1. For the 2nd floor of the facility, the facility staff failed to ensure a clean environment. Throughout the course of the survey, the surveyor observed a pervasive odor of urine in	F 584	F-584 Providing a clean environment is important to the team at The Rehab Center at Bristol. 1. A. The area on second floor has been cleaned and disinfected. B. The room for Resident #36 was deep cleaned. 2. A. All residents have the potential to affected by the same deficient practice. The decision was made to add a housekeeper to the staff on second floor starting 11/7/22. B. All residents have the potential to be affected by the same deficient practice. Environmental Services now has a schedule to deep clean each room once a month, in addition to the daily cleanings. (continued)	

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the hallway of the second floor. The surveyor also observed debris in the floor, and inside the handrails. These observations were addressed with the maintenance director and housekeeping district manager on 10/26/22 at 11:10 am during a waking tour of the 2nd floor of the facility. Surveyor asked the housekeeping district manager how often the handrails were cleaned, and housekeeping district manager stated one time per week. Surveyor asked how many housekeepers were assigned to each floor and housekeeping district manager stated one on each floor. Surveyor asked how often each resident room is cleaned and housekeeping district manager stated each room should be cleaned daily. Surveyor asked what room cleaning consisted of and housekeeping district manager stated dusting, wiping of high use surfaces (overbed tables, call bell cords), damp mopping, emptying trash, and cleaning bathrooms.

Surveyor spoke with CNA (certified nurse's aide) #4 on 10/226/22 at 10:45 am. Surveyor asked CNA #4 how often housekeeping cleaned resident rooms, and CNA stated they were not sure. CNA #4 stated there is only one housekeeper for the floor, and they do not clean every room, every day. Surveyor asked CNA #4 if they noticed an odor of urine, and CNA #4 stated, "Oh, yeah, it's like that every day".

Surveyor spoke with housekeeper on 10/26/22 at 12:25 pm. Surveyor asked housekeeper if they cleaned every resident room every day, and housekeeper replied, "Depends, I can do it every day if I just do a sweep through." Surveyor asked housekeeper how long it takes to clean a room, and housekeeper stated, "some take longer than

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(continued)

3. Team members were educated on specific cleaning requirements. Further, new members have been added to the Environmental Team.
4. EVS Director will audit common areas and rooms five times weekly for twelve weeks. Results will be reported to the QAPI Committee for further direction.
5. Systems will be in place no later than November 30, 2022.
6. Director of Environmental Services

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others, but generally 10-15 minutes". Surveyor observed housekeeper using damp mop to sweep debris from under a resident's bed.

Surveyor requested and was provided with a policy entitled "Daily Patient Room Cleaning" which read in part, "Timing and Method-C Follow 5-step room cleaning method: 1) Empty trash Get the trash out of all rooms first thing. Wipe basket-if necessary replace liner. 2) Horizontal dusting. With a cloth & disinfectant wipe all horizontal (flat) surfaces. 3) Spot clean. With a cloth & disinfectant spot clean all vertical surfaces. 4) Dust mop floor. Use dust mop to gather all trash & debris on floor. Sweep to the door; pick up with dust pan. 5) Damp mop floor with germicide solution..." and "Bathroom Cleaning: Timing and Method - B. Follow 7-step Method. Dry steps: 2. Pull trash. Wipe can and if necessary replace liner. 2. Fill dispensers Soap, paper, etc. 3. Dust mop. Wet Steps: 4. Sanitize sinks, light, mirror, sink, fixtures and pipes. 5. Sanitize commode, tank, bowl & base. Use brush for inside of bowl. 6. Spot clean-Walls, partitions, light switches. 7. Damp mop."

The concern of not providing a clean, comfortable environment was discussed with the administrator and director of nursing on 10/26/22 at 1:50 pm.

No further information was provided prior to exit.

2. For Resident #36, the facility failed to ensure a clean, comfortable environment.

Resident #36's face sheet listed diagnoses which included, but not limited to Autistic disorder, liver disease, anxiety, hypertension, hypothyroidism,

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disorder of urea cycle metabolism, and age-related osteoporosis.

Resident #36's most recent quarterly minimum data set with an assessment reference date of 08/16/22 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired.

Surveyor observed Resident #36 on 10/24/22 at 3:30 pm. Resident #36 was seated in wheelchair at side of bed. Surveyor introduced self to resident, and resident turned their face away from surveyor. Surveyor noticed a strong odor of urine in the room at this time. Surveyor observed Resident #36 again on 10/25/22 at 8:40 am. Resident was seated in wheelchair at side of bed. Surveyor noticed a strong odor of urine in the room.

Surveyor spoke with resident's family member/sibling on 10/25/22 at 1:15 pm. Surveyor asked sibling if they had any concerns with the care the resident was receiving at the facility, and sibling stated, "The biggest issue I have is with the cleanliness and smell."

Surveyor observed Resident #36 on 10/26/22 at 7:45 am. Resident was seated in wheelchair at bedside. Surveyor noticed a slight odor of urine in the room at this time. Surveyor observed the resident's bathroom at this time, and noticed a brownish substance on the toilet, toilet seat and floor.

Surveyor observed Resident #36's bathroom again on 10/26/22 at 10:45 am. Surveyor observed brownish substance on toilet, toilet seat

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F 584	Continued From page 5 and floor. Surveyor spoke with CNA #4 at this time and asked CNA #4 if the housekeeper had been in the room, and CNA #4 stated they had not yet seen housekeeping. Surveyor pointed out the brownish debris to the CNA, and CNA stated they would take care of it. The concern of not providing a clean, comfortable environment was discussed with the administrator and director of nursing on 10/26/22 at 1:50 pm. No further information was provided prior to exit.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section: and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		

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F 623	Continued From page 6 (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge. under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs. under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for	F 623		

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the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, the facility staff failed to provide copies of notice of resident transfers and discharges to a representative of the Office of the State Long-Term Care Ombudsman.

The findings included:

F 623

F-623

Providing evidence of notification of resident discharge to the Office of the State Long-Term Care Ombudsman is important to the team at The Rehab Center at Bristol.

1. The Admissions Director was in-serviced by the Administrator regarding written notification resident of the Office of the State of Long-Term Care Ombudsman.
2. All residents have the potential to be affected by this deficient practice. A review of the last six months showed that the facility was not sending out notifications to the residents or resident representatives and the representative of the Office of the State of Long-Term Care Ombudsman.
3. The Admissions Director was in-serviced by the Administrator on 11/04/2022 on faxing copy of the list of discharged residents to both the local and state Ombudsman.

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The facility staff failed to provide evidence of notification of resident transfers and discharges to the Office of the State Long-Term Care Ombudsman.

On 10/26/22 at approximately 12:00 pm, surveyor spoke with the administrator who stated they were unable to locate documentation of notice of resident transfers and discharges being sent to the ombudsman's office. The administrator stated they were reaching out to the ombudsman to find out when the facility last provided resident transfer and discharge information.

Surveyor requested and received the facility policy entitled "Notice Requirements before Transfer/Discharge" which read in part:
1. Before the facility transfers or discharges a resident, the facility will:
b. Notify the resident and if known, a family member or the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
c. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

On 10/26/22 at 1:49 pm, the survey team met with the administrator and director of nursing and discussed the concern of the facility being unable to provide evidence of ombudsman notification regarding resident transfers and discharges

No further information regarding this concern was presented to the survey team prior to the exit conference on 10/26/22.

F 623 (continued)

4. The Administrator will review weekly the fax confirmation regarding the Ombudsman's notification of discharged residents for the next 90 days and periodically ongoing. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing.
5. November 30, 2022
6. Admissions Director / Administrator

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F 677 ADL Care Provided for Dependent Residents
SS=D CFR(s): 483.24(a)(2)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene:
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, family interview, staff interview, and clinical record review, the facility staff failed to provide activities of daily living (ADL) care for 3 of 18 Residents, Resident #52, #36, and #252.

The findings include:

1. Resident #52's toenails were observed to be long, thick, and jagged. Resident #52 was unable to cut/trim their toenails.

Resident #52's diagnoses included but were not limited to, Alzheimer's disease and need for assistance with personal care

Section C (cognitive patterns) of Resident #52's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/22/22 included a brief interview for mental status (BIMS) score of 10 out of a possible 15 points

Resident #52's comprehensive care plan included the problem area Activity of Daily Living Approaches included, but were not limited to provide assistance for completion of ADL tasks

10/24/22 3:20 p.m., Resident #52 was observed ambulating in room. Resident #52 was observed with open toed shoes and their toenails were

F 677 F-677
F 677

Providing ADL care to residents at The Rehab Center at Bristol is important to the team.

1. A. The toenails of resident #52 were trimmed during survey.
   B. Resident #36 had her facial hair trimmed.
   C. Resident #252 had his fingernails trimmed shortly after survey.
2. All residents have the potential to be affected by the same deficient practices. (A.) An audit was completed during survey to ensure all nails were either trimmed or name placed on a list for the podiatrist. (B) An audit is being completed to ensure removal of facial hair for females who prefer to have hair removed. (C) an audit is being completed to ensure fingernails are trimmed per resident's preference.
3. Education is scheduled for all nursing team regarding ADL care.

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observed to be long, thick, and jagged. When asked about their toenails Resident #52 stated, who do I get to cut them? Resident #52 stated they were able to cut their fingernails at times but not their toenails.

10/25/22 10:05 a.m., Resident #52 observed in room, open toed shoes toenails remain long, thick, and jagged

10/25/22 12:20 p.m. the Administrator provided the survey team with a copy of policy titled, "Fingernails/Toenails, Care of " This policy read in part, "...The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection...Nail care includes daily cleaning and regular trimming. .Trimmed and smoothed nails prevent the resident from accidentally scratching and injuring his or her skin..."

10/25/22 4:15 p.m during an end of the day meeting, The Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Social Worker were made aware of the issue regarding Resident #52's toenails.

10/26/22 7:55 a.m., the DON stated they did an in house sweep of the residents regarding toenails, some toenails were trimmed and podiatry consults were made as needed

10/26/22, the facility staff provided the survey team with a progress note regarding Resident #52 dated 10/25/22 6:40 p.m. that read in part, "...provided foot care with toenail trimmings..."

No further information regarding this issue was provided to the survey team prior to the exit

F 677 (continued)

4. The Activities Director or designee will monitor residents to ensure nail care (toenails and fingernails) and facial hair is maintained per resident request. Audits will be conducted for five residents weekly for six months. Results will be reported to the Unit Manager for follow-up immediately. Findings will be reported to QAPI committee for further review and recommendations for the duration of the auditing.
5. November 30, 2022
6. Activities Director / Unit Managers

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F 677	Continued From page 11 conference. 2. For Resident #36 the facility staff failed to provide activities of daily living (ADL) care in regards to facial hair. Resident #36's face sheet listed diagnoses which included but not limited to Autistic disorder and cognitive communication deficit. Resident #36's most recent quarterly minimum data set with an assessment reference date of 08/16/22 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired. Section G, functional status coded the resident as total dependence, one person physical assist, in the area of personal hygiene This includes removal of facial hair Resident #36's comprehensive care plan was reviewed and contained a care plan for "Resident needs assist with ADL's R/T (related to) hx (history) of tendon rupture weakness, impaired cognition and incontinence." Approaches for this care plan included "provide assistance as needed for ADL's." Surveyor observed Resident #36 on 10/25/22 at 8:40 am. Resident was dressed in street clothes, seated in wheelchair at bedside Surveyor observed that the resident had large amount of facial hair in the chin area. Surveyor asked the resident if this bothered them, but resident turned face away from surveyor and did not answer. Surveyor spoke with the resident's sibling on	F 677		

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F 677	Continued From page 12 10/25/22 at 1:15 pm. Surveyor asked sibling if resident's facial hair seemed to bother them, and sibling stated that resident did not like having hair on their chin, and that when they lived at home, they removed it themselves. Sibling also stated that chin hair had not been removed in 2 weeks. The concern on not providing ADL care was discussed with the administrator and director of nursing on 10/26/22 at 1:50 pm. No further information was provided prior to exit. 2. For Resident #252 the facility staff failed to provide activities of daily living (ADL) in regards to nail care. Resident #252's face sheet listed diagnoses which included but not limited to acute kidney failure, dementia, type 2 diabetes mellitus, and anxiety Resident #252's most recent minimum data set with an assessment reference date of 0609/22 assigned the resident a brief interview for mental status score of 7 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Section G, functional status, coded the resident as needing extensive assistance of one person in the area of personal hygiene. Resident #252's comprehensive care plan was reviewed and contained a care plan for "... needs assistance with ADL's r/t (related to) weakness, mental health and impaired cognition." Approaches for this care plan included "provide	F 677		

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F 677	Continued From page 13 assistance with ADL's as needed." Surveyor observed Resident #252 on 10/24/22 at 3:15 pm. Resident was resting in bed. Surveyor observed resident's fingernails to be long with brownish discoloration. Surveyor asked resident if this bothered them, and they stated, "they need to be cut." Surveyor requested and the administrator provided the survey team with a copy of policy entitled "Fingernails/Toenails, Care of" which read in part, ".. The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection...Nail care includes daily cleaning and regular trimming...Trimmed and smoothed nails prevent the resident from accidentally scratching and injuring his or her skin..." The concern of not providing nail care to Resident #252 was discussed with the administrator, director of nursing, assistant director of nursing and social worked on 10/25/22 at 4:15 pm. On 10/26/22 at 7:55 am, the director of nursing informed the survey team that they had completed an in-house sweep of all residents regarding nail care. Nails were trimmed and consults made as needed. No further information provided prior to exit.	F 677		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		

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licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to follow-up on pharmacist recommendations for 2 of 19

F 756

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residents, Resident #36 and Resident #47 and failed to complete pharmacy reviews for 1 of 19 residents. Resident #44.

The findings included:

1. For Resident #36 the facility staff failed to follow-up on pharmacist recommendations.

Resident #36's face sheet listed diagnoses which included, but not limited to Autistic disorder, liver disease, anxiety, hypertension, hypothyroidism, disorder of urea cycle metabolism, and age-related osteoporosis.

Resident #36's most recent quarterly minimum data set with an assessment reference date of 08/16/22 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired.

Resident #36's comprehensive care plan was reviewed and contained care plans for "Resident has liver disease", "Resident has hypothyroidism" and "Resident is prescribed anticoagulant therapy d/t (due to) hx (history) of DVT (deep venous thrombosis [blood clot])" Interventions for these care plans included "Monitor lab work as ordered".

Resident #36's clinical record was reviewed and contained a pharmacy review form, which read in part "Note to Attending Physician/Prescriber. MRR (medication regimen review) Date: 6/21/2022. This resident is taking the following medications: Synthroid, Cal (calcium)/Vit D, Omeprazole. If appropriate consider obtaining at next lab draw CBC (complete blood count), BMP

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(basic metabolic panel), TSH (thyroid stimulating hormone), Vit D, Vit B12, Magnesium to monitor the safety and efficacy of these medication(s). RESPONSE: OBTAIN THE FOLLOWING LAB WORK: Add above. Physician/Provider Response: Agree" This form was signed/dated on 07/21/22.

Resident #36's clinical record contained a second pharmacy review form which read in part, "Note to Attending Physician/Prescriber. MRR (medication regimen review) Date: 8/19/2022. This resident is taking the following medications: Synthroid, Cal Vit D, Omeprazole, Lactulose. If appropriate consider obtaining at next lab draw CBC, BMP, TSH, Vit D, Vit B12, Magnesium, ammonia to monitor the safety and efficacy of these medication(s). RESPONSE: OBTAIN THE FOLLOWING LAB WORK: Add above. Physician/Provider Response: Agree" This form was signed/dated on 08/30/22.

Resident #36's clinical record contained a physician's order summary, which read in part "07/22/2022-07/22/2022 Basic Metabolic Panel; CBC (complete blood count) with Diff (differential); TSH (thyroid stimulating hormone); Vitamin B12; Other Test: (Vitamin D, Magnesium) Once-One Time; 07:00 AM-07:00 PM" and "08/31/2022-08/31/2022 Basic Metabolic Panel; CBC with Diff; TSH; Vitamin B12; Other Test: (Vitamin D, Magnesium, Ammonia) Once-One Time; 07:00 AM-07:00 PM"

Resident's clinical record was reviewed on 10/26/22, and surveyor could not locate any laboratory reports related to the above ordered lab tests. Surveyor informed the director of nursing (DON) of the missing lab reports on

F 756 F-756

Following up on pharmacist recommendations and ensuring a pharmacy review is completed monthly is a is important to the team at The Rehab Center at Bristol.

1. A. Order written to obtain labs for resident #36.

   B. Order was clarified for resident #47.

   C. Ensured reviews were completed since February for resident #44

2. All residents have the potential to be affected by the same deficient practices. A review of all records is scheduled to ensure medication regimen reviews have been conducted for all residents monthly and that follow-up was completed for all recommendations.
3. Education is scheduled for all nursing team regarding pharmacy recommendations and follow-up requirements.

(continued)

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10/26/22 at 12:15 pm. DON informed the surveyor on 10/26/22 at 1:40 pm that the labs were not completed as ordered.

The concern of not following up on pharmacy recommendations was discussed with the administrator and DON on 10/26/22 at 1:50 pm.

No further information provided prior to exit

2. For Resident #47, the facility staff failed to follow up on a pharmacy recommendation in regards to the topical medication Diclofenac (nonsteroidal anti-inflammatory drug).

Resident #47's diagnosis included, but were not limited to, chronic pain syndrome.

Section C (cognitive patterns) of Resident #47's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/31/22 included a brief interview for mental status (BIMS) summary score of 13 out of a possible 15 points.

The clinical record included a document titled "INTERIM MEDICATION REGIMEN REVIEW (IMRR)." This document included the following pharmacy recommendations. in regards to the medication Diclofenac (voltaren) 1% gel 1 application topically three times daily for pain. The pharmacy consultant transcribed the following "Please clarify instructions to include dose in grams and site of application."

On 09/22/22 the provider ordered Diclofenac sodium (voltaren) apply 1% apply quarter sized amount to left shoulder and lumbar area every 6 hours PRN (as needed) for pain. However, the

F 756

(continued)

4. Unit Managers or designee will monitor all pharmacy reviews monthly to ensure that a pharmacy review was completed on each person and that the recommendation was followed through. Audits will be conducted monthly for six months, and results will be reported to the QAPI committee for further review and recommendations for the duration of the auditing.
5. November 30, 2022
6. Unit Managers

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scheduled order remained active and read apply 1 application to affected area TID (three times a day) for pain.

10/26/22 8:36 a.m., the Director of Nursing (DON) was asked for information regarding the Diclofenac pharmacy recommendation.

10/26/22 10:25 a.m., the DON stated they were going to discontinue the Diclofenac scheduled order and keep the PRN order in place.

10/26/22 1:50 p.m., during a meeting with the Administrator and DON the surveyor asked if they knew why a PRN order was written for the Diclofenac instead of addressing the current order. The DON stated they could come up with different scenarios but really had no idea.

No further information regarding this issue was provide to the survey team prior to the exit conference.

3. For resident #44, facility staff failed to ensure a medication regimen review (MRR) was performed for the month of February 2022.

Resident #44 diagnosis list includes, but is not limited to the following: congestive heart failure, chronic pain syndrome, hypertension, atrial fibrillation, generalized anxiety disorder, major depressive disorder, polyosteoarthritis, and restless legs syndrome.

The most recent quarterly minimum data set (MDS) with an assessment reference date of 8-9-22, assigned the resident a BIMS (brief interview for mental status) summary score of 10

F 756

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F 756	Continued From page 19 out of 15 in section C, cognitive patterns, indicating the resident was moderately cognitively impaired. Upon review of resident #44's clinical record, surveyor was unable to locate the February 2022 medication regimen review completed by a pharmacist. On 10-26-2022 at 10:20 A.M., surveyor spoke with the Director of Nursing (DON) and the Administrator about the medication regimen review not being in the chart. DON stated that she would look for it. At 11:13 A.M., DON asked surveyor what it was that had been asked for, and again stated she would look. At 1:40 P.M. DON brought surveyor reviews for the months of June and September and stated, "February's are missing". On 10-26-2022 the survey team met with the DON and Administrator surveyor again mentioned that there is no medication regimen review for the month of February in resident #44's medical record. No further information regarding this concern was provided to the survey team prior to the exit conference.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater: This REQUIREMENT is not met as evidenced	F 759		

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F 759 Continued From page 20

by:
Based on resident interview, staff interview, clinical record review, facility document review, and during a medication pass and pour observation the facility staff failed to ensure a medication error rate of less than 5%. There were 3 errors in 32 opportunities for a medication error rate of 9.38%. These medication errors affected Resident #55.

The findings include:

During a medication pass and pour observation the facility staff failed to ensure a medication error rate of less than 5%. The medication error rate was 9.38%. LPN #2 did not administer Resident #55's Aspercreme, Colace, or Magnesium Hydroxide.

10/25/22 beginning at approximately 7:38 a.m., the surveyor observed Licensed Practical Nurse (LPN/agency nurse) #2 prepare and administer Resident #55's morning medications.

LPN #2 was observed to pick up a bottle of Magnesium Hydroxide from the cart and state it did not have the residents name on it and they would have to find out the facility procedure. LPN #2 placed the medication back into the medication cart.

Resident #55's diagnoses included, but were not limited to: pain and constipation.

Section C (cognitive patterns) of Resident #55's quarterly minimum data set (MDS) assessment with an ARD of 08/02/22 included a brief interview for mental status (BIMS) score of 14 out of a possible 15 points.

F 759

F-759

Ensuring a medication administration error rate of less than 5% is important to the clinical team at The Rehab Center at Bristol.

1. Resident #55 experienced no ill effects from the medication pass conducted on 10/25/22. Nurse re-educated immediately.
2. All residents have the potential to be affected by the same deficient practices.
3. Education is scheduled for all nursing team regarding proper medication administration practices.

(continued)

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Resident #55's clinical record included provider orders for Aspercreme apply a quarter size amount to right shoulder twice a day, Colace 100 mg 1 tab by mouth twice daily, and Magnesium Hydroxide 30 ml by mouth daily. The morning administration times on all of these medications was documented as 8:00 a.m. The surveyor did not observe these medications being administered.

Resident #55's comprehensive care plan included the problem area complaints of pain. Approaches included, but were not limited to, Administer medications as ordered.

10/25/22 10:00 a.m., the Assistant Director of Nursing (ADON) provided the survey team with a copy of policy titled, "Administering Medication." This policy read in part, "...Medications are administered in accordance with prescriber orders, including any required time frame..."

10/25/22 11:40 a.m., Resident #55 stated they did not get their Aspercreme.

10/25/22 11:44 a.m., LPN #2 stated they did not administer Resident #55's Colace or Magnesium Hydroxide.

10/25/22 4:15 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), ADON, and Social Worker the issue with the medication pass and medication error rate was reviewed.

10/26/22 1:50 p.m., during a meeting with the Administrator and DON the DON stated they had spoken with LPN #2's agency.

F 759 (continued)

4. The Assistant Director of Nurses or designee will monitor weekly for eight weeks and then monthly for six months to ensure proper medication administration. ADON will provide corrective measures during the audit as needed. Findings will be reported to QAPI committee for further review and recommendations for the duration of the auditing.
5. November 30, 2022
6. ADON

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No further information regarding this issue was provided to the survey team prior to the exit conference.

F 761 SS=D 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 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, staff interview, and facility document review, the facility staff failed to dispose of expired specimen tubes in 1 of 2 medication rooms (floor 2) and failed to ensure

F 759

F 761 F-761

Disposing of expired specimen tubes and ensuring keys to the medication cart are secure is important to the team at the Rehab Center at Bristol.

1. No resident was found to be affected by the deficient practice; however, there is the potential for all residents to be affected.

2. In order to ensure that no residents are affected, a review of the facility medication carts, and medication room was conducted by the Unit Manager and ADON during survey, to ensure no expired specimen tubes remained in medication rooms and all medication carts are locked when not observed by a nurse.

(continued)

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medication(s) were secure on 1 of 2 floors (floor 1).

The findings include:

The facility staff failed to dispose of expired specimen tubes and left the keys to the medication cart on top of the medication cart and out of view.

10/24/22 4:25 p.m., the surveyor checked the medication room on floor 2 with Licensed Practical Nurse (LPN) #1. The cabinet in this medication room included 2 opened containers of purple top blood specimen tubes with an expiration date of 09/30/22 and 1 bag (17) of white top tubes used for urine collection with an expiration date of 10/06/22.

10/24/22, LPN #1 stated they had spoken with the unit manager and they would be disposing of the expired specimen tubes

10/25/22 8:05 a.m., during a medication pass and pour observation with LPN #2 (agency nurse), LPN #2 was observed to leave their medication cart keys on top of the medication cart and entered a resident's room leaving the cart and keys unattended and out of view. No residents or staff were observed in the vicinity of the medication cart.

10/25/22 10:00 a.m., the Assistant Director of Nursing (ADON) provided the surveyor with a copy of their policy titled, "Administering Medications." This policy read in part, "...During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse..."

F 761 (continued)

3. Licensed nurses including LPN #1 and LPN #2 were re-educated by the Director of Nursing/ADON during survey on checking expiration dates and discarding appropriately. All nurses will be in-serviced on checking expiration dates and not leaving medication carts unlocked and/or not leaving keys available to access medication carts.

4. Unit Managers, Director of Nursing, ADON, will monitor medication carts and Medication room via direct observation 5 times per week for 30 days, to ensure resident specimens are not expired and ensure unlocked medication carts aren't left unattended. DON/ADON or designee will audit Medication Carts and Medication rooms randomly on a weekly basis for the next 60 days,

(continued)

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F 761 Continued From page 24

10/25/22 11:25 a.m., the ADON provided the surveyor with a copy of a policy titled, "Storage of Medications." This policy read in part, "...Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed..."

10/25/22 4:15 p.m., the Administrator, Director of Nursing (DON), ADON, and Social Worker were made aware of the issues regarding the expired specimen tubes and unattended medication cart keys.

10/26/22, the facility staff provided the surveyor with a copy of in-service started on 10/25/22 by the ADON titled, "Med Cart." Summary of content "Medication should be secured at all times, and the keys should be with the staff member conducting the med pass." The facility staff also provided the surveyor with a copy of a handwritten note that read "All expired blood tubes and urine tubes have been disposed of."

10/26/22 1:50 p.m., during a meeting with the Administrator and DON the DON stated they had spoken with LPN #2's agency.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 761

(continued)

and then monthly for the following 90 days. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing.

5. November 30, 2022

6. DON and leadership

F 770 Laboratory Services
SS=D CFR(s): 483.50(a)(1)(i)

§483.50(a) Laboratory Services.
§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality

F 770

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F 770 Continued From page 25

and timeliness of the services.
(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record the facility staff failed to obtain a physician ordered laboratory test for 1 of 19, Resident #36.

The findings included:

For Resident #36 the facility staff failed to obtain physician ordered laboratory blood tests.

Resident #36's face sheet listed diagnoses which included, but not limited to Autistic disorder, liver disease, anxiety, hypertension, hypothyroidism, disorder of urea cycle metabolism, and age-related osteoporosis.

Resident #36's most recent quarterly minimum data set with an assessment reference date of 08/16/22 assigned the resident a brief interview for mental status score of 9 out of 15 in section C, cognitive patterns. This indicates that the resident is moderately cognitively impaired.

Resident #36's comprehensive care plan was reviewed and contained care plans for "Resident has liver disease", "Resident has hypothyroidism" and "Resident is prescribed anticoagulant therapy d/t (due to) hx (history) of DVT (deep venous thrombosis [blood clot])" Interventions for these care plans included "Monitor lab work as ordered".

Resident #36's clinical record was reviewed and

F 770

F-770

Obtaining lab services as ordered by the physician is important to the team at the Rehab Center at Bristol.

1. An order was written to obtain the missing lab for Resident #36. She has experienced no ill effects from the missing lab.
2. To ensure that no other residents are affected, a review of the ordered labs will be conducted to ensure compliance with all lab orders.
3. Education will be provided to licensed team members to ensure labs are completed as ordered. A process has been developed for tracking labs to improve compliance.
4. The DON or designee will conduct audits of labs to ensure timely completion. Audits will be conducted weekly for eight weeks and then monthly for six months.

(continued)

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F 770	Continued From page 26 contained a physician's order summary, which read in part "07/22/2022-07/22/2022 Basic Metabolic Panel; CBC (complete blood count) with Diff (differential); TSH (thyroid stimulating hormone); Vitamin B12; Other Test: (Vitamin D, Magnesium) Once-One Time; 07:00 AM-07:00 PM" and "08/31/2022-08/31/2022 Basic Metabolic Panel; CBC with Diff; TSH; Vitamin B12; Other Test: (Vitamin D, Magnesium, Ammonia) Once-One Time; 07:00 AM-07:00 PM" Resident's clinical record was reviewed on 10/26/22, and surveyor could not locate any laboratory reports related to the above ordered lab tests. Surveyor informed the director of nursing (DON) of the missing lab reports on 10/26/22 at 12:15 pm. DON informed the surveyor on 10/26/22 at 1:40 pm that the labs were not completed as ordered. The concern of not obtaining the physician ordered labs was discussed with the administrator and DON on 10/26/22 at 1:50 pm. No further information provided prior to exit.	F 770	(continued) Results of the audits will be presented to the QAPI committee for further intervention. 5. November 30, 2022 6. DON and leadership	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		

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F 812 Continued From page 27

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 observations, staff interviews, and facility document review, the facility staff failed to ensure food was stored under safe and sanitary conditions in 2 of 2 unit nourishment rooms.

The findings include:

The facility staff failed to ensure resident food was appropriately stored/labeled.

The following information was found in a facility polity titled "Food: Safe Handling for Foods from Visitors" (with a revised date of July 2019):
- "Residents will be assisted in properly storing and safely consuming food brought into the facility for residents by visitors."
- "When food items are intended for later consumption, the responsible facility staff member will: ... Ensure that foods are in a sealed container to prevent cross contamination ... Label foods with the resident's name and the current date."
- "Refrigerator/freezers for storage of foods brought in by visitors will be properly maintained and: ... Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for (greater than or equal to) 7 days. (Storage of frozen foods and shelf stable items

F 812 F-812

Storing food under safe and sanitary conditions is important to the team at the Rehab Center at Bristol.

1. No residents experienced ill effects from the deficient practice. However, all residents had the potential to be adversely affected.
2. Upon learning of the improperly stored/labeled items, both nourishment rooms were completely cleaned out.
3. Education will be provided to team members to ensure proper dating, labeling, and properly sealing and storing food.
4. The DM/designee will do audits and in-service weekly for 30 days and monthly for 90 days to ensure all policies for labeling, discarding, and packaging are being followed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations for the duration of the auditing.

(continued)

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F 812	Continued From page 28 may be retained for 30 days.)" On 10/25/22 at 1:15 p.m., the nourishment room on the First Floor Unit was observed with CNA #1 An undated container housing food with a resident's name on the container was observed in the refrigerator. CNA #1 reported the food container should have been dated. On 10/25/22 at 1:25 p.m., the nourishment room on the Second Floor Unit was observed with the facility's Dietary Manager (DM). The following refrigerated food items were observed with and subsequently discarded by the DM: - Two (2) opened and partially used containers of onion dip, both with a best by date of 10/12/22. A resident's name was on these containers. - A plastic bag holding two (2) undated containers housing food; neither container was dated. A resident's name was on one (1) of these containers. - Two (2) plastic bags each containing half a sandwich; both were dated 10/19/22 - 10/22/22. - One (1) plastic bag containing a sandwich: this bag included a name and a room number but not a date. - One (1) opened package of bologna. A gap was noted in the bologna packaging. The DM reported this package of bologna should have been repackaged when opened. The survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Social Working on 10/25/22 at 4:10 p.m. The survey team discussed the observations of improperly stored and/or undated resident food items in both of the facility unit's nourishment rooms.	F 812	(continued) 5. November 30, 2022 6. Dietary Manager / designee	

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F 880 Continued From page 29 F 880

F 880 Infection Prevention & Control F 880
SS=D CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(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;

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F 880	Continued From page 30 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and facility document review, the facility staff failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the transmission of communicable diseases and/or infections, including COVID-19, for 2 of 19 residents in the survey sample, Resident #153 and Resident #55.	F 880		

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The findings included

1. On 10/24/22 and 10/25/22 the surveyor noted a sign on the door leading into Resident #153's room which included the statement "WARM ROOM - DROPLET PRECAUTIONS". This sign indicated anyone entering this room was required to use the following personal protective equipment (PPE): mask face shield, gown and gloves. h

On 10/24/22 at 3:17 p.m., the surveyor observed licensed practical nurse (LPN) #4 and certified nurse aide (CNA) #2 in Resident #153 without using a gown or eye protection. The surveyor interviewed LPN #4 and CNA #2 when they exited the room. Both LPN #4 and CNA #2 stated they should have worn a gown but indicated they were not required to use eye protection

On 10/25/22 9:01 a.m the surveyor observed Staff Member (SM) #2 in Resident #153's room. SM #2 was speaking to the resident. SM #2 was not wearing gown, gloves, or eye protection. The surveyor interviewed SM #2 when they exited the room; SM #2 reported they should have worn the gown but did not indicate they needed to wear eye protection or gloves.

On 10/25/22 at 09:05 a.m. the surveyor observed CNA #3 in Resident #153's room. CNA #3 was not wearing eye protection. The surveyor interviewed CNA #3 when they exited the room. CNA #3 reported that eye protection was not available in the PPE supply cart located outside Resident #153's room The surveyor confirmed the PPE supply cart outside Resident #153's room did not include eye protection.

F 880 F-880

Maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and/or infections is important to the team at the Rehab Center at Bristol.

1. No ill effects were experienced by Resident #153 or Resident #55 due to the deficient practices.
2. All residents have the potential to be affected by the same deficient practices. Therefore, an infection preventionist team from the Mt Rogers health district has visited to assess practices and offer guidance to improve processes.
3. Education has been provided to team members on donning and doffing PPE appropriately as well as proper infection prevention techniques during a medication pass and pour.

(continued)

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On 10/25/22 at 10:35 a.m., the surveyor interviewed the facility's Administrator, Director of Nursing (DON), and Assistant DON about the PPE required to enter Resident #153's room. The DON confirmed Resident #153 was on quarantine and required droplet precautions.

The following information was found in a facility policy titled "Coronavirus Disease (COVID-19) - Identification and Management of Ill Residents" (with a revision date of September 2021): "All unvaccinated residents who are new admissions or readmissions are placed in a 14-day quarantine, even if they have a negative test upon admission."

On 10/26/22 at 12:36 p.m. the Director of Nursing (DON) reported Resident #153 was in quarantine using droplet precautions.

On 10/26/22 at 1:50 p.m., the survey team met with the facility's Administrator and DON. Observations of staff members entering Resident #153's room without the appropriate PPE was discussed.

2. During a medication pass and pour observation the facility staff were observed to touch Resident #55's medications with their bare hands.

10/25/22 beginning at approximately 7:38 a.m., the surveyor observed Licensed Practical Nurse (LPN) #2 (agency nurse) prepare and administer Resident #55's morning medications. During this observation LPN #2 was observed to touch each oral medication tablet with their bare hands and then put the medication in the medication cup.

F 880

(continued)

4. ADON or designee will observe five medication passes each week for eight weeks to ensure infection prevention standards are followed. Additionally, ADON will audit appropriate PPE usage ten times weekly ensuring proper ppe is worn, paying particular attention to rooms with isolation precautions. Audits will be reported to QAPI for further review.
5. November 30, 2022
6. ADON / designee

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F 880

Prior to LPN #2 administering these medications the surveyor asked LPN #2 about touching the medications. LPN #2 stated they should not have touched the medications with their bare hands, they did not know who anyone was (staff), and this was their first time in the building. After speaking with the Assistant Director of Nursing/Infection Control Nurse (ADON) and receiving the instructions to dispose of the touched medications in the sharps container LPN #2 discarded the medications and prepared a second set of medications to administer to this resident.

10/26/22. the facility staff provided the survey team with a copy of an in-service titled "Medication preparation" that was started by the ADON on 10/25/22 Summary of content "Do not touch medication with ungloved hands. Use clean gloved hands if it is necessary to touch the medication Using gloves reduces contamination of the medication. Some medications may be harmful to the nurse. If they have direct contact with the skin."

10/25/22 4 15 p.m.. the Administrator, Director of Nursing (DON). ADON. and Social Worker were made aware of the infection control issue during the medication pass.

10/26/22 1:50 p.m. during a meeting with the Administrator and DON the DON stated they had spoken with LPN #2's agency.

No further information regarding this issue was provided to the survey team prior to the exit conference

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F 881	Continued From page 34	F 881	F-881	
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 document review the facility staff failed to maintain an infection prevention and control program to include an antibiotic stewardship program. The findings included The facility staff failed to safeguard and maintain documentation regarding the facility antibiotic stewardship program. On 10/26/22 at 12:39 pm, surveyor met with the administrator and director of nursing (DON) regarding the facility infection prevention and control program. The DON began employment with the facility on 6/27/22 and the administrator began on 9/20/22. The DON stated the previous assistant director of nursing (ADON), who also served as the Infection Preventionist, had the facility antibiotic stewardship documentation on their computer and current staff have been unable to retrieve this information following their departure from the facility. The administrator stated an FRI (Facility Reported Incident) was completed and submitted. Administrator provided	F 881	Safeguarding and maintaining documentation regarding the facility antibiotic stewardship program is important to the team at The Rehab Center at Bristol. 1. An Antibiotic Stewardship Program committee has been formed to oversee the program and development. 2. All residents have the potential to be affected by the deficient practice, therefore the committee plans to present the charter at the next QAPI meeting. 3. ADON or designee will monitor all infections and use of antibiotics. Information will be shared with the Antibiotic Stewardship Committee. 4. All reports and minutes from the Antibiotic Stewardship Committee meetings will be housed on a company computer and shared with the entire committee. Minutes from the meeting will be shared with the QAPI committee for further review. 5. November 30, 2022 6. ADON / designee	

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F 881	Continued From page 35 a copy of an FRI dated 10/05/22 which stated in part "The ADON/Infection Control, (name omitted) sent out an immediate resignation via email effective 9/19/22 at 6:35 pm ... (name omitted) stated to me that (he/she) had communication with the former ADON and questioned the whereabouts of some records related to COVID, infection control, and antibiotic stewardship. (He/she) stated that it was on (his/her) personal computer. (He/she) stated that (he/she) had informed (him/her) to please send to the appropriate recipients since it was not on the share drive...(name and position omitted) ...informed me that on the previous Monday, (ADON) placed (his/her) computer on the desk of the (name omitted) office, stated this was what (he/she) thought of this place, and reset the computer to factory settings and deleted all the records ...As of this date, no records have been retrieved". The DON stated corrective actions have been put into place but a written plan of correction had not been developed. On 10/26/22 at 1:49 pm, the survey team met with the administrator and DON and discussed the concern of the missing antibiotic stewardship documentation. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/26/22.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495425		10/26/2022

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F 883	Continued From page 36 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization, and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883	F-883 It is important to the team at The Rehab Center at Bristol to provide the resident and/or representative education regarding the benefits and potential side effects of the pneumonia vaccine 1. Resident #97 was assessed and offered the pneumococcal vaccine; however, the vaccines were not available prior to discharge. 2. All residents have the potential to be affected. The Director of Nursing or designee will complete an audit of current residents to ensure anyone consenting to a vaccine, will receive the vaccine. 3. The Director of Nurses is completing a 100% audit of all records to develop a list of residents who have not received the vaccine. Those residents will (continued)	

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F 883 Continued From page 37

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, clinical record review, and facility document review, the facility staff failed to offer and provide the resident and/or resident representative education regarding the benefits and potential side effects of the pneumonia vaccine for 1 of 5 sampled residents (Resident #97) reviewed for immunizations.

The findings included:

For Resident #97, the facility staff failed to offer the pneumonia vaccine and provide education regarding the benefits and potential side effects of the vaccine.

Resident #97's diagnosis list indicated diagnoses which included, but not limited to Metabolic Encephalopathy, Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Chronic Kidney Disease Stage 3b, and Chronic Diastolic Heart Failure.

The admission minimum data set (MDS) with an assessment reference date (ARD) of 9/21/22

F 883 (continued)

be assessed to determine their eligibility and desire to receive the vaccine. Residents and their representatives are provided education as to the risks and benefits of receiving the vaccination.

4. The Director of Nursing or designee will complete an audit of new admissions to ensure that residents that consented to vaccines obtained the vaccination following the appropriate physician orders. They will complete this audit monthly for three months. The results of these audits will be reviewed with the QAPI committee. Following the three months, the committee will determine the future need/ frequency of the audit.
5. November 30, 2022
6. DON / designee

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F 883 Continued From page 38

assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15 indicating the resident was moderately cognitively impaired.

Surveyor reviewed Resident #97's clinical record and was unable to locate documentation of the resident's pneumococcal vaccination status or documentation of the resident and/or resident representative being offered and provided education regarding a pneumonia vaccine.

On 10/25/22 at 9:25 am, surveyor spoke with the administrator and requested documentation regarding the pneumococcal vaccine for Resident #97. At 9:31 am, the director of nursing (DON) returned and stated they did not have a signed refusal for the resident.

On the morning of 10/26/22, the administrator provided a copy of a nursing progress note dated 10/25/22 7:22 pm which stated in part "Resident representative contacted regarding pneumonia and COVID vaccination status. Educated on risks and benefits of both vaccines. (Adult child) stated that (he/she) could be vaccinated with pneumonia vaccine ..."

Surveyor requested and received the facility policy entitled "Vaccination of Residents" which read in part "All residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated or the resident has already been vaccinated 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations ..."

F 883

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F 883	Continued From page 39 On 10/26/22 at 1:49 pm, the survey team met with the administrator and DON and discussed the concern of Resident #97's pneumococcal vaccine. No further information regarding this concern was presented to the survey team prior to the exit conference on 10/26/22.	F 883		