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	495115	A. BUILDING _____ B. WING _____	C 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

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E 000	Initial Comments A unannounced Medicare/Medicaid abbreviated standard survey and COVID-19 Focused Emergency Preparedness Survey was conducted onsite 04/03/2023-04/06/2023. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 196 certified bed facility was 177 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and Medicare/Medicaid abbreviated standard survey was conducted 04/03/2023 through 04/06/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Corrections are required for compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Six complaints were investigated during the survey: VA00058392- substantiated without deficient practice VA00058333- substantiated without deficient practice VA00058136- substantiated with deficient practice VA00058073- unsubstantiated	F 000		

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

Electronically Signed | 04/19/2023

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F 000	Continued From page 1 VA00057804- unsubstantiated VA00057615- unsubstantiated The census in this 196 certified bed facility was 177 at the time of the survey. The survey sample consisted of 12 resident reviews and 7 employee reviews.	F 000		
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) 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	F 657		5/10/23

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F 657	Continued From page 2 by: Based on observation, Resident interview, staff interview, Resident record review and facility documentation review, the facility staff failed to have an active care plan to address an elopement risk for 1 Resident (Resident #14) who had a prior known elopement from the facility. The findings included: A clinical record review was conducted of Resident #14's record. This review revealed an entry dated 2/28/23, that read, "Resident eloped from facility @ 1445 2/28/2023; resident was found at grocery store not in assistive device (wheelchair). When asked why she left the building without telling anyone, she said she was going to get cigarettes. Resident was brought back to the facility and educated as to why she cannot just leave the facility; a wander guard was put in place. MD [medical doctor] and RP [responsible party] were both called atnotified [sic]". An elopement risk assessment was completed 2/28/23, following the actual elopement. This assessment identified Resident #14 as being "High Risk for elopement/exit seeking". Review of Resident #14's active care plan revealed that the elopement risk was not an active care plan in place. A staff interview with LPN B, a unit manager, revealed that Resident #14's wander guard was discontinued due to her scoring high on a MMSE (mini-mental status exam). The clinical record revealed that Resident #14 had notations throughout the record that indicated	F 657	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F657 1. Resident #14 had the Wanderguard reinstated on 4/4/23 and the care plan revised to include risk of exit seeking behavior on 4/6/23. 2. Current Residents were reviewed to ensure that risk of elopement/exit seeking is identified and included in the care plan as indicated. 3. All Nurses will be educated by the Assistant Director of Nursing/designee on completion of the Elopement Risk Tool at time of admission, with significant change of condition, and quarterly to identify risk of elopement/exit seeking behaviors and care plan to address the risk and interventions for prevention. 4. An audit of newly admitted residents will be completed by the Unit Manager/designee weekly times 4 and monthly times 2 to ensure that the Elopement Risk Tool was completed, and care plan initiated for identified risk. An audit of Residents with scheduled significant change of condition MDS assessment will be completed by the Unit Manager/designee weekly times 4 and	

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F 657	Continued From page 3 her cognitive functioning varied. Resident #14 was seen by psychiatric services on 2/28/23, an excerpt from this note read, "...Short term memory: poor, Long-term memory: poor, Concentration: poor, Insight: poor, Judgement: poor...". On 4/4/23, an interview was conducted with Resident #14. During this interview, the Resident appeared very confused and was oriented x 1 (to person only) upon surveyor questioning. Surveyor B met with the facility's assistant administrator and Director of Nursing and corporate nurse consultant. When asked about the above incident and the facility's response, they indicated that following the incident and a re-assessment of her cognitive functioning she scored high so to avoid the wander guard being considered a restraint it was discontinued. At the same time the wandering care plan was discontinued. They were notified of Resident #14's evidence of cognitive impairment when Surveyor B met with Resident #14. The meeting with the facility Administration included a discussion that Resident #14 had an actual elopement just over 30 days ago and her most recent elopement risk assessment identified her as "high risk", but she did not have an active care plan to address this. The facility staff indicated they would reassess her cognitive functioning. The facility's Director of Nursing and Corporate Nurse Consultant stated that the facility conducts quarterly assessments and review the Resident's comprehensive care plan at that time. Resident #14 was re-assessed for cognitive functioning on 4/4/23, by facility staff and she	F 657	monthly times 2 to ensure that the Elopement Risk Tool was completed, and care plan initiated for identified risk. An audit of Residents with quarterly MDS assessments scheduled will be completed weekly times 4 and monthly times 2 to ensure that the Elopement Risk Tool was completed, and care plan initiated for identified risk. The results of the audits will be discussed at the monthly QAPI meeting. 5. Completion date: May 10, 2023	

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F 657	Continued From page 4 scored a 9, which indicated moderate cognitive impairments. Upon reassessment of the facility and following the Surveyor's questioning, the facility staff re-instituted the wander guard. On 4/6/23, during an end of day meeting, the facility Administration were made aware of the above findings with regards to Resident #14's elopement risk not being identified on her active care plan. No further information was provided.	F 657		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F 883		5/10/23

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F 883	Continued From page 5 immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide influenza vaccines for 1 Residents (Resident #20) in a survey sample of 5 residents reviewed for influenza immunization and facility staff failed to provide a pneumococcal vaccine for 2 Residents (Residents #15 and #22) in a survey sample of 5 residents reviewed for	F 883	F883 1. Resident #20 received the influenza vaccine on April 14, 2023. 2. Current Residents were reviewed to ensure that the Residents were offered the influenza vaccine and received the influenza vaccine unless refused or	

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F 883	Continued From page 6 pneumococcal immunization. The findings include: 1. The facility staff failed to provide influenza immunization for Resident #20. For Resident #20, a clinical record review was performed on 4/5/23 and revealed Resident #20, who was initially admitted to the facility on 7/23/21, and had several readmissions in 2023, during the flu season. Resident #20's clinical record revealed under the immunization tab that the flu vaccine noted, "Immunization required". The record had no clinical assessment regarding influenza immunization, to include the resident's current influenza vaccination status, offer to provide immunization against influenza infection, or documentation of resident refusal or medical contraindication. On 4/6/23, an interview was conducted with the facility's Infection Preventionist (IP) who accessed the clinical record for Resident #20 and verified the findings. The IP further stated that Resident #20's family had consented to the Resident receiving the flu vaccine 11/3/22. The IP said that when she went to give the immunization the Resident had a fever and therefore it was not given. There was no documentation of this in the clinical record, nor any further attempts to immunize the Resident. The IP stated that she currently has flu immunizations available in stock, in the facility, available for Administration. When asked about the purpose and importance of immunization, the IP said, "It's not just important for the person but everyone else. If they have chronic	F 883	medically contraindicated. 3. All Nurses will be educated by the Assistant Director of Nursing/designee on offering and administering the influenza vaccine unless previously received, refused, or medically contraindicated. 4. An audit of newly admitted Residents will be completed by the Infection Preventionist/designee weekly times 4 and monthly times 2 to ensure that the influenza vaccine was offered and administered unless refused or medically contraindicated. The results of the audits will be discussed at the monthly QAPI meeting. 5. Completion date: May 10, 2023	

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F 883	Continued From page 7	F 883		

co-morbidities, it helps keep them healthy and the more people we have immunized helps protect the health of our entire community".

Review of the facility policy entitled, "Influenza and Pneumococcal Vaccinations", effective 2/6/2020, was conducted. This policy read, "1. Influenza Vaccination. a. An effective influenza vaccine program offers a two-fold defense against influenza in a nursing center. It can: prevent an outbreak in inducing resistance of the group to spread influenza, reduce the impact of an outbreak when it does occur.... c. Influenza vaccine should be given annually. According to the CDC, the timing of flu is unpredictable and can vary from season to season...".

On 2/6/23 during the end of day meeting, the Facility Assistant Administrator and DON were made aware of the findings.

No further information was provided.

2. The facility staff failed to provide pneumococcal immunizations for Residents #15 and #22.

2a. For Resident #15, a clinical record review was performed on 04/05/23 and revealed Resident #15, who was admitted to the facility on 1/26/23, had no clinical assessment regarding pneumonia immunization, to include the resident's current pneumonia vaccination status, offer to provide immunization against pneumonia infection, or documentation of resident refusal or medical contraindication.

On 04/06/23, an interview was conducted with the

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F 883	Continued From page 8	F 883		

facility's Infection Preventionist (IP) who accessed the clinical record for Resident #15 and verified the findings. The IP stated she had no additional information with regards to Resident #15 being offered the pneumonia vaccine.

2b. For Resident #22, a clinical record review was performed on 4/5/23 and revealed Resident #22, who was admitted to the facility on 1/3/23, had no clinical assessment regarding pneumonia immunization, to include the resident's current pneumonia vaccination status, offer to provide immunization against pneumonia infection, or documentation of resident refusal or medical contraindication.

On 4/6/23, an interview was conducted with the Infection Preventionist (IP)who accessed the clinical record for Resident #22 and verified the findings and stated she had no additional information that would indicate Resident #22's immunization status with regards to pneumonia or that the immunization was offered.

The IP stated that she currently has pneumonia immunizations available in stock, in the facility, available for Administration. When asked about the purpose and importance of immunization, the IP said, "It's not just important for the person but everyone else. If they have chronic co-morbidities, it helps keep them healthy and the more people we have immunized helps protect the health of our entire community".

A review of the facility policy entitled, "Influenza and Pneumococcal Vaccinations", was conducted. This policy read, "...2. Pneumococcal Vaccination. a. Pneumococcal vaccination is

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F 883	Continued From page 9 available for protection against some types of bacterial pneumonia... f. A Patient Pneumococcal Vaccine Tracking Log will be maintained by the Infection Preventionist. All patients' names are to be included on the Tracking Log. New patients' names will be placed on the log at the time of admission and offered the Pneumococcal vaccination if not received as indicated". On 4/6/23 during the end of day meeting, the Facility Assistant Administrator and DON were made aware of the findings. No further information was provided.	F 883		
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a	F 885		5/10/23

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F 885	Continued From page 10 confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to notify Residents and families when new cases of COVID-19 were identified in the facility, affecting all 177 Residents residing in the facility. The findings included: On 4/3/23, during an entrance conference held with the facility's assistant administrator, a request for "Evidence of Resident and family notifications of COVID cases for the year of 2023" was made. On 4/3/23, the facility staff provided the survey team with evidence of automated calls being made to Resident's families on 3/10/23, to notify of a new COVID-19 case being identified. Review of the facility's COVID infection surveillance and testing revealed the following: A Resident tested positive for COVID-19 on 3/23/23, which was a facility acquired case of COVID-19. Facility staff tested positive for COVID-19 on the following dates: 3/15/23, 3/17/23, and 3/25/23. On 4/6/23, during an interview with the facility's infection preventionist, she confirmed the above findings with regards to dates of COVID-19 cases that were acquired in-house. When asked about the notification of Residents and families, she (the infection preventionist) indicated she doesn't	F 885	F885 1. Current Residents, representatives, and families have been notified of the current Covid-19 status of the facility. 2. Current Residents have the potential to be affected. 3. The Infection Preventionist/designee will be educated by the Regional Director of Clinical Services to notify the Administrator/designee of the occurrence of either a single confirmed infection of Covid-19 or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other so the Administrator/designee can ensure that notification occurs by 5pm of the next calendar day. 4. The Administrator/designee will audit the Covid-19 status of the facility weekly basis times 4 and monthly times 2 to ensure that notification occurs in a timely manner. The results of the audits will be discussed at the monthly QAPI meeting. 5. Completion date: May 10, 2023	

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F 885	Continued From page 11	F 885		

handle that and didn't feel comfortable speaking to the requirements.

On 7/13/22, the facility staff provided an infection surveillance log with the last entry being 5/20/22, where a staff member tested positive for COVID-19.

The infection preventionist did acknowledge that the notifications are recorded in the Resident's clinical records and reviewed the clinical record of several Residents and noted the last notification she could see was from 3/10/23.

During the above interview, the facility infection preventionist did confirm that one single case of COVID-19 constituted an outbreak.

On 4/5/23 at 5:37 PM, the assistant administrator confirmed that the calls made on 3/10/23, were the last time Resident and Resident families were made aware of a COVID case within the facility. During this meeting, the assistant administrator confirmed that the facility follows CMS (Centers for Medicare and Medicaid Services) and CDC (The Centers for Disease Prevention and Control) recommendations/requirements.

Review of the facility policy titled, "Emerging Infectious Disease: COVID-19" with an effective date of 1/10/23, was conducted. This policy read, "...11. Case Reporting: ... f. Notify all patients, families/RPs, and employees no later than 5pm the following calendar day of any new case...".

On 4/6/23, the assistant administrator, director of nursing and infection preventionist were made aware of the above findings.

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F 885	Continued From page 12 No further information was submitted prior to the end of survey.	F 885		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886		5/10/23

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F 886	Continued From page 13 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with CDC (Centers for Disease Control) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements and/or notify the physician of a positive COVID-19 test result for 3 residents, Residents #11, #20, and #22, out of a survey sample of 5 Residents reviewed for COVID testing. The facility staff also failed to provide evidence of conducting contact	F 886	F886 1. Resident #11 no longer resides at the facility. Residents #20 and #22 have been symptom free and have been tested with negative results. There are currently no Covid-19 positive Residents or staff members residing in the facility. 2. Current Residents have the potential to be affected. 3. The Infection Preventionist/designee	

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F 886	Continued From page 14 tracing or broad-based testing following a COVID-19 outbreak. The findings included: 1. For Resident #11, who tested positive for COVID-19, the facility staff failed to notify the physician. A clinical record review revealed that Resident #11 tested positive for COVID-19 on 12/22/23. There was no indication within the clinical record that the physician or family of the Resident were made aware of the positive test results. The progress notes revealed that the medical provider saw Resident #11, the following day, on 12/23/23, and made no indication that the Resident was COVID-19 positive. On 4/6/23, the facility's infection preventionist (IP) reviewed the chart and confirmed the above findings. The IP also stated that the physician and family are to be notified of a positive COVID-19 test result "when it happens". Review of the facility policy titled, "COVID-19" read, "... 11. Case Reporting... e. Notify the attending physician...". On 4/6/23, during an end of day meeting, the facility Assistant Administrator, Director of Nursing and IP were made aware of the above findings. No further information was provided. 2. For Residents #20 and #22, the facility staff failed to conduct COVID-19 testing upon their	F 886	will be educated by the Regional Director of Clinical Services on testing requirements for Covid-19 and on documentation of contact tracing when an outbreak occurs in the facility. 4. The Assistant Director of Nursing/designee will audit testing requirements for Covid-19 and documentation of test results weekly times 4 and monthly times 2. The Assistant Director of Nursing/designee will audit documentation of contact tracing weekly times 4 and monthly times 2. The results of the audits will be discussed at the monthly QAPI meeting. 5. Completion date: May 10, 2023	

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F 886	Continued From page 15	F 886		

admission/readmission to the facility, while the facility was in an area of high community transmissibility for COVID-19.

2A. For Resident #20, the facility staff failed to conduct COVID-19 testing upon the Resident's re-admission to the facility.

On 4/5/23, a clinical record review was conducted and revealed that Resident #20 was transferred to a local hospital on 2/2/23 and was re-admitted to the facility on 2/6/23. There was no evidence of COVID-19 testing conducted by facility staff upon their re-admission to the facility.

Resident #20 then had another hospitalization on 3/28/23 and returned to the facility on 3/30/23. Upon Resident #20's return, a COVID test was conducted. There was no follow-up testing conducted on day 3 or day 5 following readmission as per the CDC guidance.

On 4/6/23, a meeting was held with the facility's Infection Preventionist (IP). The IP accessed Resident #20's clinical record and confirmed there was no evidence of any COVID-19 testing performed as noted above. The IP also confirmed that the facility's county community transmission rate was high at the time Resident #20 was re-admitted.

2B. For Resident #22, the facility staff failed to conduct COVID-19 testing upon the Resident's admission/re-admission to the facility on 12/16/22 and 1/3/23.

On 3/31/23, a clinical record review was conducted and revealed that Resident #22 was

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admitted to the facility on 12/16/22. There was no evidence of COVID-19 testing conducted by facility staff upon her admission to the facility.

Resident #22 then discharged from the facility on 12/23/22 and was readmitted on 1/3/23. Upon readmission there was no COVID testing performed.

On 4/6/23, a meeting was held with the facility's Infection Preventionist (IP). The IP accessed Resident #22's clinical record and confirmed there was no evidence of any COVID-19 testing performed as noted above. The IP also confirmed that the facility's county community transmission rate was high at the time Resident #22 was admitted and readmitted.

The IP stated that the facility's infection control program includes following all recommended CDC guidelines.

The IP confirmed that when the community transmissibility levels are high, COVID-19 testing is conducted on residents who are being admitted to the facility or returning to the facility after being gone for 24 hours or longer. The IP stated, "testing begins on Day 1 of arrival, then again in 48 hours, (Day 3), and again in another 48 hours, (which would be Day 5)".

Review of the facility policy titled, "COVID-19", effective date January 10, 2023, read, "... 8. New Admissions and readmissions who have been out of the facility for > 24 hours: ... b. Testing is recommended on admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test...".

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The CDC document entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 11, subheading, "Nursing Homes", item 3 "Managing admissions and residents who leave the facility", read, "In general, admissions in counties where Community Transmission levels are high should be tested upon admission...Testing is recommended at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test".

On 4/6/23, the Facility Assistant Administrator, Director of Nursing and IP were made aware of the above findings.

No further information was provided.

3. The facility staff failed to conduct contact tracing or broad-based testing following a COVID outbreak within the facility.

A. Review of the facility's COVID-19 surveillance log/COVID testing log revealed that on the following dates the facility had a Resident and/or staff member test positive: 3/3/23, 3/4/23, 3/15/23, 3/17/23, 3/23/23, and 3/25/23.

On 4/6/23, an interview was conducted with the facility's Infection Preventionist (IP). When asked about testing, the IP said, "When we have an exposure we test". When asked about if they perform contact tracing or broad-based testing, the IP stated they conduct contact tracing. When asked to provide evidence of this, she stated she

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had no credible evidence to provide.

The IP was asked to explain how she does the contact tracing and she explained that she looks at the schedule and interviews the staff assigned to the Resident. When asked if she uses any other tools to identify if someone else may have responded to a call bell, provided care while the assigned staff member is busy, etc. she stated she had not done that.

On 4/6/23, an interview was conducted with the Epidemiologist at the local department of health, who the facility identified as one of their contacts. When asked about training for contact tracing, the Epidemiologist stated she had not performed any training with the facility's IP regarding this.

Review of the facility policy titled, "COVID-19", effective date January 10, 2023, read, "... 9. Containment/management... a. Identification of a new case in a patient... Initiate contact tracing and identify close contacts/high-right exposures. Initiate outbreak testing (refer to Nursing policy #1704) ... b. Identification of a positive case in an employee... Initiate contact tracing and identify close contacts/high-risk exposures. Initiate outbreak testing (Refer to nursing policy 1704) ...".

Review of the Nursing Policy Number 1704, which was titled, "COVID-19 Testing" was conducted. This policy read, "...4. Exposure testing for patients and employees: Testing is performed immediately post-exposure (generally not sooner than 24 hours), and if negative, again 48 hours later, and if negative, again 48 hours later... 6. Outbreak testing will occur immediately and should be conducted by 1. Contact tracing

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approach (preferred), Preferred if the center has the expertise/resources, the center tests only close contacts/high-risk exposures, identified through a documented contact tracing investigation...".

3b. Following a known exposure, the facility staff failed to conduct COVID-19 testing as per recommendations.

Review of the facility's COVID-19 surveillance log/COVID testing log revealed that on 12/27/22, an employee was tested for COVID-19 due to a known exposure to a co-worker that he/she commuted to and from work with.

The facility performed a COVID test on 12/27/22, which was negative and conducted no further testing.

On 4/6/23, an interview was conducted with the facility's Infection Preventionist (IP). When asked about testing, the IP said, "When we have an exposure we test". The IP stated that she was not at work during this time and was not able to answer why 2 additional tests were not performed.

On 4/6/23, an interview was conducted with the facility Assistant Administrator and Director of Nursing (DON). When asked who filled the role of the infection preventionist in the absence of the IP, the DON stated,

Review of the facility policy titled, "COVID-19", effective date January 10, 2023, read, "... 9. Containment/management... a. Identification of a new case in a patient... Initiate contact tracing and identify close contacts/high-right exposures.

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Initiate outbreak testing (refer to Nursing policy #1704) ... b. Identification of a positive case in an employee... Initiate contact tracing and identify close contacts/high-risk exposures. Initiate outbreak testing (Refer to nursing policy 1704) ...".

Review of the Nursing Policy Number 1704, which was titled, "COVID-19 Testing" was conducted. This policy read, "...4. Exposure testing for patients and employees: Testing is performed immediately post-exposure (generally not sooner than 24 hours), and if negative, again 48 hours later, and if negative, again 48 hours later... 6. Outbreak testing will occur immediately and should be conducted by f1. Contact tracing approach (preferred), Preferred if the center has the expertise/resources, the center tests only close contacts/high-risk exposures, identified through a documented contact tracing investigation...".

The Centers for Disease Prevention and Control (CDC) gives the following guidance in their document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 27, 2022", was referenced. It read, "...Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5...".

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F 886	Continued From page 21 On 4/6/23, during an end of day meeting, the facility Assistant Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 886		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a	F 887		5/10/23

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F 887	Continued From page 22 COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff record review, staff interview and facility documentation review, the facility staff failed to offer and/or provide up to date COVID-19 immunization for 4 staff members (Staff #1, 2, 4, and 6), in a survey sample of 5 facility employed staff members reviewed for COVID-19 vaccination and for 5 Residents (Resident #15, 19, 20, 21, and 22) in a survey sample of 5 Residents reviewed for COVID-19 immunizations. The findings include:	F 887	F887 1. The bivalent booster vaccine has been offered to Staff #1, 2, 4, and 6. Resident #15 no longer resides at the facility. Residents #19 and #22 have received the bivalent booster vaccine. Resident #21 was offered and declined administration of the bivalent booster. Resident #20 has been offered the bivalent booster. 2. Current Residents and Staff were	

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F 887	Continued From page 23 1. The facility staff failed to offer and/or provide COVID-19 bivalent booster vaccines for Staff #1, 2, 4, and 6. On 4/5/23, an interview was conducted with the Infection Preventionist (IP), who confirmed the facility policies and procedures follow CDC (Centers for Disease Control and Prevention) guidance and recommendations for staff COVID-19 immunization. The facility COVID vaccination policies were requested and received. On 4/5/23, staff vaccination records for Staff #1, 2, 4 and 6, were reviewed and revealed the following: Staff #1 completed a primary series of Pfizer COVID-19 immunization on 7/26/21. Staff #1 had not received any COVID-19 booster doses. Staff #2 completed a primary COVID-19 vaccine series on 2/16/21 and a monovalent booster on 1/26/22 but had not received a bivalent booster dose. Staff #4 completed a primary COVID-19 vaccine series on 2/18/21 and a monovalent booster on 1/26/22 but had not received a bivalent booster dose. Staff #6 completed a primary COVID-19 vaccine series on 1/29/21 and a monovalent booster on 10/27/21 but had not received a bivalent booster dose. On 4/5/23, an interview was conducted with the Facility Infection Preventionist (IP). The IP stated that it is important for Residents and staff to remain up to date with immunizations because it	F 887	reviewed to ensure that the Covid-19 vaccine was offered and provided as indicated. 3. The Infection Preventionist/designee will be educated by the Regional Director of Clinical Services on monitoring the offer of Covid-19 vaccine for newly admitted Residents and newly hired Staff. 4. The Unit Managers/designees will complete an audit weekly time 4 and monthly times 2 to ensure that newly admitted Residents and newly hired Staff have received the offer of Covid-19 vaccine if indicated. The results of the audits will be discussed at the monthly QAPI meeting. 5. Completion date: May 10, 2023	

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not only protects them but also the entire facility staff and Residents. The more people they have immunized will decrease the risk of an outbreak. When asked about the process for offering COVID-19 vaccines, the IP stated that she has a sign-up sheet. She said the process with the current pharmacy is a bit cumbersome as she has to have their consent, a copy of their insurance card and identification to be able to order the COVID-19 vaccine. The IP said that staff will say they want it but then drag their feet on getting her the documents. The IP confirmed that the facility doesn't have informed consent forms or declination forms for staff members related to COVID-19 vaccines.

On the afternoon of 4/5/23, an interview was conducted with Staff #2. When asked about COVID-19 immunization, Staff #2 verbalized that he thought he was up to date. When asked about the bivalent booster, Staff #2 said he had not received any education or offering of such.

On the afternoon of 4/5/23, during an end of day meeting, the facility Assistant Administrator and Director of Nursing were made aware that there was no evidence that facility staff had been educated on the benefits of and availability to receive a COVID-19 bi-valent dose.

On 4/6/23, the facility staff provided Surveyor B with a "town hall meeting" held on 10/7/22, and in-service education that was provided throughout the month of October 2022, when COVID-19 immunizations were discussed. Review of these documents revealed that Staff #1, 2, 4, and 6 had not attended either of these meetings/trainings.

Review of the facility's policy titled, "COVID-19

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COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Vaccinations", with an effective date of 9/26/22, read, "1. CDC recommends everyone stay up to date with COVID-19 vaccination, including all primary series doses and boosters for their age group: a. Individuals ages 12 years and older are recommended to receive one updated Pfizer or Moderna (bivalent) booster...". Section 3. of this policy read, "Prior to administering any COVID-19 Vaccine (and for each dose) complete the following for employees: a. Provide Emergency Use Authorization (EUA) "Fact Sheet for Recipients and Caregivers" to employee and educate regarding benefits and potential side effects. b. Screen employee for contraindications and precautions. c. Obtain completed consent form. d. Provide vaccine card to employee. Maintain a proof in the employee's record...".

The CDC (Centers for Disease Control and Prevention) document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States", updated March 16, 2023, page 3, "Recommendations for COVID-19 vaccine use", subtitle, "Booster vaccination", read, "People ages 6 months and older are recommended to receive 1 bivalent mRNA booster dose after completion of any FDA-approved or FDA-authorized primary series or previously received monovalent booster dose(s)".

The CDC (Centers for Disease Control and Prevention) document titled, "Stay Up to Date with COVID-19 Vaccines Including Boosters", updated March 2, 2023, page 2, "COVID-19 Boosters", subtitle, "Updated Boosters", read, "The updated boosters are called 'updated' because they protect against both the original virus that causes COVID-19 and the Omicron

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variant BA.4 and BA.5...Updated COVID-19 boosters became available on: September 2, 2022, for people aged 12 years and older...You are up to date with your COVID-19 vaccines when you have completed a COVID-19 vaccine primary series and got the most recent booster dose".

The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 2, item 1, read, "1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Encourage everyone to remain up to date with all recommended COVID-19 vaccine doses...HCP [Healthcare Personnel], patients, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine".

The CDC (Centers for Disease Control and Prevention) document titled, "Strategies to Mitigate Healthcare Personnel Staffing Shortages", updated September 23, 2022, page 2, item 3, read, "As part of conventional strategies [to minimize staffing shortages], it is recommended that healthcare facilities: Ensure any COVID-19 vaccine requirements for HCP [Healthcare Personnel] are followed, and where none are applicable, encourage HCP to remain up to date with all recommended COVID-19 vaccine doses".

On 4/6/23, the Facility Assistant Administrator, Director of Nursing, and Infection Preventionist were notified of the findings. No further

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information was provided.

2. The facility staff failed to provide education and offer the COVID-19 bivalent booster to 5 Residents (Resident #15, 19, 20, 21, and 22).

On 4/5/23, a random sample of Residents was selected for review of COVID-19 immunizations. A clinical record review was then conducted and revealed the following:

Resident #15's immunization tab within the clinical record had no information recorded with regards to COVID-19 immunization status.

Residents #19, 20, 21, and 22, had no evidence of being educated or offered the COVID-19 bivalent booster dose.

On 4/6/23, Surveyor B met with the facility's Infection Preventionist (IP) and reviewed each of the above noted Residents. The IP confirmed all of the above findings and indicated the Resident's had not been offered the bi-valent COVID vaccine.

For Resident #20, the IP had documentation that she had called and left a voicemail for the family on 10/24/22 but has made no further attempts to reach the family to obtain consent.

The IP stated that the facility changed pharmacies December 15, and after the change she had difficulty accessing the pharmacy's system to order vaccines. Then she had an extended leave from employment and was gone the entire month of January. Upon her return the first week of February, she has been working on

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immunizations.

The IP stated that it is important for Residents and staff to remain up to date with immunizations because it not only protects them but also the entire facility staff and Residents. The more people they have immunized will decrease the risk of an outbreak.

Review of the facility's policy titled, "COVID-19 Vaccinations", with an effective date of 9/26/22, read, "1. CDC recommends everyone stay up to date with COVID-19 vaccination, including all primary series doses and boosters for their age group: a. Individuals ages 12 years and older are recommended to receive one updated Pfizer or Moderna (bivalent) booster...". Section 2. of this policy read, "...d. Routinely provide education and offer COVID-19 vaccinations and boosters to patients. Document attempts and refusals in the medical record...".

The CDC (Centers for Disease Control and Prevention) document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States", updated March 16, 2023, page 3, "Recommendations for COVID-19 vaccine use", subtitle, "Booster vaccination", read, "People ages 6 months and older are recommended to receive 1 bivalent mRNA booster dose after completion of any FDA-approved or FDA-authorized primary series or previously received monovalent booster dose(s)".

The CDC (Centers for Disease Control and Prevention) document titled, "Stay Up to Date with COVID-19 Vaccines Including Boosters", updated March 2, 2023, page 2, "COVID-19

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Boosters", subtitle, "Updated Boosters", read, "The updated boosters are called 'updated' because they protect against both the original virus that causes COVID-19 and the Omicron variant BA.4 and BA.5...Updated COVID-19 boosters became available on: September 2, 2022, for people aged 12 years and older...You are up to date with your COVID-19 vaccines when you have completed a COVID-19 vaccine primary series and got the most recent booster dose".

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F 887	Continued From page 30 On 4/6/23, the Facility Assistant Administrator, Director of Nursing, and Infection Preventionist were notified of the findings. No further information was provided.	F 887		