STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495328	A. BUILDING ______ B. WING ______	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE OF TAPPAHANNOCK	**1150 MARSH STREET** **TAPPAHANNOCK, VA 22560**

(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 A unannounced COVID-19 Focused Emergency Preparedness Survey was conducted 04/12/2023 - 04/14/2023. 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 60 certified bed facility was 49 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 04/12/2023 through 04/14/2023. 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 and 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey: VA00054174- unsubstantiated. The census in this 60 certified bed facility was 49 at the time of the survey. The survey sample consisted of 11 resident reviews and 9 employee reviews.	F 000		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii)	F 773		5/18/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/27/2023

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 773	Continued From page 1 §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. 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 notify the physician of a positive COVID-19 test result for 1 resident (Resident #18) in a survey sample of 6 Residents reviewed for COVID testing. The findings included: 1. For Resident #18, who tested positive for COVID-19, the facility staff failed to notify the physician. A clinical record review revealed that Resident #18 tested positive for COVID-19 on 3/23/23. There was no indication within the clinical record that the physician of the Resident was made aware of the positive test results. On 4/13/23, the facility's Director of Nursing/Infection Preventionist (IP) reviewed the chart and confirmed the above findings. The IP also stated that the physician and family are to be	F 773	Regarding # 18, Staff notified MD of Positive Covid result of 3/23/2023 on 4/14/2023. Upon interview with MD the notification was Validated. Late entry regarding the MD notification was completed. Audit of MD notification of abnormal covid results was conducted on current residents from 4/20/23 to present to identify any others at risk. In-service with All Facility licensed nursing staff concerning notification to the MD of abnormal Covid results. Facility Covid policies were reviewed and an addendum was added to address MD notification following a positive covid result. Daily audit of covid results for appropriate notification to MD daily x 1 month, then	

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F 773	Continued From page 2 notified of a positive COVID-19 test result when it happens. Review of the facility's COVID policies didn't address notification to the doctor following a positive result. On 4/13/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided prior to the conclusion of the survey.	F 773	weekly x 8, then quarterly. Audits regarding MD notification of abnormal Covid labs will be addressed with QAPI committee and reviewed for gaps and opportunities. Monthly x 3 then quarterly until resolved by the QAPI committee.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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;	F 880		5/18/23

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F 880	Continued From page 3 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents 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.	F 880		

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F 880	Continued From page 4 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to 1) handle linen in a manner to prevent the spread of infection on 1 of 2 resident care halls and 2 & 3) failed to wear proper personal protective equipment (PPE) prior to providing care to Resident's on transmission-based precautions for 2 Residents (Resident #19 and #20) in a survey sample of 11 Residents. The findings included: 1. The facility staff failed to handle soiled linen and perform hand hygiene in a manner to prevent the spread of infection. On 4/13/23 at 10:50 AM, CNA C was observed coming out of Resident #20's room wearing gloves, carrying soiled linen, not bagged, which was against her clothing and proceeded to walk to the other end of the hall. After putting the soiled linen into a bin in the hallways, CNA C then proceeded with her gloved hands to push the medication cart to the side and proceeded to push two linen bins to the other end of the hall. CNA C performed no hand hygiene and did not remove the gloves at any point during this observation. On 4/13/23, an interview was conducted with CNA C. CNA C was asked about the handling of linen. CNA C stated she should have bagged the linen prior to exiting the room.	F 880	F880 All residents have the potential to be affected. CNA C was coached and re-educated on proper linen handling, wearing gloves, hand hygiene and isolation signs on day of survey. CNA B & E were coached and re-educated on need for eye protection when working with Covid positive residents on day of survey. Resident #20 was assessed by RN and there was no further sign/symptom of infection or affect from deficient practices. His isolation status was reviewed with MD/ARNP and determined to have no further need for isolation and subsequent order was received to discontinue Precautions. Residents on this hall were reviewed by RN and no infections or apparent effect was identified due to this deficient practice. Resident # 19 remained on isolation with 1-1 during waking hours until completing the required isolation period. There were no further positive residents after this occurrence. No staff involved in this residents care became positive after occurrence	

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F 880 Continued From page 5

On 4/13/23, an interview was conducted with the Infection Preventionist (IP). The IP was made aware of the above observation and confirmed that staff should not be wearing gloves into the hall and should bag linen and perform hand hygiene prior to exiting a room to prevent the risk of cross contamination.

Review of the facility policy titled, "Laundry and Bedding, Soiled" was reviewed. This policy read, "Handling: 1. All used laundry is handled as potentially contaminated until it is properly bagged and labeled for appropriate processing...Transport: 1. Contaminated laundry bags/containers are not held close to the body or squeezed during transport...".

On 4/13/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.

No further information was provided.

2. The facility staff failed to wear proper personal protective equipment (PPE) prior to interaction with Resident #19 who was known to be COVID-19 positive.

On 4/12/23, Resident #19 was observed wandering in the hallway with a mask below his chin. CNA B approached the Resident and redirected him back to his room. CNA B then put on an isolation gown and gloves and entered the room of Resident #19. CNA B failed to put on any eye protection. Upon CNA B's exit from the room, Surveyor C conducted an interview.

F 880

In-service All Facility nursing staff on proper linen handling, wearing gloves, hand hygiene, post glove use and isolation signs showing needed PPE and protective eye wear.

Contacted Health department - Three rivers Health District Epidemiologist.

Contacted QIO to help achieve compliance.

Review CDC guidelines in reference to policy updates.

Adhoc committee meeting for team involvement to conduct a root cause analysis and process improvement plan.

Review isolation requirements/PPE when initiating further new isolation precautions with Nursing staff

Random visual audits throughout shifts of linen handling, glove use, hand hygiene, following of PPE in isolation rooms, including eyewear weekly x 8, then monthly.

Review of audits with QAPI committee for gaps and opportunities monthly x 3, then quarterly until resolved by QAPI Committee.

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F 880	Continued From page 6 CNA B confirmed that Resident #19 had COVID-19 but is known to wander so they have to keep redirecting him back to his room. CNA B was asked about PPE and CNA B said that staff are already wearing masks, but have to put on an N-95, isolation gown and gloves prior to entering the room. On 4/13/23, Resident #19 was noted to have a staff member with him one on one to keep the Resident from wandering out of the room. CNA E was observed sitting in the room wearing an isolation gown, mask, and gloves. No eye protection was noted. CNA E was wearing prescription glasses, but they didn't have any type of safety feature that would prevent any contaminate from entering the eyes. On 4/13/23, an interview was conducted with the facility's Director of Nursing (DON)/Infection Preventionist (IP). The IP stated that because the Resident is a wanderer, they have someone assigned as 1:1 and she expected staff to wear all PPE prior to entering the room. Review of the facility policy titled, "Coronavirus Disease (COVID-19)- Identification and Management of Ill Residents" was conducted. An excerpt from this policy read, "...3. Symptomatic residents, regardless of vaccination status, are restricted to their rooms and cared for by staff using a NIOSH-approved N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and a gown pending evaluation for SARS-CoV-2 infection...". The Centers for Disease Control and Prevention (CDC) gives guidance in their document titled,	F 880		

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F 880	Continued From page 7	F 880		

"Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 27, 2022". It read, "... Personal Protective Equipment: HCP [healthcare personnel] who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) ...".

On 4/13/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above observations.

The facility Administration provided Surveyor C with evidence of staff education that had been performed regarding the use of PPE.

No further information was provided.

3. The facility staff failed to wear proper personal protective equipment (PPE) prior to entering the room of Resident #20 who is on transmission-based precautions (TBP).

On 4/13/23 at approximately 9 AM, Surveyor C approached Resident #20's room and observed signage on the door to indicate the Resident was on TBP. The signage instructed one to put on a mask, gloves, and gown prior to entering the room. Upon Surveyor C's entry into the room, CNA C was observed in the room wearing only a procedure mask, no gloves or gown were being used. CNA C stated she had been providing care to the Resident. When asked why she didn't

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F 880	Continued From page 8	F 880		

have PPE on as instructed by the signage on the door, CNA C said, "I didn't know what that sign was about". CNA C then exited the room.

On 4/13/23, following the above observation, interviews were conducted with LPN's C and D, who confirmed Resident #20 was on isolation for ESBL (Extended Spectrum Beta-Lactamase) in his urine.

On 4/13/23, the Director of Nursing (DON)/Infection Preventionist (IP), was made aware of the above observation. The DON stated that Resident #20 had completed his course of antibiotics, but they were waiting on lab results to identify that it was colonized before they discontinued his transmission-based precautions.

A review was conducted of the facility policy titled, "Isolation- Initiating Transmission-Based Precautions". This policy read, "...3. When Transmission-Based Precautions are implemented, the Infection Preventionist: ... d. Determines the appropriate notification on the room entrance door and on the front of the Resident's chart so that personnel and visitors are aware of the need for and type of precautions...e. Ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the Resident's room so that anyone entering the room can apply the appropriate equipment...".

On 4/14/23, the facility's DON provided Surveyor C with a copy of the in-service education that was conducted with facility staff regarding the use of PPE and TBP.

No further information was provided.

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F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		5/18/23

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 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

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F 883	Continued From page 10 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 clinical record failed to provide evidence within the clinical record on being educated on and offered influenza vaccines for 4 Residents (Resident #14, 15, 16, and 17) in a survey sample of 5 residents reviewed for influenza immunization and the facility staff failed to provide pneumococcal vaccines for 3 Residents (Residents #14, 16 and #17) in a survey sample of 5 residents reviewed for pneumococcal immunization. The findings include: 1. The facility staff failed to maintain documentation within the clinical record for Resident #14, 15, 16, and 17) regarding the Resident's immunization status for flu and failed to offer the influenza vaccine. On 4/13/23, a Resident sample of 5 Residents was selected for review of influenza	F 883	F883 All residents and staff had the potential of being affected by the lack of documentation of the flu program. Residents # 14,15,16 & 17 were re-evaluated for flu vaccine administration for the 22-23 season including medical record documentation and use of Virginia Immunization Information System. Resident #14 received Flu vaccine on 10/20/22 by Walgreens(outside provider) Resident # 15 received flu vaccine on 11/19/22 by Walgreens (outside provider) Resident # 16 received Flu vaccine, and documented Residents identified upon audit of not receiving a 22-23 Flu vaccine were	

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F 883	Continued From page 11 immunizations. Clinical record reviews were conducted and revealed the following: a. Under the immunization information for each Resident no information was noted with regards to the Resident's status for influenza vaccine. b. There was no documentation within the clinical record to indicate the Residents had been educated on the benefits and risk(s) of influenza immunization. c. There was no evidence within the clinical record of the Residents being offered the flu vaccine. On the afternoon of 4/13/23, the Administrator and Director of Nursing sat with Surveyor C to review the above findings. They confirmed that the above findings were not recorded in the clinical record. The Director of Nursing stated they had found a binder in the previous Director of Nursing's office that had evidence that a flu vaccine campaign had been held in October. Within the binder she had some consent and declination forms. The Director of Nursing further confirmed that all those documents should have been in the clinical record of the Resident so that everyone [staff and medical providers] would have access to the Resident's immunization status. In the binder located in an office they were able to find where Resident #17 refused the flu vaccine. In addition they found where on admission Resident #16 declined the flu vaccine, but this was not documented in the clinical record. The Director of Nursing confirmed that the facility had the flu vaccine/immunization in-house and had not had any difficulty obtaining the vaccine for administration.	F 883	reviewed by RN and Medical Director, showed no sign or symptom of flu. However due to timing, MD requested resuming of flu shot offering and education for 23-24 Flu season in late fall 2023. Due to the completion of the 2022-23 flu vaccine season, a plan was established for the 2023-24 flu vaccination program to involve all residents and staff. The program will include education and documentation. Audit was conducted on residents in facility for Pneumococcal vaccine status and documentation. All residents and/or responsible parties were educated on risks and benefits of Pneumococcal vaccine. Documentation was obtained of acceptance or refusal. Orders were obtained when appropriate. Vaccinations were provided when available and documented in the medical record. In-service all facility licensed nursing staff regarding offering and educating of flu vaccine during flu season and the Pneumococcal vaccine upon admission or significant change. Incorporate Pneumococcal education and vaccination opportunity (ie Covid and Flu during season) into admission process. Review audit for any potential residents needing further vaccinations. Audit all new admissions for vaccination	

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F 883	Continued From page 12 On 4/14/23, the facility Administration provided Surveyor C with a spreadsheet that was titled "Flu Given Spreadsheet". This document listed the Resident's names and under the heading "Vaccination and Type" it indicated given. There was no information as to the date, what vaccine was given, who administered it, where it was administered, nor that any education was provided. The Director of Nursing confirmed that she found this document to be woefully inadequate in the documentation she would expect to see with regards to immunizations. Review of the facility policy titled; "Influenza Vaccine" was conducted. Excerpts from this policy read, "... Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees...4. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine...5. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering, and the site of vaccination will be documented in the resident's/employee's medical record. 6. A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the resident's medical record...". On the afternoon of 4/13/23, and again on 4/14/23, the above findings were reviewed with the facility Administrator and Director of Nursing. No further information was received.	F 883	program acceptance or refusal and documentation weekly x 8, then monthly x 1, then quarterly. Review audit and acceptance rate of Pneumococcal vaccine and proper documentation @ monthly QAPI committee. Review Flu acceptance rate and documentation during season monthly Review Flu/ Pneumococcal vaccine program in QAPI for gaps and opportunities monthly x3 then Quarterly until resolved by QAPI committee.	

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2. For Residents #14, 16, and 17, the facility staff failed to provide pneumococcal immunizations.

On 4/13/23, a Resident sample of 5 Residents was selected for review of pneumococcal immunizations. Clinical record reviews were conducted and revealed the following:
a. For Residents #14, 16 and 17, the immunization information was blank and had no data with regards to the Resident's immunization status for pneumonia.
b. There was no documentation within the clinical record to indicate the Residents had been educated on the benefits and risk(s) of the pneumonia immunization.
c. There was no evidence within the clinical record of the Residents being offered the pneumonia vaccine.

On the afternoon of 4/13/23, the Administrator and Director of Nursing sat with Surveyor C to review the above findings. They confirmed that the above findings were not recorded in the clinical record. The Director of Nursing stated that the clinical record of the Resident should contain information as to the Resident's status of immunization as well as that they were offered the immunization so that everyone [staff and medical providers] would have access to the information.

A review of the facility policy entitled, "Pneumococcal Vaccine", was conducted. This policy read, "1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series...2. Assessments of pneumococcal vaccination status will be conducted within five (5) working

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F 883	Continued From page 14 days of the resident's admission if not conducted prior to admission. 3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine...Provisions of such education shall be documented in the resident's medical record...". On 4/13/23 during the end of day meeting, the Facility 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		5/18/23

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F 885	Continued From page 15 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 49 Residents residing in the facility. The findings included: On 4/12/23, 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 4/12/23, the facility Administrator stated that the facility had been posting a notice on the front door if they had active COVID in the facility and had no evidence that calls, or any other form of notification was made. Review of the facility's COVID infection surveillance and testing revealed the following: Residents tested positive for COVID-19 on 3/17/23, 3/21/23, 3/22/23, 3/23/23, 3/24/23, 3/27/23 and 4/4/23, which were all facility acquired cases of COVID-19. Facility staff tested positive for COVID-19 on the following dates: 3/2/23, 3/13/23, 3/14/23, 3/16/23, 3/18/23, 3/20/23, 3/21/23, 3/22/23, 3/24/23, 3/26/23, and 3/31/23. On 4/13/23 and 4/14/23, during interviews with	F 885	F885 All residents and responsible parties have the potential to be affected. A Robocall with facility update on current covid status was conducted on 4/20/2023. This was sent to responsible parties of record. A letter including the same covid status information was discussed with and given to alert and oriented residents. Documentation was placed in the medical record. Information was reviewed at the resident council meeting on 4/20/2023. In-service department managers regarding appropriate notification of covid status. Follow-up Robocalls and resident notification will continue with all status changes, outbreaks by 5 pm on the following business day. Policy on covid19 was submitted for an update regarding communication to residents and families. Infection control preventionist or designee will audit for compliance with resident and family notification after declaring an	

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F 885	Continued From page 16 the facility's Administrator and Director of Nursing, they confirmed they had nothing to indicate any Resident and family notifications were made following incidents of COVID positive cases being identified within the facility. Both confirmed they had the capability of doing automated calls and this should have been done. Review of the facility policies related to COVID-19 were reviewed. It was noted that the policies didn't address the notification of COVID-19 within the facility being communicated to Residents and families. A review was conducted of the Centers for Medicare & Medicaid Services (CMS) document titled, "QSO-20-29-NH- Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes". This document read, "... (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 confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with	F 885	outbreak. Timeliness of notification will be reviewed by QAPI committee for gaps and opportunities. Monthly x 3, then quarterly until resolved by QAPI committee.	

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F 885	Continued From page 17 new onset of respiratory symptoms occur within 72 hours of each other...". On 4/13/23 and on 4/14/23, the Administrator and DON/IP were made aware of the above findings. No further information was submitted prior to the end of survey.	F 885		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the	F 886		5/18/23

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F 886	Continued From page 18 transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to conduct and document COVID-19 testing for 4 Residents (Resident #14, 15, 16, and 17) and failed to implement mitigating strategies for	F 886	F886 All residents have the potential to be affected.	

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one Resident (Resident #16) who refused testing in a survey sample of 5 Residents reviewed for COVID testing.

The findings included:

1. For Resident #15, who had an exposure to COVID-19, the facility staff failed to conduct additional COVID-19 testing.

On 4/13/23, a clinical record review of Resident #15's chart was conducted. This review revealed that Resident #15 was tested for COVID-19 on 4/4/23, which was noted by the facility's social worker. There was no evidence of any testing following the test on 4/4/23, within the chart.

On 4/13/23, the facility's Director of Nursing (DON) confirmed that Resident #15's roommate had tested positive for COVID-19 on 4/4/23, and therefore Resident #15 had a known exposure. The DON confirmed that the facility follows CDC's guidance with regards to testing.

Review of the facility policy titled; "Coronavirus Testing" was performed. This policy read, "...Testing of Staff with a Higher-Risk Exposure and Residents who had a Close Contact: 1. Asymptomatic residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after 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) ...".

F 886

Residents #14,15,16 & 17 were tested under current biweekly testing schedule. Resident # 16 did receive testing on next scheduled biweekly testing date after her refusal. All testing negative 4/1/23 and after.

All testing conducted 4/1/2023 to current was conducted and documented according to the biweekly schedule.

In-service all facility licensed staff regarding resident testing schedule. In-service all facility staff regarding the need for testing per schedule, according to outbreak status and transmission rate. In-service all facility licensed nursing staff regarding protocol on resident refusing testing. In-service licensed nurses on need for testing day 1,3,5 upon admission, re-admission, or LOA of greater than 24 hours.

Audit new admission, re-admissions, and residents LOA greater than 24 hours will be tested on day 1,3,5 then fall into testing schedule of the center. Results of testing will be documented in the medical record. Testing added as part of the admission process.

Random audit of staff and resident testing compliance weekly x 8 and then monthly.

Review of audits in QAPI for gaps and opportunities monthly x 3, then quarterly, until resolves by QAPI committee.

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The Centers for Disease Control and Prevention (CDC) gave 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". 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...".

On the afternoon of 4/13/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.

No additional information was received.

2. For Residents #16, the facility staff failed to conduct COVID-19 testing on day 3 following admission.

A clinical record review was conducted of Resident #16's chart. This review revealed that Resident #16 was admitted to the facility on 3/22/23. The chart was reviewed in its entirety and revealed no evidence of COVID-19 testing (or refusal) on day 3 following admission.

On 4/13/23, the facility Administrator provided Surveyor C with an electronic log/spread sheet

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that was found on a computer that was titled, "March 1-3-5 Day COVID testing". Review of this log revealed that Resident #16 was not noted on the spreadsheet.

The Administrator and Director of Nursing confirmed that there was no evidence of Resident #16 having been COVID tested following her admission to the facility, despite the facility being in an active COVID-19 outbreak at the time of the Resident's admission. The Director of Nursing further confirmed that the facility should be testing new admissions on days 1, 3, and 5 following admission.

Review of the facility policy titled, "Coronavirus Testing", was conducted. An excerpt from this policy read, "...Resident Testing- New Admissions and residents that leave the facility 24 hours or long...4. 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 test...".

The Centers for Disease Control and Prevention (CDC) gave 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". It read, "... Managing admissions and residents who leave the facility: 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. In general, admissions in counties where Community Transmission levels are high should be tested upon admission; admission testing at lower levels of Community Transmission is at the discretion of

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the facility...".

No further information was provided.

3. For Residents #14, 15, and 17, the facility staff failed to document instances of COVID-19 testing and the results of such testing in the clinical record.

On 4/13/23, clinical record reviews were conducted of Residents #14, 15, and 17's chart. This review revealed that there was missing documentation of COVID testing in the clinical chart.

On 4/13/23, the Administrator and Director of nursing were made aware of the above findings.

On 4/13/23, the facility Administrator provided Surveyor C with an electronic log/spread sheet that was found on a computer that was titled, "March 1-3-5 Day COVID testing". Review of this log revealed the following:

A. For Resident #14, the log indicated the Resident was tested on 3/25/23, 3/27/23 and 3/29/23. There were no details as to what type of test was used, who performed the test, nor the results of the testing. This information was also not in the clinical record of Resident #14.

B. For Resident #15, the spreadsheet indicated that a COVID test was conducted on 3/30/23, and 4/2/23. There was no documentation in the clinical record with regards to the COVID testing performed on 3/30/23 or 4/2/23.

C. For Resident #17, the spreadsheet indicated

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that COVID testing was conducted on 3/17/23, 3/19/23 and 3/21/23. The clinical record had no evidence of any COVID testing being conducted nor the results of such testing.

On the afternoon of 4/13/23, the above findings were discussed with the facility Administrator and Director of Nursing. The Director of Nursing indicated that the facility has a form that is to be filled out with each instance of testing that would indicate the staff performing the test, the date of the test and the results and this should be scanned into the clinical record. The Director of Nursing further confirmed that the above-mentioned form was not being used by the facility and therefore was not in the clinical record.

Review of the facility policy titled, "Coronavirus Testing", was conducted. An excerpt from this policy read, "...f. The facility will document resident test results in the medical record in accordance with standard for protected health information...".

The Centers for Medicare and Medicaid Services (CMS) referenced the code of federal regulations: "§483.80 (h) ((3) For each instance of testing: ... (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...".

No further information was received.

4. For Resident #16, who refused COVID-19 testing, the facility staff failed to implement additional precautions to mitigate the spread of COVID-19.

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On 4/13/23, a clinical record review was conducted of Resident #16's clinical chart. This review revealed a progress note written 3/23/23, which indicated Resident #16 had refused COVID testing. There was no documentation with regards to any additional precautions or mitigating strategies implemented in response to the refusal of testing. Review of the infection line listing and COVID testing documents revealed the facility was in an active COVID outbreak at the time Resident #16 refused COVID testing.

A review of the facility policy titled, "Coronavirus Testing) was performed. An excerpt from this policy read, "... Refusal of Testing... 4. Residents have a right to refuse COVID-19 testing. The facility will use person-centered approaches when explaining the importance of COVID-19 testing. 5. The facility will have procedures in place to address residents who refuse testing and how they are managed in accordance with CDC guidance for use of transmission-based precautions...".

On the afternoon of 4/13/23, Surveyor C met with the facility Administrator and Director of Nursing. They were made aware that Resident #16 was documented as having refused a COVID test the day after admission and there was no evidence of how the facility responded to this refusal of testing.

On 4/14/23, the facility Administrator and Director of Nursing confirmed that they had no information to submit in response to the lack of documentation with regards to Resident #16's refusal of COVID testing.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 25 No additional information was received.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education 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 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	F 887		5/18/23

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	495328	A. BUILDING ______ B. WING ______	C 04/14/2023

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F 887	Continued From page 26 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 5 staff members (Staff #1, 2, 3, 4, and 5), in a survey sample of 6 facility employees reviewed for COVID-19 vaccination and for 4 Residents (Resident #14, 16, 17, and 18) in a survey sample of 5 Residents reviewed for COVID-19 immunizations. The findings include: 1. The facility staff failed to offer and/or provide COVID-19 bivalent booster vaccines for Staff #1, 2, 3, 4, and 5. On 4/13/23, an interview was conducted with the	F 887	F887 All residents and staff have the potential to be affected. In-service all facility staff regarding risks and benefits of Covid 19 bivalent booster. Offer Covid 19 bivalent booster to facility staff. Obtain documentation of acceptance or refusal. Documentation of vaccines will include all appropriate information. Periodic booster clinics will be offered. Covid 19 bivalent booster status will be obtained upon hire subsequent education and vaccine will be offered and	

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Director of Nursing/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 4/13/23, staff COVID vaccination records for the employees sampled, was reviewed. The review revealed the following:

Staff #1, 2, 3, 4, and 5, all had documented that they had received the primary COVID immunizations. None of the employees had any documentation with regards to being educated on or offered the bi-valent booster dose.

On 4/13/23, in the afternoon, an interview was conducted with Staff #5. Staff #5 stated the previous Director of Nursing had mentioned the bi-valent booster in February and was trying to determine if there was enough interest for her to try to hold a clinic. Prior to that DON's end of employment, in April 2023, nothing had been scheduled or mentioned with regards to the facility offering or encouraging staff to receive the bi-valent booster.

On 4/13/23, an interview was conducted with the facility Director of Nursing (DON)/Infection Preventionist (IP). The IP stated that it is important for everyone to remain up to date with immunizations "to prevent the spread of a disease".

On the afternoon of 4/13/23, 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

documented.

Random audits of facility staff vaccination status will be conducted monthly x 1, then quarterly.

Audits reviewed by QAPI committee for gaps and opportunities monthly x 3, then quarterly until resolves by QAPI committee.

Educate and offer Covid 19 bivalent booster vaccine to all current residents. Obtain documentation of acceptance or refusal. Vaccinate and document as appropriate.

Review all new admissions and re-admissions for Covid 19 bivalent booster status. Obtain documentation of acceptance or refusal. Vaccinate and document as appropriate.

In-service licensed nurses regarding educating residents and family of risk and benefits of Covid 19 vaccine and proper documentation of vaccine.

Random audit of residents for documentation of Bivalent vaccine monthly x 1, then quarterly.

Audits reviewed by QAPI committee monthly x 3, then quarterly until revolved by QAPI committee.

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educated on the benefits of and availability to receive a COVID-19 bi-valent dose.

Review of the facility's policy titled, "Coronavirus Disease (COVID-19)- Vaccination of Staff", read, "... Education and Consent...2. In situations where COVID-19 vaccination requires multiple doses, the staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses ...".

The 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 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

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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 4/14/23, the Facility Administrator and Director of Nursing/Infection Preventionist were notified of the findings.

No further information was provided.

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2. The facility staff failed to provide education and offer the COVID-19 vaccinations to 4 Residents (Resident#14, 16, 17, and 18).

On 4/13/23, a random sample of Residents was selected for review of COVID-19 immunizations. A clinical record review was then conducted and revealed the following:

The immunization tab of the clinical record was blank for each of the Residents. The progress notes and Medication Administration Records were reviewed, with no reference to COVID immunization status, nor immunization being offered.

Resident #14, 16, 17, and 18, had no evidence within their clinical record of their current COVID-19 immunization status, being educated, or offered the COVID-19 immunizations.

On 4/13/23, Surveyor C met with the facility's Administrator and Director of Nursing/Infection Preventionist (IP) and reviewed each of the above noted Residents. The facility administration confirmed all the above findings and indicated they had no evidence of the Resident's having been educated on and offered the COVID vaccine or booster doses.

Review of the facility's policy titled, "Coronavirus Disease (COVID-19)- Vaccination of Residents", read, "1. Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so. 2. The resident (or resident representative) has the opportunity to accept or refuse a COVID-19 vaccine, and to change his/her decision. 3. COVID-19 vaccine education, documentation and reporting are overseen by the

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F 887	Continued From page 31 infection preventionist and coordinated by his or her designee... Documentation and Reporting. 1. 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, b. signed consent, and c. Each dose of COVID-19 vaccine that was administered to the resident...". 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 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".	F 887		

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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".

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On 4/13/23 and 4/14/23, the Facility Administrator and Director of Nursing/ Infection Preventionist were notified of the findings.

No further information was provided.