STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495235	A. BUILDING ______ B. WING ______	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAMSBURG POST ACUTE & REHABILITATION	1235 MT VERNON AVENUE WILLIAMSBURG, VA 23185

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/11/23 through 4/13/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/11/23 through 4/13/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 130 certified bed facility was 71 at the time of the survey. The survey sample consisted of 33 resident reviews.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		5/16/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/02/2023

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 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, document review, and policy review, the facility failed to ensure allegations of abuse were reported for one of three (Resident (R) 16) residents reviewed for abuse out of a total sample of 33 residents. The facility did not report to the State Survey Agency (SSA) resident-to-resident abuse and the investigation results when R56 alleged that R16's care was neglected by R16's attending physician. Findings include: 1. Review of the facility's investigation files provided by the Administrator on 04/13/23 at 9:30 AM revealed an incident occurred on 01/10/23 and reported to the facility on 01/11/23 in which R56 accused R16's physician of neglect of care. Further review of the facility's investigation file revealed a typed document dated "01/16/23" to the SSA which indicated, "On the morning on 01/10/23, [name of R56] sent an email to the Hills Valley Healthcare general information email address alleging that [R16] was neglected by her	F 609	1.The facility has resent the (Facility Reported Incident) FRI and has a Fax confirmation. 2.All residents of the facility have the potential to be affected by this deficient practice. Audit completed of last 30 days to ensure faxed with confirmation. 3.The leadership of the facility have been provided education on the Hill Valley Healthcare Abuse and neglect policy by the regional nurse consultant. The Director of Nursing will provide campus wide education on Hill Valley Abuse and Neglect policy. 4.The facility Interdisciplinary Team (IDT) will complete an audit of all FRI□s for 8 weeks. Results of the audits will be reported monthly by the NHA to the QAPI Committee x 3 months. The facility QAPI Committee is responsible for the on-going monitoring of Compliance.	

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F 609	Continued From page 2 attending physician [name of physician, Employee G]. The email was later forwarded to the facility from the cooperate office and the leadership of the facility began the investigation ...On the morning of 01/10/23 the clinical staff noted that [R16] had a significant amount of rectal bleeding noted during care. The MD [Employee G] was contacted and the resident was sent to the Emergency Room (ER) for evaluation and treatment ...The resident was seen in the ER and diagnosed with rectal bleeding and rectal prolapse. She received treatment in ER and returned to the facility 5 hours later with instructions to set up outpatient surgery to repair the rectal prolapse. The [R56] alleged that the attending physician neglect to see [R16] causing her to have to go to the hospital ..." Review of the investigation file revealed no documented evidence that the SSA was notified of the allegation of neglect of care. Interview on 04/13/23 at 11:42 AM, the Administration stated that he thought he had faxed the information to the SSA but was unable to find any evidence that the SSA was notified of the allegation of neglect of care. Review of the facility's policy titled, "Abuse Investigation and Reporting" dated 01/13/23, revealed, "Policy. All reports of resident abuse, neglect .... shall be promptly reported to .... state ...agencies ...Reporting-1. All alleged violations involving abuse, neglect .... will be reported by the facility Administrator or designee to the following person or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility ...2. An alleged	F 609	5.DOC- 5/16/2023	

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F 609	Continued From page 3 violation of abuse, neglect ...will be reported immediately, but not later than: b. Twenty-four (24) hours if the alleged violation ...has not resulted in serious bodily injury ..."	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to code the "Minimum Data Set (MDS)" assessments accurately in the areas of falls, antipsychotics, and weight loss for three of three residents (Residents (R)61, R53, and R41) reviewed for "MDS" accuracy in a total sample of 33 residents. Findings include: 1. R61 was admitted to the facility with diagnoses that included low back pain, hyperlipidemia, stage 4 chronic kidney disease, and unsteadiness. Review of the EMR "Progress Note," located in the "Progress Notes" tab and dated 12/24/22, revealed R61 had a fall in the smoking area while propelling herself after a supervised smoke break resulting in facial pain and abrasion to her nose and bottom lip. An additional EMR "Progress Note" revealed a CT scan of the face that showed a small fracture to inferior portion of nose. Review of the quarterly "MDS" with an Assessment Reference Date (ARD) of 01/31/23 revealed R61 had a fall with one injury [not a	F 641	1.The facility MDS Nurse corrected the MDS assessments for Residents R61, R53, and R41. 2.Residents of the facility in the areas of falls, antipsychotics, and weight loss have the potential to be affected by this deficient practice. MDS submitted for the last 30 days will be audited for accuracy. 3.Nursing Administration will be educated by the Regional Nurse consultant on accurate coding of the MDS. 4.The MDS Nurse or designee will audit 3 resident MDS assessments a week for accuracy for 8 weeks. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 month. The QAPI Committee is responsible for the on-going monitoring of compliance. 5.DOC-5/16/2023	5/16/23

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F 641		F 641		

Continued From page 4
major injury].

During an interview on 04/12/23 at 11:39 AM, the MDS Coordinator Employee J stated she follows a book for coding and according to the book the resident having a nose fracture was not a major injury.

During an additional interview on 04/12/23 at 11:45 AM, Employee J confirmed R61 did have a major injury. She stated she does have a manual that she follows and at the time she received the guidance that the nose fracture wasn't a major injury. She did not go back to refer to the manual.

During an interview on 04/12/23 at 3:10 PM with the Regional Registered Nurse Employee K confirmed the MDS staff follows the Resident Assessment Instrument (RAI) manual to complete coding on the "MDS" for residents.

During an interview on 04/13/23 at 1:15 PM with Employee K stated his expectation is for MDS staff to code the "MDS" accurately to reflect the needs of the resident.

2. Review of R53's "Consultant Pharmacist Recommendation to Physician" document, dated 02/08/23 and provided by the Regional Nurse Consultant, Employee K, revealed R53's physician approved the Gradual Dosage Reduction (GDR) of the antipsychotic medication Seroquel Oral Tablet 50 milligram (MG) (Quetiapine Fumarate) BID (twice per day) to the decreased dosage of 25mg BID.

Review of the EMR "Medication Administration

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F 641	Continued From page 5	F 641		

Record (MAR)," dated 01/01/23 through 01/31/23 under the "Orders" tab, revealed Seroquel 50 mg was administered BID with diagnoses of UNSPECIFIED DEMENTIA, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY.

Review of the EMR's "MAR," dated 02/01/23 through 02/28/23 under the "Order" tab, revealed R53 received Seroquel 50 mg BID from 02/01/23 through 02/07/23. On 02/08/23 through 02/28/23, the order read Seroquel 25 mg BID. R53 received the 25 mg BID dosage from 02/08/23 through 02/28/23.

Review of the EMR's "MAR" dated 03/01/23 through 03/31/23 under the "Order" tab revealed R53 received Seroquel 25 mg BID.

Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/09/23 revealed, "Did the resident receive an antipsychotic medication since admission/entry?" with the response of "0" indicating "Antipsychotics were not received." For the question "Has a GDR reduction been attempted." The response was blank. For the question "Date of last attempted GDR" the response was blank.

During an interview on 04/13/23 at 9:45 AM, Employee K reviewed the R53's quarterly "MDS" with an ARD of 03/09/23 and confirmed the questions on antipsychotic use and GDR were coded incorrectly. Employee K stated that the MDS should have indicated that R53 was receiving an antipsychotic medication and that a GDR occurred on 02/08/23.

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F 641	Continued From page 6 Interview on 04/13/23 at 10:15 AM, the MDS Coordinator, Employee J confirmed the quarterly "MDS" was coded incorrectly for antipsychotic use and GDRs. 3. Review of R41's admission "MDS" with an ARD of 02/07/23 revealed for the question "Weight Loss of 5% or more in the last month or loss of 10% or more in the last 6 months" the response was "2, Yes, not on physician prescribed weight loss regime." During an interview on 04/12/23 at 8:50 AM, Employee J confirmed that R41 weighed 159 pounds on admission of 02/03/23 but lost five pounds when the MDS was completed on 02/07/23. Employee J calculated that a five percent loss from 159 pounds to 154 pounds would require 7.95 pounds weight loss. Employee J confirmed that the MDS was coded incorrectly in that R41 had not lost five percent of his weight when the MDS was completed on 02/07/23.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		5/16/23

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F 657	Continued From page 7 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, document review, record review, and policy review, the facility failed to invite the resident and/or the resident's representative to the care plan meeting for four residents (Resident (R)47, R16, R31, and R12) in the sample of 33 residents. Findings include: 1. During an interview on 04/11/23 at 10:54 AM, R47 stated that she was not invited to her care plan meetings. Review of the Electronic Medication Record (EMR) revealed the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/28/23 indicated a Brief Interview of Mental Status (BIMS) score of eight of 15 which indicated the resident's cognition was moderately impaired.	F 657	1.The care plan meeting for Residents R47, R16, R31 and R12 has passed and cannot be corrected. 2.All residents of the facility have the potential to be affected by this deficient practice. 3.The leadership of the facility has been provided education on the Hill Valley Healthcare process on inviting residents and/or the resident’s representative to care plan meetings. 4.The Social Service Director or designee will audit 2 residents weekly who have had a care plan scheduled to ensure the resident and/or representative is invited to care plan meetings for 8 weeks. Results of the weekly audits will be reported	

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F 657	Continued From page 8 During an interview with the MDS Coordinator, Employee J, and the Social Service Director (SSD), Employee E on 04/12/23 at 9:08 AM, Employee J confirmed that R47 was not on the list corporate sent out of residents invited to their care plan meeting on 02/23. 2. During an interview on 04/11/23 at 10:11 AM, R16 stated that she had not been invited to her care plan meetings. Review of the EMR revealed the quarterly "MDS" with an ARD of 12/21/22 revealed a BIMS score of nine of 15 which indicated the resident's cognition was moderately impaired. During continued interview on 04/12/23 at 9:08 AM, Employee J confirmed R16 did not attend according to the "care plan meeting note" in EMR under the "progress notes" tab dated 11/30/22. On 04/12/23 at 9:08 AM, Employee J stated the facility went several months without anyone as the MDS Coordinator position. "We went for about three to four months. During that time, the corporate office notified residents and their representatives of their upcoming care plan meetings. Corporate provided me this list which indicated [the following residents and/or representatives were not invited to the care plan meeting]: 3. Employee J confirmed that R31's care plan meeting dated 01/09/23 revealed no	F 657	monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5.DOC-5/16/2023	

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F 657	Continued From page 9 documentation that the resident was invited or attended the care plan meeting. 4. R12 was not invited to the care plan meeting. Review of the facility's policy titled, "Resident Participation-Assessment/Care Plans" dated 01/13/23 revealed, "Specific Procedures/Guidance ...7. An advance notice of the care planning conference is provided to the resident and his or her representative ...The Social Services Director ...is responsible for notifying ....and maintaining records of such notices ..."	F 657		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview, document review, and policy review, the facility failed to ensure there was a Registered Nurse (RN) on duty for eight	F 727	1.The facility cannot correct this deficient practice. 2.All residents of the facility have the	5/16/23

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F 727	Continued From page 10 consecutive hours per day on 01/19/23, 01/22/23, 01/27/23, 01/30/23, 01/31/23, 02/01/23, and 02/07/23. Findings include: Review of the facility's daily nurse staff posting documents for 01/12/23 through 01/31/23 revealed no RN worked on 01/19/23, 01/22/23, 01/27/23, 01/30/23 and 01/31/23. Review of the facility-provided daily staffing sheets for 01/01/23 through 01/31/23 confirmed that there was no RN scheduled to work on any shifts for the above dates. Review of the facility's daily nurse staff posting documents for 02/01/23 through 02/28/23 revealed no RN worked on 02/01/23 and 02/07/23. Review of the facility-provided daily staffing sheets for 02/01/23 through 02/28/23 confirmed there was no RN scheduled to work on any shifts for the above dates. Review of the facility's daily nurse staff posting documents for 04/01/23 through 04/13/23 revealed no RN worked on 04/07/23. Review of the facility-provided daily staffing sheets for 04/01/23 through 04/13/23 confirmed there was no RN scheduled to work on any shifts on 04/07/23. During an interview and review of the nurse staffing sheets for 01/01/23 through 04/13/23, the Administrator confirmed that the facility did not have eight hours of RN coverage on the dates	F 727	potential to be affected by this deficient practice. 3.The facility partnered with Medical Solutions (Staffing agency) to secure an Administrative Registered Nurse to ensure the needs of the residents are met per regulation for 8 weeks while the facility recruits additional Registered Nurses. The facility recruited an Administrative Nurse and is currently being oriented to the campus. 4.The facility has a staffing meeting Monday through Friday to ensure Registered Nurse coverage for a minimum of 8 consecutive hours 7 days a week. The facility has contracted with several local staffing agencies as a contingency plan in the event the facility employed Registered Nurses have a call off. The monthly staffing schedule will be reviewed by the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5.DOC- 5/16/23	

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F 727	Continued From page 11 indicated above. During the interview, the Administrator stated that he was notified when there was not going to be RN coverage. Review of the facility's policy titled, "Department Duty Hours- Nursing Services" dated 01/13/23 revealed, "Specific Procedures/Guidance ...7. Registered Nurse will be eight consecutive hours per day, 7 days a week."	F 727		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure proper sanitary conditions for two residents' pantry refrigerators in two resident pantries.	F 812	1.The refrigerators on Freedom and Colonial pantries have been deep cleaned and the chocolate milk discarded when identified.	5/16/23

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F 812	Continued From page 12 Findings include: An interview and observation on 04/11/23 at 10:59 AM with the Regional Dietary Manager Employee L of the two resident pantries revealed the following: Observation on the Freedom Hall pantry refrigerator revealed numerous amounts of food spillage/splatter on the doors and the bottom of the refrigerator with an expired chocolate milk dated March 2023. Observation of the refrigerator on the Colonial Hall revealed food spillage and splatter. Interview with Employee L at the time of observation revealed that the dietary staff were not responsible for cleaning the pantry refrigerators. Interview on 04/12/23 at 4:20 PM with the Administrator revealed there are daily rounds completed for the residents' pantries and refrigerators. He stated he was unaware of the expired milk in the refrigerator, and he expects the refrigerators and pantry to be clean with no expired foods. Review of the undated "Live Well HealthCare Solutions" policy, provided by the facility, revealed "Procedure 2. The responsible facility staff member will determine whether the food item is for immediate consumption, the responsible facility staff member will: d. determine if food items are shelf stable and whether they can be stored in the resident room or stored under refrigeration. 5. Refrigerator/freezers for storage of food brought in by visitors will be properly	F 812	2.All residents of the facility have the potential to be affected by this deficient practice. 3.The Nursing, Dietary, and housekeeping departments were provided education on Hill Valley HealthCare's process for Food Safety Requirements by the Nursing Home Administrator. 4.The facility Unit Managers or designee will complete sanitation audits of the resident food pantry's 3 times a week for 8 weeks. Results of the daily audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance. 5.DOC- 5/16/23	

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F 812	Continued From page 13 maintained and : c. Daily monitoring for refrigerated storage duration and discard of any food items that have been stored > 7 days. d. Cleaned weekly."	F 812		
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 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	F 883		5/16/23

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F 883	Continued From page 14 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 3 residents, Residents #6, #41, and #55, out of 6 residents reviewed for influenza immunization and facility staff failed to provide a pneumococcal vaccine for 4 residents, Residents #38, #41, #55, and #62, out of 6 residents reviewed for pneumococcal immunization. The findings included: 1. The facility staff failed to provide influenza immunization for Residents #6, #41, and #55. On 4/12/23 at approximately 10:30 AM, clinical	F 883	1.Residents R6, R41 R55, and/or resident representatives have been provided education regarding the benefits and potential side effects of the influenza immunization in addition to the education the immunization was offered. Residents #38, #41, #55, and #62, and/or resident representative have been provided education regarding the benefits and potential side effects of the pneumococcal vaccine in addition to the education the vaccine was offered. 2.All residents of the facility have the potential to be affected by this deficient practice. The facility completed a facility	

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record reviews were performed and revealed the following:

A. Resident #6, who was readmitted to the facility on 3/25/23, had no documentation with regard to 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.

B. Resident #41 was admitted to the facility on 2/3/23. Review of Resident #41's clinical record revealed a document entitled, "Informed Consent for Influenza Vaccine", dated 2/6/23, signed by Resident #41, with a check mark placed next to the statement which read, "I accept and GIVE the facility permission to administer the influenza vaccine". There was no evidence that an influenza vaccine had been administered to Resident #41.

C. Resident #55, who was admitted to the facility on 10/20/22, had no documentation with regard to 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 4/12/23 at approximately 2:30 PM, an interview was conducted with the Regional Nurse Consultant (RNC) who accessed the clinical records for the residents sampled and verified the findings. The RNC confirmed there was no additional information and stated, "it appears to be an oversight". A facility policy was requested and received.

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wide audit of resident immunizations. The DON or designee will complete an audit of all residents to ensure education was provided on the benefits and potential side effects of the influenza immunization and the pneumococcal vaccines. In addition to the education the facility will offer the immunization and vaccines to the residents.

3.The Interdisciplinary team of the facility will be educated by the Director of Nursing or designee on the company policy and CDC guidance for Immunizations and vaccines.

4.The Facility will audit the status of 3 residents weekly for 8 weeks, and all new admissions. New Admissions will also be provided the education on benefits and potential side effects of the immunization and vaccines. Results of the audit will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.

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On 4/12/23 at approximately 3:00 PM, a review of the facility policy entitled, "Influenza Vaccination" was conducted. It stated under the subtitle, "Policy", "All residents who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza" and subtitle, "Specific Procedures/Guidance", item 1 read, "Residents of the long-term care facility will be offered the influenza vaccination upon initial admission...".

On 4/12/23 at approximately 4:00 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.

2. The facility staff failed to provide pneumococcal immunizations for Residents #38, #41, #55, and #62.

On 4/12/23 at approximately 10:30 AM, clinical record reviews were performed and revealed the following:

A. Resident #38 was admitted to the facility on 6/21/22. Review of Resident #38's clinical record revealed a document entitled, "Informed Consent for Pneumococcal Vaccine", dated 6/21/22, signed by Resident #38, with a check mark placed next to the statement which read, "I accept and GIVE the facility permission to administer the pneumococcal vaccine". There was no evidence that a pneumococcal vaccine had been administered to Resident #38.

B. Resident #41 was admitted to the facility on 2/3/23. Review of Resident #41's clinical record

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revealed a document entitled, "Informed Consent for Pneumococcal Vaccine", dated 2/6/23, signed by Resident #41, with a check mark placed next to the statement which read, "I accept and GIVE the facility permission to administer the pneumococcal vaccine". There was no evidence that a pneumococcal vaccine had been administered to Resident #41.

C. Resident #55, who was admitted to the facility on 10/20/22, had no documentation with regard to pneumococcal immunization, to include the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication.

D. Resident #62, who was admitted to the facility on 6/14/22, had no documentation with regard to pneumococcal immunization, to include the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication.

On 4/12/23 at approximately 2:30 PM, an interview was conducted with the Regional Nurse Consultant (RNC) who accessed the clinical records for the residents sampled and verified the findings. The RNC confirmed there was no additional information and stated, "it appears to be an oversight". A facility policy was requested and received.

On 4/12/23 at approximately 3:00 PM, a review of the facility policy entitled, "Pneumococcal Vaccine" was conducted. It stated under the subtitle "Policy", "Residents will be offered pneumococcal vaccines to aid in preventing

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F 883	Continued From page 18 pneumonia/pneumococcal infections" and subtitle, "Specific Procedures/Guidance", item 1 read, "Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility..." and item 2 read, "Residents of the long-term care facility will be offered the pneumococcal vaccination upon initial admission...". On 4/12/23 at approximately 4:00 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 883		
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;	F 886		5/16/23

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(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or

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F 886	Continued From page 20 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 1) conduct COVID-19 testing in accordance with CDC (Centers for Disease Control) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements during a facility wide COVID-19 Outbreak for facility staff and residents and 2) the facility staff failed to document COVID-19 test results for 3 residents, Residents #9, #41, and #61, out of 4 newly admitted residents reviewed for COVID testing. The findings included: 1. The facility staff failed to conduct COVID-19 testing on 1/18/23 following the identification of a COVID-19 Outbreak within the facility on 1/17/23. On 4/13/23 at approximately 1:30 PM, an interview was conducted with the Regional Nurse Consultant (RNC). The RNC stated a COVID-positive case was identified within the facility on 1/17/23 and facility-wide broad-based testing was conducted for all staff members and residents. The RNC stated that the facility's COVID Outbreak ended on 2/10/23. The RNC stated that the facility's infection control program includes following all recommended CDC guidelines. The facility's COVID-19 Outbreak testing records and facility policy was requested. The facility COVID testing policy was received. On 4/13/23 at approximately 3:30 PM, a review of	F 886	1.The 1/18/23 COVID outbreak has passed and cannot be corrected. 2.All residents of the facility have the potential to be affected by this deficient practice. 3.The Interdisciplinary team of the facility will be educated by the Regional Nurse Consultant on the company policy and CDC guidance for COVID-19 Testing. 4.The facility will monitor the COVID-19 county transmission rate weekly and will report to the QAPI committee monthly monitoring compliance with most up to date CDC guidance. The QAPI Committee is responsible for the on-going monitoring of compliance. 5.DOC- 5/16/2023	

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the facility's COVID-19 Outbreak testing records was conducted with the RNC present. The RNC stated that the facility staff did not conduct the COVID Outbreak testing as required as there was only evidence of facility-wide testing for all staff and residents that occurred on 1/19/23 (2 days following the initial positive COVID) and 2/10/23 (the day the facility declared the COVID Outbreak was over).

The RNC stated, "My expectation is that COVID Outbreak testing would have been conducted for all staff and residents beginning on the 18th, the 20th, and the 22nd [January 2023] and then every 3 to 7 days until there were no [COVID] positive cases identified for 14 days, so that would have at least included testing on or around the 26th, the 31st, [January 2023] and the 4th, before ending the Outbreak on the 10th [February 2023], I don't find this acceptable at all".

On 4/13/23 at approximately 4:15 PM, a review of the facility policy titled, "COVID-19 Infection Control and Management", effective date March 2023, was conducted. It stated on page 11, "Responding to a Newly Identified SARS-CoV-2-infected Staff or Resident", item 4, "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".

The CDC document entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated

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September 23, 2022, page 11, subheading, "Nursing Homes", item 6 "Responding to a newly identified SARS-CoV-2 infection in any HCP [Healthcare Personnel] or resident", read, "Perform testing for all residents and HCP....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" and "Testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days".

On 4/13/23 at approximately 5:00 PM, the Facility Administrator and Director of Nursing were updated on the findings. No further information was provided.

2. For Residents #9, #41, and #61, the facility staff failed to document COVID-19 test results.

On 4/13/23 at approximately 3:30 PM, clinical record reviews were performed and revealed the following:

A. Resident #9, who was admitted to the facility on 2/23/23, had received COVID testing on 2/23/23, 2/25/23, and 2/28/23, however there were no testing results documented within his clinical record.

B. Resident #41, who was admitted to the facility on 2/3/23, had received COVID testing on 2/3/23, 2/5/23, and 2/7/23, however there were no testing results documented within his clinical record.

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F 886	Continued From page 23 C. Resident #61, who was admitted to the facility on 1/11/23, had received COVID testing on 1/11/23, 1/13/23, and 1/16/23, however there were no testing results documented within her clinical record. On 4/13/23 at approximately 3:45 PM, an interview was conducted with the Regional Nurse Consultant (RNC) who confirmed the findings and stated, "It is my expectation that all results of COVID testing be documented in the residents' medical charts...I do not know why this was not done". The RNC stated that the facility's infection control program includes following all recommended CDC guidelines. Review of the CMS (Centers for Medicare & Medicaid Services) Memo Ref: QSO-20-38-NH, revision date 9/23/2022, page 9, revealed, "For residents, the facility must document [COVID-19] testing results in the medical record". On 4/13/23 at approximately 5:00 PM, the Facility Administrator and Director of Nursing were updated on the findings. No further information was provided.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the 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	F 887		5/16/23

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F 887	Continued From page 24 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 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	F 887		

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F 887	Continued From page 25 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 1) offer and/or provide up to date COVID-19 immunization for 6 residents, Residents #6, #38, #41, #46, #55, and #62, in a survey sample of 6 residents reviewed for COVID-19 vaccination, and 2) for 5 staff members, RN C, LPN B, CNA F, CNA G, and Employee U, in a survey sample of 6 staff members reviewed for COVID-19 vaccination. The findings include: 1. The facility staff failed to offer and/or provide a COVID-19 bivalent booster vaccine for Residents #6, #38, #41, #46, #55, and #62. On 4/12/23 at approximately 10:30 AM, clinical record reviews were performed and revealed the following: A. Resident #6 completed a primary COVID-19 vaccine series on 2/26/21 and a monovalent booster on 3/7/22, however there was no evidence that Resident #6 had been offered or received a COVID-19 bivalent booster dose. B. Resident #38 completed a primary COVID-19	F 887	1.Residents R6, R38, R41, R46, R55, R62and/or resident representatives and staff members RN C, LPN B, C.N.A. F, C.N.A G and Employee U have been provided education regarding the benefits and potential side effects of the COVID-19 vaccination in addition to the education the vaccination was offered. 2.All residents of the facility have the potential to be affected by this deficient practice. The facility conducted a facility wide audit for resident and staff vaccination status. 3.The Interdisciplinary team of the facility will be educated by the Director of Nursing or designee on the company policy and CDC guidance for the COVID-19 vaccination. All residents/staff will be provided education and complete an acceptance or declination form for the COVID-19 booster. 4.The Facility will audit the status of 3 residents weekly for 8 weeks, and all new admissions. New Admissions will also be provided the education on the benefits and potential side effects of the COVID-19	

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vaccine series on 9/1/22, however there was no evidence that Resident #38 had been offered or received a COVID-19 bivalent booster dose.

C. Resident #41 completed a primary COVID-19 vaccine series on 4/26/21. A document titled, "COVID-19 Vaccine Information and Consent Form", dated 2/6/23, signed by Resident #41, with a check mark placed next to the statement which read, "I accept and give the center permission to administer the COVID-19 Vaccine" was located within the clinical record, however there was no evidence that Resident #41 had received a COVID-19 bivalent booster.

D. Resident #46 completed a primary COVID-19 vaccine series on 2/10/21 and a monovalent booster on 5/9/22, however there was no evidence that Resident #46 had been offered or received a COVID-19 bivalent booster dose.

E. Resident #55 completed a primary COVID-19 vaccine series on 5/25/21. A progress note dated 3/7/23 read, "Social services called the son to ask if he wanted the resident to have the Bivalent Booster. The son mentioned that yes he wants him to have the Booster". There was no evidence that Resident #55 had received a COVID-19 bivalent booster.

F. Resident #62 completed a primary COVID-19 vaccine series on 8/16/22, however there was no evidence that Resident #62 had been offered or received a COVID-19 bivalent booster dose.

On 4/12/23 at approximately 1:15 PM, an interview was conducted with the Regional Nurse Consultant (RNC) and the Infection Preventionist (IP), both of whom confirmed the facility policies

Provider's Plan of Correction (F 887):

vaccine. Results of the audit will be reported monthly to the facility QAPI committee for 3 months. The QAPI committee is responsible for the on-going monitoring of compliance.

5.DOC-5/16/2023

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and procedures follow CDC (Centers for Disease Control and Prevention) guidance and recommendations for resident COVID-19 immunization.

The RNC stated there were no concerns with the facility's ability to provide COVID immunizations to residents. The IP stated that it is expected for all residents to be provided the opportunity to be up to date with COVID-19 immunizations, including the bivalent COVID booster.

The RNC accessed the clinical records for the residents sampled and verified the findings. The facility's COVID vaccination policy for residents was requested and received.

On 4/12/23 at approximately 3:00 PM, a review of the facility's policy titled, "COVID-19 Vaccination for Residents" was conducted. it stated under the subheading "Policy", "In order to protect residents and staff from COVID-19, the facility...will offer vaccines to all residents and staff" and item 3 read, "Residents will be encouraged to accept COVID-19 vaccinations in accordance with CDC [Centers for Disease Control and Prevention] guidance".

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

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F 887	Continued From page 28 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". 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". On 4/12/23 at approximately 4:00 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 887		

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2. The facility staff failed to offer and/or provide COVID-19 bivalent booster vaccines for RN C, LPN B, CNA F, CNA G, and Employee U.

On 4/11/23 at approximately 10:30 AM, an interview was conducted with the Facility Administrator and the Infection Preventionist (IP), both of whom confirmed the facility policies and procedures follow CDC (Centers for Disease Control and Prevention) guidance and recommendations for staff COVID-19 immunization. A staff COVID vaccination matrix and COVID vaccination policies were requested and received.

On 4/12/23 at approximately 12:45 PM, staff vaccination records were reviewed and revealed the following:

A. RN C completed a primary COVID-19 vaccine series on 4/29/21 and a monovalent booster on 10/14/21, however there was no evidence that RN C had been offered or received a COVID-19 bivalent booster dose.

B. LPN B completed a primary COVID-19 vaccine series on 12/16/21, however there was no evidence that LPN B had been offered or received a COVID-19 bivalent booster dose.

C. CNA F completed a primary COVID-19 vaccine series on 10/13/21, however there was no evidence that CNA F had been offered or received a COVID-19 bivalent booster dose.

D. CNA G completed a primary COVID-19 vaccine series on 9/24/21, however there was no evidence that CNA G had been offered or

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F 887	Continued From page 30 received a COVID-19 bivalent booster dose. E. Employee U completed a primary COVID-19 vaccine series on 6/24/21 and a monovalent booster on 4/7/22, however there was no evidence that Employee U had been offered or received a COVID-19 bivalent booster dose. On 4/12/23 at approximately 1:45 PM, an interview was conducted with the Regional Nurse Consultant (RNC) who stated, "While we certainly would encourage staff members to consider staying up to date with [COVID-19] boosters, there is no formal process to review or educate each individual staff member on current [COVID-19] boosters". On 4/12/23 at approximately 3:15 PM, a review of the facility's policy titled, "COVID-19 Vaccination for Staff" was conducted. It stated under the subheading "Policy", "In order to protect residents and staff from COVID-19, the facility...will offer vaccines to all residents and staff" and item 3 read, "Staff will be encouraged to accept COVID-19 vaccinations in accordance with CDC [Centers for Disease Control and Prevention] guidance". 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	F 887		

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F 887	Continued From page 31	F 887		

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".

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

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F 887	Continued From page 32 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 4/13/23 at approximately 3:30 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 887		