STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

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BURKE HEALTH & REHABILITATION CENTER	9640 BURKE LAKE ROAD BURKE, VA 22015

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/27/23 through 6/29/23. 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 6/27/23 through 6/29/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints were investigated during the survey as follows: VA00059031 Unsubstantiated VA00057425 Substantiated with Deficiency VA00055519 Substantiated with Deficiency VA00055350 Substantiated with Deficiency VA00054396 Unsubstantiated VA00054283 Substantiated with Deficiency The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 38 resident reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		8/1/23

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

Electronically Signed | 07/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 1 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to offer and/or provide Advance Directive planning for 1 Resident, (Resident #317), in a survey sample of 38 Residents.	F 578	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s	

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F 578	Continued From page 2 The findings included: The facility staff failed to identify the wishes of Resident #317 with regards to code status, to uphold the Residents wishes in the event of cardiac arrest. On 06/27/23, a clinical record review of Resident #317's record was conducted. This review revealed that in the hospital records Resident #317 was noted as a code status of "DNR" (do not resuscitate). Review of the physician orders noted there was no order with regards to code status, which would direct facility staff in the event of cardiopulmonary arrest, if they were to perform CPR (cardiopulmonary resuscitation) or not. Review of the care plan for Resident #317 was reviewed and the code status and advance directive wishes of Resident #317 were not addressed. All the progress notes for Resident #317 were reviewed and there was no evidence of a discussion being held with Resident #317, to identify her wishes. In the banner section of the clinical record code status was blank. 06/28/23 at 04:56 PM, an interview was conducted with the director of discharge planning/social work, Employee J. Employee J was asked to explain the process with regards to Advance Directives and code status. Employee J said, "we would discuss that [referring to advance directives] after admission, we inquire if they have a POA [power of attorney], advanced directive, etc. and we have a packet that is premade that has information to include notary publics.... Code status is done from the clinical team during the jump start meeting or initial 5-day assessment and would be documented in the progress notes".	F 578	allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F578 Advance Directive 1. For Resident #317 the Discharge planner spoke with the resident concerning Advance Directives and the code status was changed in the medical record on 6/29/23. 2. An audit of current residents was conducted to ensure that an advanced directive discussion was present in the residents□ medical record and to ensure that the correct code status was present. 3. The Administrator or designee will educate the Discharge planning department on the admission process of a new resident to ensure that their Advance Directive status is discussed and documented in the medical record. 4. The Director of Discharge Planning or designee will audit new admission charts weekly for the presence of Advance Directive discussion in the medical record and correct code status is present. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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F 578	Continued From page 3	F 578		

During the end of day meeting held on 6/28/23, the facility Administrator, Director of Nursing and Corporate staff were made aware that the hospital records indicate Resident #317 was a do not resuscitate. However, the facility doesn't address code status and even note in the admission assessment that the Resident is a full code. Surveyor C made them aware that there was no evidence of a discussion being held to determine the Resident's current wishes. The facility staff were asked to provide any information they may have with regards to this.

On 6/29/23 at 12 Noon, an interview was conducted with LPN C. When asked what the process is to determine someone's wishes, she stated, "When they come in, the MDS (minimum data set) nurse comes out to them and does an interview and asks about code status. When asked if she, as an admitting nurse has this conversation with Residents, LPN C said "no".

On 6/29/23 at approximately 12:15 PM, an interview was conducted with RN D, who was the MDS coordinator. RN D stated that "during the jump start meeting social work asks about advance directives". RN D accessed in the clinical record a "Discharge Planning Admission Assessment" that noted on the very last page the following: "9. Identify code status: Full code". This assessment had been completed by Employee K, a discharge planner.

On 6/29/23 at approximately 12:25 PM, an interview was conducted with Employee K. Employee K was asked about the discussion of code status when completing the assessment. Employee K said he doesn't ask about code status and discuss full code versus do not

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F 578	Continued From page 4	F 578		

resuscitate, he just marks the box based on what is the in the banner of the Resident's information in the clinical chart. Employee K accessed Resident #317's record and stated, "since nothing was there, we mark full code".

Review of the admissions agreement revealed that there were forms for a Resident to indicate if they have/had an advance directive and forms to execute one if they so desired.

On 6/29/23 at approximately 1 PM, an interview was conducted with Employee L, the admissions director. Employee L stated that the admissions agreement is conducted electronically, usually the day after admission. It is completed with the Resident if they can complete it and if not, then the family. Employee L confirmed that admissions do not discuss code status and explain a do not resuscitate during the admission process.

On 6/29/23, the facility administration provided the survey team with a copy of a progress note entered Resident #317's record on 6/29/23. This note read, "This DCP [discharge planner] and DCP [name redacted] spoke with [Resident #317's name redacted] on this date about her wishes regarding code status. Full code vs DNR was thoroughly reviewed, and the patient stated she wishes to be a DNR and has a DNR at home on her refrigerator. Patient's hospital records reflect patient has a durable DNR. This dcp also reviewed AD/POA [advance directives/power of attorney] again and patient stated she has both and that she's already been asked about these and was displeased we asked for them again. Patient stated her son will be in to visit today around noon. This dcp will f/u [follow up] with son

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F 578	Continued From page 5	F 578		

[son's name redacted] to obtain DNR/AD/POA. NP [nurse practitioner] [name redacted] made aware on this date of the dcp's conversation with [Resident #317's name redacted] regarding wish to be DNR".

The facility administration was asked to provide any policies and procedures they had with regards to advance directives and code status. The facility provided a policy titled, "Advance Directives". This policy read, "Social work and discharge planning staff will assist with requests for information regarding Advance Directives upon patient's admission to the center and throughout the patient's stay to allow each patient an opportunity to plan in advance for medical treatment. Procedure: 1. Upon patient and/or responsible party requests, provide information and education to patients/responsible party regarding living wills, durable power of attorney for healthcare and anatomical gifts. Include preproperate medical and clinical staff as needed for clarification and assistance. 2. If requested, assist patient/responsible part with resources for obtaining Advance Directive forms...4. If patient/responsible party expresses a desire to pursue a Do Not Resuscitate order (DNR), escort them to the licensed nurse or attending physician for further assistance. Do not independently initiate any DNR directives or proceedings. 5. Provide a written summary note of initiatives and outcomes in Social Work and Discharge Planning Progress Notes and indicate status of Advance Directive throughout assessment process".

On 6/29/23, during the end of day meeting, Surveyor C shared with the facility administrator, Director of Nursing and Corporate staff that the facility had failed to provide any evidence that the

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F 578	Continued From page 6 discussion had been had with Resident #317 regarding her wishes and advance directives. No further information was provided.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		8/1/23

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F 584	Continued From page 7 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to provide a clean homelike environment for 1 Resident (Resident #38) in a survey sample of 38 Residents. The findings included: For Resident #38, the facility staff failed to provide a clean and homelike environment by ensuring cobwebs were removed. On 6/27/23 at approximately 2:00 PM, Surveyor C visited Resident #38 in his room. Surveyor C noticed 2 cobwebs in the ceiling corner of the room over the Resident's bedside table. On 6/27/23 at 2:50 PM, LPN C accompanied Surveyor C to Resident #38's room. LPN C was shown the cobwebs and confirmed them. On 6/27/23 at approximately 3 PM, the Director of Nursing came to the room and confirmed the above findings. The DON confirmed that this was not acceptable and reported rooms are cleaned by housekeeping. On 6/28/23, an interview was conducted with the housekeeping manager/Employee F. Employee	F 584	F584 Safe Clean Comfortable Environment 1. The cobwebs in Resident #38□s room were removed during the survey. 2.Current residents have the potential to be affected. 3. The Regional Housekeeping Manager or designee will educate all housekeeping staff on the proper cleaning of a room to include corners, edges, and high low surfaces to ensure cobwebs are not present. 4. The Administrator or designee will perform random room rounds 5 times per week to identify cleanliness issues and cobweb in the resident rooms. 5.Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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F 584	Continued From page 8 F confirmed that housekeeping cleans rooms daily and performs deep cleaning of rooms monthly. Employee F provided Surveyor C with a calendar of scheduled deep cleaning, which listed Resident #38's room as being scheduled to be deep cleaned the third Friday of each month. On the facility provided "Detailed Cleaning Check Off List" form it noted the following to be completed, "... 4. Sanitize all ceilings... 14. Sanitize all walls thoroughly...". On 6/28/23, during an end of day meeting the facility Administrator was made aware of the above findings. No further information was received.	F 584		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to ensure nursing standards of practice were followed for 2 Residents (Resident #15 and #217) in a survey sample of 38 Residents. The findings included: 1) For Resident #15, LPN D failed to verify the right resident during medication pass.	F 658	F658 Services Meet Professional Standards 1. For Resident # 15 the medication was not administered. Resident # 217 medication was documented in the medical record during the survey. LPN D was removed from the medication cart during the survey and placed back in orientation. 2. Current Residents have the potential to	8/1/23

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F 658	Continued From page 9 On 6/29/23 at 9:58 AM, LPN D was observed during the medication administration. LPN D pulled and prepared the medication for Resident #217, which was a total of 8 pills (tablets and capsules). The medications were: Amlodipine Besylate 10 MG tablet for hypertension/blood pressure, Oxycodone 5 mg immediate release tablet for pain, Budesonide extended release 3 mg capsule for Crohn's disease, Carvedilol 6.25 mg tablet for hypertension, Venlafaxine HCl extended release 150 mg capsule for depression, Prevacid delayed release 30 mg capsule for gastroesophageal reflux, Dicyclomine HCl 20 mg tablet for irritable bowel syndrome and Sodium Bicarbonate 650 mg tablet for hyponatremia. Upon entering the room, LPN D approached Resident #15, who was the roommate of Resident #217. LPN D made no attempts to verify the Resident's identity. LPN D then scooped the pills onto a spoon and was approaching Resident #15's face with the spoon while saying "I have your medications". Surveyor C intervened and asked the Resident to state her name. Resident #15 stated her name and LPN D then realized she was giving Resident #15 the medications that belonged to Resident #217. LPN D apologized and then approached Resident #217 and administered the medications. Had Surveyor C not intervened LPN D was going to administer all the medications noted above to the wrong Resident. Review of the facility policy titled; "Administration Procedures for All Medications" was conducted. This policy read, "...IV. Administration.... 2. Identify the resident before administering the medication...".	F 658	be affected. 3. The Director of Nursing or Designee will educate all licensed nursing staff on the 5 rights of medication administration and the correct documentation of medication administered during the medication pass in the medical record. 4. The Director of Nursing or designee will observe 3 medication passes weekly to ensure the 5 rights are being observed and followed, and the medication is documented in the medical record per policy. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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F 658	Continued From page 10	F 658		

On 6/29/23, during an end of day meeting, the facility administrator, Director of Nursing (DON) and corporate staff were made aware of the above observations. The Corporate Clinical Director indicated that it could be very dangerous and result in the need for clinical interventions.

No further information was provided/received.

2) For Resident #217, the facility staff failed to correctly document medications that were administered.

On 6/29/23 at 9:58 AM, LPN D was observed during the medication administration. LPN D pulled and prepared the medication for Resident #217, which included Oxycodone 5 mg immediate release tablet for pain and Budesonide extended release 3 mg capsule for Crohn's disease.

Following the administration, LPN D returned to the medication cart and proceeded to sign out the narcotic oxycodone 5 mg tablet onto the sheet as if she had pulled oxycodone 10 mg tablet. LPN D realized her error and said she would let her manager know so it could be corrected. On 6/29/23 at approximately 11:10 AM, a review of the MAR (medication administration record) of Resident #217 was conducted. It was noted that LPN D had administered Budesonide extended release 3 mg capsule during the observation, but failed to sign off on the MAR that the medication was given.

A review of the facility policy titled, "Administration Procedures for All Medications" was conducted.

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F 658	Continued From page 11 This policy read, "...IV. Administration... 7. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR or TAR and the controlled substance sign out record, if necessary...". On 6/29/23, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No further information was received.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, clinical record review and facility documentation review, the facility staff failed to provide assistance with eating for 1 resident (Resident #84) in a survey sample of 38 Residents. The findings included: For Resident #84, who was dependent upon facility staff for assistance with eating, the facility staff failed to provide meal set-up and feeding assistance. Resident #84's most recent MDS (minimum data set) assessment with an assessment reference date of 5/24/23. This assessment noted Resident	F 677	F677 ADL Care Provided 1. Resident #84□s dinner tray was set up and offered on 6/29/23. 2. Current residents that require assistance have the potential to be affected. 3. The Director of Nursing or designee will educate all Nursing staff on proper meal set up of resident meal trays to included ensuring they are within reach of the resident. The Nursing staff will be educated how to properly assist residents that require assistance with feeding. 4. The Director of Nursing or designee will audit residents□ meal pass for proper set	8/1/23

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F 677	Continued From page 12 #84 as having required extensive assistance of one staff member for eating. Review of the clinical record was conducted. This review revealed Resident #84 was on hospice care. Resident #84 was identified in his care plan as being at risk for weight loss. It read, "Nutritional Risk: [name redacted] is at nutritional risk d/t [due to] hx [history] pressure ulcers, on hospice care with expended medical decline". The goal read, [different Resident name, not Resident #84, name redacted] will have adequate nutrition for comfort/autonomy through next review". Interventions read, "Provide diet as ordered. Monitor intake and record each meal. Offer substitute when intake less than 50%, provide supplements as ordered, treat risk factors as ordered, weights per protocol". Resident #84 was also noted on the care plan to "needs assistance for ADL's due to impaired mobility/ cognition/ communication/ swallowing". On 6/27/23 at 2:13 PM, Resident #84 was observed lying in bed. His lunch tray was on a tray table by the bed, cover in place and none of the items opened. The tray was out of reach of the Resident. Resident #84 didn't verbally respond when spoken to. On 6/27/23 at 2:15 PM, an interview was conducted with Resident #320, who was the roommate of Resident #84. Resident #320 verbalized concern over Resident #84. When asked about meals, Resident #320 said they just drop off the tray and leave the room. On 6/27/23 at approximately 2:30 PM, an interview was conducted with CNA B. CNA B acknowledged she was assigned to Resident	F 677	up and observe residents requiring assistance with meals 5 times per week to ensure residents were set up and proper assistance was offered. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 677	Continued From page 13	F 677		

#84. When asked about Resident #84's ability to feed himself, CNA B stated, the Resident feeds himself. When asked, how he could feed himself with the tray not set-up and out of reach, CNA B stated she had asked the Resident if he wanted to eat, and he told her no.

On 06/29/23 at 01:44 PM, Resident #84 was noted to be in bed asleep. His meal tray was at the bedside, out of reach and not set-up, covered with a tray lid. Surveyor C talked with LPN B who was assigned to Resident #84. LPN B stated the Resident could feed himself. LPN B accompanied Surveyor C to the room and acknowledged the tray was not set-up and the Resident could not reach it. LPN B then set-up the meal tray and encouraged Resident #84 to eat.

Review of Resident #84's activities of daily living sheets, revealed the resident required limited to extensive assistance of facility staff for eating. The forms also indicated Resident #84 consumed 0-25% of most meals. On 6/27/23, Resident #84 was only recorded as having been offered one meal.

The facility administration was asked to provide the survey team with a policy regarding activities of daily living (ADL's). The facility stated they did not have a policy but follow Mosby's standards for the practice of nursing assistants. The facility provided copies from "Mosby's Textbook for Long-Term Care Nursing Assistants Seventh Edition" which addressed bathing.

On 6/29/23, during the end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.

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F 677	Continued From page 14 No further information was provided.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 provide respiratory care as ordered by the physician and consistent with professional standards of practice for 1 Resident (Resident #38) in a survey sample of 38 Residents. The findings included: For Resident #38, the facility staff failed to 1) provide oxygen via a concentrator, at the level ordered by the physician 2) failed to store the suction Yankauer in a manner to prevent contamination, 3) failed to replace the suction tubing routinely, 4) failed to change the oxygen tubing weekly as ordered, 5) failed to change the humidifier bottle weekly as ordered, 6) failed to change the nebulizer tubing weekly as ordered. On 6/27/23 at approximately 2:00 PM, Surveyor C visited Resident #38 in his room. Resident #38	F 695	F 695 Respiratory/ Trach Care and Suctioning 1. For Resident # 38 the Yankauer, suction tubing, oxygen tubing, humidifier bottle and nebulizer tubing was discarded, replaced, and stored properly on 6/27/23. The oxygen concentrator was placed on the correct setting on 6/27/23. 2. Current residents requiring oxygen, respiratory treatments, or suctioning have the potential to be affected. An audit of current residents receiving oxygen, respiratory treatments or suctioning will be conducted to ensure all are within date and as ordered by the physician. 3. The Director of Nursing or designee will educate all Licensed nursing staff on the policy and procedures to store and change oxygen tubing, suction tubing, nebulizer tubing and the Yankauer. Licensed Nursing staff will be educated on	8/1/23

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F 695	Continued From page 15 was able to communicate and when asked about the oxygen, the Resident was not able to recall the rate of oxygen flow ordered. Surveyor C noted the oxygen concentrator was set on 5 liters of oxygen. Further observations in the room revealed a suction machine at the bedside and the canister had some brown appearing liquid in it. The tubing had copious amounts of scattered brown residue and stains throughout the tubing. The yankauer suction tip (an oral suctioning tool used in medical procedures and is the part that enters the oral cavity) was noted to be on the bedside table wrapped in a medical procedure glove. Further observations revealed the oxygen tubing and humidifier bottle were not dated. There was also a nebulizer mask on the bed, open to air, which was dated 5/29/23. When Resident #38 was asked about the frequency of suctioning, he stated it is not often. On 6/27/23 at 2:50 PM, LPN C accompanied Surveyor C to Resident #38's room. LPN C stated that Resident #38, "had a change in condition on Sunday, spiked a fever and should be on 2 liters of oxygen", she looked at the oxygen concentrator settings and confirmed that it was running at 5 liters. LPN C confirmed that suction yankauer should be stored in a bag when not in use to prevent contamination that could cause respiratory infections. At this time, it was noted to be laying on the floor, still wrapped in a medical procedure glove. LPN C found the bag the suction tip was to be stored in and it was dated 4/5/23. LPN C also confirmed that Resident #38 would not have been able to adjust/change the setting for the rate of oxygen flow. LPN C looked at the oxygen concentrator	F 695	administering oxygen at the amount ordered by the physician. 4. The Unit Manager of Designee will monitor the storage and dating of the respiratory tubing and those patients□ requiring oxygen for the correct flow rate and storage five times weekly. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 16	F 695		

confirmed that there was no date as to when the tubing was changed or the humidifier bottle. LPN C stated that it is done weekly, "every Saturday on night shift and should be dated". LPN C also confirmed that the nebulizer mask was laying on the bed, open to air, had not been disassembled and cleaned and was dated 5/29/23. LPN C said the nebulizer tubing and masks are "changed every Monday, Wednesday and Friday, on night shift".

On 6/27/23 at approximately 3 PM, the Director of Nursing came to the room and confirmed the above findings. The DON confirmed that this was not acceptable.

A clinical record review was conducted. This review revealed that Resident #38 had a physician order dated 6/24/23, that remained active that read, "Supplemental Oxygen via NC [nasal cannula] at 2L AS NEEDED/PRN for SOB [shortness of breath]/SPO2 [oxygen saturation] <92%-WEAN AS ABLE, every 8 hours as needed". Resident #38 was also noted to have a diagnosis of "chronic obstructive pulmonary disease". This review revealed that Resident #38 had a physician order for Oxygen and nebulizers as needed.

The facility provided the survey team with a policy titled, "Respiratory/Oxygen Equipment". This policy read, "Policy: Licensed staff will administer and maintain respiratory equipment, oxygen administration, and oxygen equipment per provider's order and in accordance with standards of practice... Medicated Nebulizer Treatment: ... 5. Rinse out nebulizer reservoir with tap water, dry and place in a plastic bag when not in use. Nebulizers and bags should be changed

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F 695	Continued From page 17 weekly... Oxygen Therapy via Nasal Cannula, Simple Mask, Venturi Mask, and Oximizer... 3. Set appropriate flow rate and place oxygen delivery device on patient... 6. Nasal cannulas, simple masks, Venturi mask, and oximizer and tubing should be changed weekly. 7. If flow rate is greater than 4 liters/minute, a pre-filled disposable humidifier bottle should be used. Humidifier bottles are to be changed weekly. 8. Store oxygen tubing/mask in plastic bag when not in use...". The policy titled, "Suctioning" was received and reviewed. This policy read, "Oral Suctioning...4. Suction catheters are to be changed after each use... General Considerations: ... 2. Disposable suction canisters and connecting tubing are to be disposed of and changed every day and dated if used...". On 6/27/23, during the end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. When asked about the associated risks to a Resident receiving oxygen at a higher rate of flow than ordered, the Corporate Clinical Consultant stated that it could cause them to retain more carbon dioxide and could cause a medical emergency. No further information was received.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		8/1/23

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F 755	Continued From page 18 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to implement a system to account for and reconcile controlled drugs on 1 of 2 nursing units. The findings included: 1. The facility staff failed to implement their system of reconciliation to ensure the appropriate quantity of controlled medications was accurate	F 755	F 755 Pharmacy Services 1. All medication carts in the building were counted to ensure the correct count for controlled medication was present during the survey on 6/28/23. The Director of Nursing collected all controlled medications that had been discontinued and remained in the nursing cart on the units and were destroyed per policy on the	

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F 755	Continued From page 19 on 2 of 4 medication carts inspected. 1a. On 06/28/23 at 05:19 PM, a medication storage inspection was conducted of the second floor, medication cart 1 with LPN E. During the verification of the controlled medications, it was determined that the controlled count was not correct. For one Resident who had Gabapentin 100 mg capsules, the medication card had 25 capsules, the reconciliation sheet said there should be 24 capsules present. For another Resident who had Armodafinil 200 mg tablets, the medication card had 19 tablets and the count sheet/reconciliation sheet indicated that 18 tablets should be present. LPN E confirmed the above findings. When asked about the process, LPN E said that at each shift change the off-going and on-coming nurses are to count the narcotics together. LPN E stated she "took the cart keys at 2 PM", meaning she assumed responsibility of the cart at that time. LPN E further confirmed that a count of the controlled medications had not been conducted and she did not know that the count was not correct. On 06/28/23 at 05:51 PM, the unit manager, RN D was made aware that the controlled count on cart 1 was incorrect. RN D stated, "This is my first week here...". A few minutes later, RN D told Surveyor C that the off-going nurse for cart 1 "is coming back to correct the count, she was having trouble with her eyes and signed the wrong thing, she is correcting it". On 6/29/23, during the mid-morning, RN D approached Surveyor C and said she had given	F 755	evening on 6/28/23. 2. Current residents have the potential to be affected. 3. The Director of Nursing will educate all Licensed nursing staff on how to count and sign the controlled count log sheet when finished counting by the oncoming and off going nurse and the process to sign out a controlled on the controlled log sheet. All Licensed nursing staff will be educated to count all controlled medications in the lock box to include controlled medications that have been discontinued or when a resident has discharged, the medication will be counted until removed from the medication cart by the DON/ADON. The Regional Director of Clinical Services will educate the Director of Nursing/ Assistant Director of nursing on the policy for controlled reconciliation and disposal of controlled substances within the facility. 4. The Unit Managers will monitor the controlled medication count 10 times weekly to ensure the appropriate quantity of controlled medication is present and accurate. All discrepancies will be reported to the DON immediately. The DON/ ADON will remove controlled medications from the medication carts on the units two times weekly. The controlled medication will be disposed of per policy two times weekly when controlled medications are removed from the medication cart and a destruction log will be kept of those controlled medications disposed of. The Administrator or Designee will audit the logs weekly to ensure compliance.	

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	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 755	Continued From page 20 incorrect information on the day prior. RN D said, that with regards to the controlled count not being correct on cart 1, the day shift nurse was still in the building at the time of the inspection. When asked if the controlled count verification is supposed to be done prior to the on-coming nurse accepting the keys and assuming responsibility of the cart, RN D said, "yes". 1b. On 06/28/23 at 05:34 PM, an inspection was conducted of the 2nd floor, medication cart two (2). This review was conducted with LPN F. During review of the narcotics/controlled medications, it was noted that one Resident had a bottle of Morphine 20 mg/ml concentrate, which contained 30 Ml. There was no count/reconciliation sheet present for the nursing staff to verify that the quantity on-hand was accurate. LPN F said, "The day nurse said the nurse manager has it". 1c. During the inspection of medication cart 2, LPN F had a stack of controlled medication cards that were bound with a rubber band and the controlled count/reconciliation sheets were attached. She stated that they were controlled medications for Residents who had been discharged, but the box they put them in is full, so she was told to keep them on her cart. LPN F confirmed that they were not being counted at each shift change. Review of the stack of medications revealed there was controlled medications for 5 Residents. The medications included: oxycodone immediate release 5 mg, Percocet 5-325 mg, Tramadol, Gabapentin, Lorazepam concentrate, and morphine concentrate.	F 755	5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 755	Continued From page 21	F 755		

2. The facility staff failed to implement their system of reconciliation and disposal of controlled medications to ensure that there is a system to account for the controlled substances stored within the facility.

On 6/28/23 at approximately 5:40 PM, LPN F took Surveyor C to the medication room, for the surveyor to observe the locked box where they normally put controlled medications once a Resident is discharged. Upon observation it was noted that the box was so full of medications that no additional medication cards could be inserted.

Surveyor C then requested for the Director of Nursing (DON) and Corporate Clinical Director to come to the medication room. Upon their arrival the DON opened the box and pulled out a substantial amount of controlled medication cards. The DON and Corporate Clinical Director retrieved all the controlled medications and took them to the office to make an accounting of what was present and then destroy them.

Surveyor C sat with the DON and Corporate Clinical Director while they made an accounting of what was present. There was a total of 84 cards of controlled drugs, that contained over 1600 capsules/tablets, that had been stored in the locked box on the second-floor medication room. During their reconciliation, it was determined that they had 12 cards of medications that they had no count sheet for, therefore they were unaware if there were any medications missing. In addition, they had 3 count sheets that they had no medication for.

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F 755	Continued From page 22	F 755		

When asked if they had any way to identify if there were medications that were missing, the DON and Corporate Clinical Consultant both agreed that they had no way to know.

When asked about the process for destruction of narcotic medications, the DON stated, "every Friday we go to the medication cart and destroy. I knew we keep narcotics in the safe [referring to the box, similar to a drop box made of file cabinet material]".

When asked why it is important to have a process to account for and reconcile narcotics, they indicated because controlled drugs are at risk for diversion and without counting, they would not know if Residents were getting the medications or if they are being diverted.

Review of the facility policy titled; "Shift Change Report" was conducted. This policy read, "... 3. Licensed nurses from the previous shift will complete the narcotic counts with a nurse coming on duty...".

The facility policy titled; "Storage of Controlled Substances" was reviewed. An excerpt from this policy read, "... 5. Unless otherwise indicated in a facility policy and/or as required by state regulations, the following will be performed: a. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel, and is documented... 6. Any discrepancy in controlled substance counts is reported to the Director of Nursing immediately and/or in accordance with facility policy...10. Controlled substances remaining in the facility after the order has been discontinued or the

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F 755	Continued From page 23 resident has been discharged are retained in the facility in a securely locked area with restricted access until destroyed in accordance with facility policy and state regulations. Accountability records for discontinued controlled substances are maintained with the unused supply until it is destroyed or disposed of, and then stored for five years or as required by applicable law or regulation...". On 6/28/23, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No additional information was received.	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation, the facility staff failed to ensure the medication error rate was less than 5%. There were 9 medication errors in 31 opportunities, resulting in an 29.03% error rate. The findings included: On 6/29/23 at 9:58 AM, LPN D was observed during medication administration. LPN D pulled and prepared the medication for Resident #217,	F 759	F 759 Free of Medication Error 1. For Resident # 15 the medication was not administered. Resident # 217 medication was documented in the medical record during the survey. LPN D was removed from the medication cart during the survey and placed back in orientation. 2. Current Residents have the potential to be affected. 3. The Director of Nursing or Designee	8/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 759	Continued From page 24 which was a total of 8 pills (tablets and capsules). The medications were: Amlodipine Besylate 10 MG tablet for hypertension/blood pressure, Oxycodone 5 mg immediate release tablet for pain, Budesonide extended release 3 mg capsule for Crohn's disease, Carvedilol 6.25 mg tablet for hypertension, Venlafaxine HCl extended release 150 mg capsule for depression, Prevacid delayed release 30 mg capsule for gastroesophageal reflux, Dicyclomine HCl 20 mg tablet for irritable bowel syndrome and Sodium Bicarbonate 650 mg tablet for hyponatremia. Upon entering the room, LPN D approached Resident #15, who was the roommate of Resident #217. LPN D made no attempts to verify the Resident's identity. LPN D then scooped the pills onto a spoon and was approaching Resident #15's face with the spoon while saying "I have your medications". Surveyor C intervened and asked the Resident to state her name. Resident #15 stated her name and LPN D then realized had the wrong resident. LPN D apologized and then approached Resident #217 and administered the medications. Review of Resident #15's physician orders revealed she did not have an order for any of the 8 medications that LPN D was stopped from administering. On 6/29/23 at 9:58 AM, LPN D was observed to prepare and administer medications to Resident #41. Resident #41's scheduled medications included "Tiotropium Bromide Monohydrate Capsule 18 MCG, also known as Spiriva. LPN D looked in the medication cart, went to another cart and looked and indicated that it was not available. LPN D then administered the other	F 759	will educate all licensed nursing staff on the 5 rights of medication administration and the correct documentation of medication administered during the medication pass in the medical record. 4. The Director of Nursing or designee will observe 3 medication passes weekly to ensure the 5 rights are being observed and followed, and the medication is documented in the medical record per policy. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 759	Continued From page 25	F 759		

medications and returned to the medication cart and proceeded to the next Resident for medication administration. LPN D made no attempts to call the pharmacy to inquire about the delivery of the Spiriva, nor did she attempt to notify the provider that the medication was not available.

On 6/29/23 at 9:45 AM, LPN D was asked about the process if medications are not available. LPN D said, "If it isn't available in the cart, we go downstairs to the machine [referring to the Omnicell, which is a medication dispensing machine]". LPN D then said, "If the medication isn't available in the machine, we call the pharmacy and the doctor".

During the late morning of 6/29/23, the Corporate Clinical Consultant let Surveyor C know they had removed LPN D from the medication cart.

Review of the facility policy titled; "Administration Procedures for All Medications" was conducted. This policy read, "...IV. Administration.... 2. Identify the resident before administering the medication...".

The facility policy titled, "Medication Management/Medication Unavailability" was received and reviewed. This policy read, "... 3. If medications are determined to be unavailable for administration, licensed nurse will notify the provider of the unavailability. Licensed nurse will document notification to the provider of the unavailability in the medical record...".

On 6/29/23, during an end of day meeting, the facility administrator, Director of Nursing (DON) and corporate staff were made aware of the

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	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

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F 759	Continued From page 26 above observations and medication error rate being greater than 5%. No further information was provided/received.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation the facility staff failed to properly store medications on 2 of 4 medication carts inspected.	F 761	F761 Label/Store Drugs and Biologicals 1. The medication was discarded and re-ordered on 6/28/23.	8/1/23

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F 761	Continued From page 27 The findings included: For 2 of 4 medication carts inspected, the facility staff failed to label insulin with the open date to ensure it is not used beyond the expiration date. On 06/28/23 at 05:19 PM, an inspection was conducted of the second-floor cart 1, in the presence of LPN E. The following was noted: A Lantus Solostar pen was open, had been used, and had no open date. A Humalog 100-unit multi-dose vial was dated 5/28/23. LPN E stated, "today is last day", indicating it was good for 31 days. On 06/28/23 at 05:34 PM, an inspection of the 2nd floor, cart 2, was conducted. LPN F was present during the inspection and confirmed the findings. The following was noted. An Insulin Aspart 100 U/ML multi-dose vial was opened and had no date to indicate when it was opened. The label said, "discard after 28 days". LPN F confirmed she had no way to know when to discard it because she didn't know when it was opened. There was a Humalog 100 U/ML 3 ml multi-dose vial, which had no open date. The facility administration provided the survey team with a document titled, "Medications with shortened expiration dates". It noted the following: Lantus Solostar Pen: "Once opened, do not refrigerate. Store at room temperature. Product expires 28 days after first use or removal from refrigerator, whichever comes first". Humalog vial: "Once opened, store below 86 degrees Fahrenheit. Product expires 28 days after first	F 761	2. Current residents have the potential to be affected. Medication carts for each unit was inspected to ensure no outdated/ expired medications were present. 3. The Director of Nursing or Designee will educate all licensed nursing staff on proper labeling and storage of medication to include insulin. 4. The Director of Nursing or designee will audit medication carts weekly to ensure no outdate/expired medication is present on medication carts. 5. Results of the audit will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, audits will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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F 761	Continued From page 28 use or removal from refrigerator, whichever comes first". This means that the Humalog noted on the second floor, cart 1 should have not been used beyond 6/25/23. NovoLog/Aspart vial: Product expires 28 days after first use or removal from refrigerator, whichever comes first. By not having the insulins dated with an open date, the facility staff had no way of knowing if the insulin being administered was expired or not. On 6/28/23, during the end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were made aware of the above findings. No additional information was provided.	F 761		
F 883 SS=D	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:	F 883		8/1/23

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F 883	Continued From page 29 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative 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 an influenza vaccine for 1	F 883	F883 Flu and PNA Vaccines 1. Resident #54 was offered the flu	

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F 883	Continued From page 30 resident, Resident #54, out of 5 residents reviewed for influenza immunization and facility staff failed to provide a pneumococcal vaccine for 1 resident, Resident #67, out of 5 residents reviewed for pneumococcal immunization. The findings included: 1. The facility staff failed to provide influenza immunization for Resident #54. On 6/28/23 at approximately 2:30 PM, a clinical record review was performed for Resident #54 and revealed that Resident #54 had received influenza immunization on 10/19/21, however there was no documentation of the flu vaccine being offered, refused, contraindicated, or administered for the current year, 2022. On 6/28/23 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON) who accessed the clinical records for Resident #54 and verified the findings stating, "it appears to be an oversight". A facility policy was requested and received. On 6/28/23 at approximately 3:00 PM, a review of the facility policy entitled, "Influenza Vaccination", effective date 5/01/23, was conducted. It stated under the subtitle, "Procedure", item 1a, "Influenza vaccine should be offered annually...optimal time to administer influenza vaccine is in late September or early October of each year. The vaccine can be given after the flu season begins...Those who have not had a flu vaccine will be offered one upon admission". On 6/28/23 at approximately 5:15 PM, the Facility Administrator and Director of Nursing were made	F 883	vaccine and declined on 7/13/23. Resident # 67 was offered PNA vaccine and declined on 7/13/23. 2. A review of current resident□s pneumococcal vaccination status and Flu vaccination status was preformed to ensure documentation in the medical record was present. 3. The DON or designee will educate the Infection Preventionist and Nursing Management on ensuring the pneumococcal and Flu vaccination status is present and correct in the medical record. 4. The DON or designee will audit new admission charts 5 times per week for the presence of pneumococcal and flu vaccine status in the medical record. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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F 883	Continued From page 31 aware of the findings. No further information was provided. 2. The facility staff failed to provide pneumococcal immunization for Resident #67. On 6/28/23 at approximately 2:30 PM, a clinical record review was performed which revealed Resident #67, who was admitted to the facility on 3/18/21, had no clinical assessment with regard to pneumococcal immunization, to include the resident's current pneumonia vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication. On 6/28/23 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON) who accessed the clinical records for Resident #67 and verified the findings stating, "it appears to be an oversight". A facility policy was requested and received. On 6/28/23 at approximately 3:00 PM, a review of the facility policy entitled, "Pneumococcal Vaccinations", effective date 5/01/23, was conducted. It stated under the subtitle, "Policy", "Vaccination against pneumonia will be offered to center patients". On 6/28/23 at approximately 5:15 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 883		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii)	F 887		8/1/23

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F 887	Continued From page 32 §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 was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and	F 887		

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F 887	Continued From page 33 (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 interview, clinical record review, and facility documentation review, the facility staff failed to provide COVID-19 bivalent vaccines for 4 residents, Residents #19, #31, #54, and #67, out of 5 residents reviewed for COVID-19 bivalent immunization. The findings included: The facility staff failed to provide COVID-19 bivalent immunization for Residents #19, #31, #54, and #67. On 6/28/23 at approximately 2:30 PM, clinical record reviews were performed and revealed the following: A. For Resident #19, the clinical record review revealed no evidence of an offer to provide the resident with a COVID-19 bivalent vaccine or	F 887	F 887 COVID-19 Immunization 1. Resident #19 was offered the vaccine on 7/13/23 and consented, Resident #31 was offered the vaccine on 7/10/23 and consented. The vaccines will be administered during the next Bivalent clinic in July. Resident # 54 and Resident #67 were offered the vaccine on 7/13/23 and declined. 2. A review of current resident□s COVID-19 vaccination status was preformed to ensure documentation in the medical record was present. 3.The DON or designee will educate the Infection Preventionist and Nursing Management on ensuring the COVID-19 vaccination status is present and correct in the medical record. 4. The Infection Preventionist or designee	

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F 887	Continued From page 34 documentation of resident refusal or medical contraindication. B. For Resident #31, the clinical record review revealed no evidence of an offer to provide the resident with a COVID-19 bivalent vaccine or documentation of resident refusal or medical contraindication. C. For Resident #54, the clinical record review revealed no evidence of an offer to provide the resident with a COVID-19 bivalent vaccine or documentation of resident refusal or medical contraindication. D. For Resident #67, the clinical record review revealed no evidence of an offer to provide the resident with a COVID-19 bivalent vaccine or documentation of resident refusal or medical contraindication. On 6/28/23 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON) who accessed the clinical records for the residents sampled and verified the findings stating "it appears to be an oversight". A facility policy was requested and received. On 6/28/23 at approximately 3:00 PM, a review of the facility policy entitled, "COVID-19 Vaccinations", effective date 5/01/23, was conducted. It stated under the subtitle, "Procedure", item 1, "CDC [Centers for Disease Control and Prevention] recommends that everyone stay up to date with COVID-19 vaccination" and item 2c read, "If contraindicated or refused, document in the patient's immunization record, including that the patient and/or RP [Responsible Party] was provided	F 887	will audit new admission charts 5 times per week for the presence of COVID-19 vaccine status in the medical record. 5. Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

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F 887	Continued From page 35 education regarding the benefits and potential risks associated with the COVID-19 vaccine". The CDC (Centers for Disease Control and Prevention) document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States", updated May 12, 2023, page 2, "Recommendations for the use of COVID-19 vaccines", read, "COVID-19 vaccination is recommended for everyone ages 6 months and older in the United States for the prevention of COVID-19" and "CDC recommends that people ages 6 months and older receive at least 1 bivalent mRNA COVID-19 vaccine". On 6/28/23 at approximately 5:15 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 887		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, Resident and family interview, staff interviews and facility documentation review, the facility staff failed to maintain a sanitary and comfortable environment for Residents on 2 nursing halls in a sample of 6 nursing halls inspected. The findings included: On 6/27/23, during initial tour observations were	F 921	F 921 Safe/ Functional/Sanitary/ Comfortable Environment 1. Resident #230 privacy curtain was changed on 6/28/23 during the survey. An audit of all privacy curtains was performed during the survey and those identified were changed during the survey. 2. Current residents have the potential to be affected.	8/1/23

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F 921	Continued From page 36 made in multiple rooms on the first floor, halls 2 and 3 of privacy curtains (located to wrap around the bed for each Resident) to have brown stains and brown solid matter on them. On the afternoon of 6/27/23, an interview was conducted with Resident #320, who had a family member visiting. Resident #320 pointed out to Surveyor C the privacy curtain which had brown stains and solid matter that the Resident identified as feces. Resident #320 reported he had let facility nursing staff know but nothing had been done. The family member of Resident #320 showed Surveyor C her bag that she brings in daily with a disinfectant cleaner and Lysol spray because when she arrives, she, "has to empty, clean and disinfect the bedside commode, because the facility staff do not do it". The family member also pointed out the trash can within the room that had a large quantity of dried brown substance on it. In addition, Resident #320 lifted his body off the sheets to show Surveyor C that his bed linen had what he identified as feces on it. Resident #320 stated that his family member has to change his sheets when she comes daily because the facility staff do not. During the end of day meeting held on 6/27/23, the facility Administrator, Director of Nursing and Corporate staff were made aware of the concerns with regards to the cleanliness and sanitary conditions of Resident rooms, including privacy curtains. On 6/28/23 at approximately 1:30 PM, Resident #320 was visited in his room. The privacy curtain remained stained with the solid brown matter on it. Resident #320 reported they had changed his roommate's curtain the night before, but not his.	F 921	3. The Regional Housekeeping Manager or designee will educate all housekeeping staff on the proper cleaning of a room to include the schedule of changing privacy curtains and to change the curtain if soiled as needed. 4. The Administrator or designee will perform random room rounds 5 times per week to identify cleanliness issues and ensure privacy curtains are not soiled. 5.Results of the monitoring will be presented to the QAPI committee for review and recommendations. Once the QAPI determines the problem no longer exists, the monitoring will be conducted on a random basis. 6. Date of Compliance August 1, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495248	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKE HEALTH & REHABILITATION CENTER	9640 BURKE LAKE ROAD BURKE, VA 22015

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F 921	Continued From page 37 On 6/28/23 at 3:24 PM, an interview was conducted with the housekeeping supervisor/Employee F. Employee F said that privacy curtains are changed by housekeeping and maintenance staff when staff make them aware that they are soiled. As for routine cleaning/changing of the curtains, he reported it is done when the rooms are deep cleaned, which is monthly. Employee F stated they had changed a lot of privacy curtains the night before, but he was made aware of another one that needed changing and was getting ready to go do that. When asked which room he was going to, Employee F identified the room of Resident #320. Review of the schedule for deep cleaning, that Employee F provided, revealed that Resident #320's room was scheduled to be deep cleaned on the first Friday of each month. In addition, Employee F provided the survey team with a document titled, "Admission/Discharge Cleaning". Review of this document read, "... Procedure: Discharge: Discharge rooms should be turned over either one hour after discharge or the following day if discharge happened after hours. In addition to the general method of cleaning, discharge rooms require additional attention, as follows: ... 6. Curtains should be replaced, and any remote controls, pull lights and call bells should also be disinfected...". On 6/29/23, during the end of day meeting, the facility Administrator, Director of Nursing and Corporate staff were again made aware of the above concerns. No further information was provided.	F 921		