STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495268	A. BUILDING _____ B. WING _____	C 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/6/2023 through 6/8/2023. The facility was in substantial compliance with 42 CFR Part 483.73, Emergency Preparedness requirements 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 and abbreviated survey was conducted 6/6/2023 through 6/8/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. VA00056315-Substantiated without deficiency. The census in this 66 certified bed facility was 56 at the time of the survey. The survey sample consisted of 26 resident reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, resident interview and clinical record review, the facility staff failed to ensure reasonable accommodation	F 558	1. Resident #35 continues to reside at the facility. The Maintenance Director was notified of the clock needing batteries	7/15/23

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

Electronically Signed | 06/30/2023

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F 558	Continued From page 1 of needs for one Resident (Resident #35) in a survey sample of 26 residents. The findings include: For Resident #35, the facility staff failed to ensure the large clock on the bedroom wall was working. Resident #35's most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 5/19/2023. Resident # 35's BIMS (Brief Interview for Mental Status) Score was a 8 out of 15 indicating severe cognitive impairment. Review of the clinical record was conducted on 6/6/2023-6/7/2023. During the initial tour on 6/6/2023 11:45 a.m., the clock in Resident # 35's room had the time of 3:24. Resident 35 was in the room, sitting in the bed and watching television. On 6/6/2023 at 2:40 p.m., the clock had the time of 3:24. The second hand was not moving. Resident # 26 was observed sitting in his wheelchair and propelling himself in the hallway. He stated he was going back to his room after participating in an activity. On 6/6/2023 at 3:00 p.m., the clock had the time of 3:24. Resident # 35 was sitting on his bed watching TV. On 6/7/2023 at 9:30 a.m., the clock had the time of 3:24. Resident # 35 was sitting in the wheelchair in the room. When asked if he could tell time, he replied "yes." When asked what time	F 558	and time correction. Batteries were replaced and time adjusted to show the correct time. 2. Current residents in the center have potential to be affected by alleged deficient practice. All rooms were checked ensuring clocks were displaying the correct time. 3. DON/Designee will re-educate facility staff on the residents□ rights to reasonable accommodation specific to clocks in resident□s rooms being set to the correct time. LNHA will re-educate department heads on checking clocks during room rounds. 4. Audits will be conducted daily x 5 days a week x 2 weeks, 3 x week x 2 weeks, 1x week for 3 week by the Maintenance Director/ designee to ensure that all residents clocks are set to the correct time and functioning properly. Results of audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 558	Continued From page 2 it was, Resident # 35 looked and the clock and stated the clock was wrong. He stated the Activities personnel lets him "know when it is time to go to Activities." On 6/7/2023 at 12:10 p.m., the clock had the time of 3:24. On 6/7/2023 at 4:40 p.m., the clock had the time of 3:24. During the end of day debriefing on 6/7/2023 at 5:45 p.m., the Regional Vice President, Director of Nursing and Corporate Nurse Consultants were informed of the issue. They all stated the clocks should be accurate. During an interview with the Director of Nursing, she stated it was important for clocks to be accurate because they would help with orientation of the residents. The Corporate consultants stated they would check all of the clocks for accuracy. They stated the Maintenance Director would be informed of the need to replace batteries where needed. No further information was provided.	F 558		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		7/15/23

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F 655	Continued From page 3 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to develop and implement a baseline care plan that included instructions to provide person-centered care for one resident (Resident #255) in a sample of 26 residents.	F 655	1. On June 8, 2023 resident #255□s baseline care plan was corrected to include a care plan to address the use of a CPAP machine, PICC line, and wounds to the resident□s right foot. 2. Current residents in the center have	

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F 655	Continued From page 4 The findings included: For Resident #255, the facility staff failed to develop a baseline care plan to address the care needs of the Resident which would include the use of a 1) CPAP (continuous positive airway pressure) machine when sleeping, 2) wounds on his right foot, and 3) a PICC (peripherally inserted central catheter), that were present on admission and required facility staff management. Resident #255 was admitted to the facility on 05/25/2023. Physician orders on admission included order for the treatment of wounds and care of a PICC line. On 6/6/23, Resident #255 was visited in his room. Upon initial interaction it was noted that Resident #255 had a bandage on his right foot/ankle. Resident #255 was unable to give any details as to what was wrong. Surveyor E also noticed that Resident #255 had a PICC line to the right side and a CPAP machine was noted at the bedside. On the afternoon of 6/6/26, Employee L, the unit manager, told Surveyor E that Resident #255 had been in the facility previously and they had healed his foot wounds. She went on to say Resident #255 discharged home but has now been back about 2 weeks and has wounds again that require treatment. On 6/7/23, during the morning, Resident #255 was visited in his room and observed to be asleep with his CPAP in use. On the afternoon of 06/8/23, the facility management staff provided Surveyor E with	F 655	potential to be affected by deficient practice. The facility will audit 100% of all current resident□s baseline care plans to ensure they are developed and followed specific to each resident. 3. DON/Designee will re-educate MDS and all Licensed nurses on baseline care plans and development for specific residents. 4. DON/Designee will conduct audits on all new admissions daily x 5 days x 7 weeks ensuring baseline care plans are present and resident specific. Results of audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 655	Continued From page 5 Resident #255's care plan and indicated that items initiated on admission were part of the baseline care plan. This review revealed that the baseline care plan for Resident #255 did not address the use of a CPAP machine, PICC line or wounds to the Resident's right foot. On 06/8/23, during an end of day meeting, the administrator, director of nursing (DON), and corporate staff were made aware of the above findings. No further information was provided.	F 655		
F 658 SS=D	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, interview, clinical record review and facility documentation the facility staff failed to provide care that meets professional standards of care for 1 Residents (#5) in a survey sample of 26 Residents. The findings included: 1. For Resident #5, the facility staff administered 2 doses of Rosuvastatin 80 mg when the order stated Rosuvastatin 40 mg. On 6/7/23 during the medication administration pass for Resident #5, the nurse pulled up the Resident #5's record and began pulling	F 658	1. On June 7, 2023 resident # 5 had an order for Rosuvastatin 40mg, Rosuvastatin 80mg available on cart. On June 8, 2023 the pharmacy was contacted and medication for resident #5 was corrected. Pharmacy sent correct dosage to facility. LPN E was re-educated on the rights of medication administration. 2. Current residents in the center have potential to be affected by deficient practice. Audit of all residents receiving Rosuvastatin ensuring correct doses are available. An audit of all current residents medication orders and medication cart ensuring accuracy of orders to include	7/15/23

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F 658	Continued From page 6 medications. When she came to Resident #5's Rosuvastatin, she read the dosage out loud (Rosuvastatin 40 mg) and then read the card containing 28 pills and it said Rosuvastatin 80 mg. She stopped and said the amounts are not the same. When asked what her next step is, she stated that she would finish pulling the rest of the meds, give them, and notify the Nurse Practitioner (NP) of the pharmacy error. She stated she would also notify her Unit Manager and document the medication that was found and let the NP know that the wrong dose had been pulled and given on the 2 previous days. On 6/8/23 at approximately 245 PM, an interview was conducted with LPN E who was asked if she had administered medications the previous 2 days and she stated that she had. When asked, did she sign off for the medication Rosuvastatin, she indicated that she did. When asked if she was aware of the dose, she stated that she had been told when she came to work it was an "error from pharmacy." The acting DON forwarded an email to this surveyor where she had been in communication with the pharmacy since the error was discovered. The pharmacy was to send the correct medication dose on the next run. According to the Lippincott website: https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration "Rights of Medication Administration 1. Right patient -Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. When available, use	F 658	correct dose (MAR/Cart Match). 3. DON/Designee will re-educate all license staff on rights of medication administration. 4. DON/Designee will conduct weekly medication administration audits 3x week x 7 weeks ensuring the rights of med administration are being followed. DON/ designee will conduct MAR to cart match audits 1x weekly for 7 weeks. Results of the audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	

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F 658	Continued From page 7	F 658		

technology (for example, bar-code system).

2. Right medication -Check the medication label Check the order.

3. Right dose -Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well.

4. Right route-Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route.

5. Right time -Check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time.
Confirm when the last dose was given.

6. Right documentation - Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.

7. Right reason -Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use.

8. Right response -Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your monitoring of the patient and

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F 658	Continued From page 8 any other nursing interventions that are applicable." On 6/8/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 658		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to 1) mitigate hazards for Residents that use slings, for 1 Resident (#33) in a survey sample of 26 Residents and 2) the facility staff failed to maintain water temperatures in a range to mitigate burns, scalding and other injuries. The findings included: 1) For Resident #33, the facility staff used a mechanical lift without the safety clips being on the hook to prevent the sling from backing out. On 6/7/23 at approximately 11:45 AM CNA's C and D were observed as they prepared to transfer Resident #33 from the bed to the shower stretcher. One CNA was on either side of the bed as they carefully rolled the Resident side to side	F 689	1. A. While staff was transferring resident # 33 in the hoyer lift, the lift was noted without 2 safety clips. All hoyer lifts were inspected on June 7, 2023. Hoyers with missing safety clips were removed from use. B. On 6/6/23 water temp in resident # 4 room was 118-120.7 degrees. On June 6, 2023 the facility maintenance director purchased new thermometers and made adjustments to the water mixing valve. Assure Plumbing came out to ensure valves were working correctly. 2. All residents are at risk for deficient practices. A. All hoyer lifts inspected on 6/7/23 by maintenance director. B. Audit of all water areas utilized by residents by maintenance director.	7/15/23

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F 689	Continued From page 9 to get the lift sling positioned under her correctly. The CNAs began explaining everything to the Resident who was responding and following directions. At that time, the Resident requested to be weighed and the CNA's stated that would be no problem as the lift has a weight scale on it. As the CNA's were getting the pad clipped onto the lift, it was noted that 2 of the hooks did not have clips on them. When asked what the clips were for CNA D stated that they were to prevent the lift sling from backing out and slipping off of the hook. CNA D stated that they had notified the former DON and she was supposed to have maintenance fix it. She stated she was told the facility had only lift with a scale, so they had to continue to use it. CNA C started "we have another lift, but it does not have a scale on it. We also have 2 different lifts, but we were told we could not use them as they belong to a sister facility." CNA C told the surveyor where the lifts were located. There were 4 lifts on the back hall 1 without a scale and 2 that appeared to be new. On 6/7/23, an interview was conducted with the acting DON at approximately 1PM, who stated that she was unaware of the condition of the lift, and it has been taken out of service until the maintenance director could repair it. The sister facility's lifts were being used in the meantime. A review of the manufacturer's instructions read: "After the first year of use, the hooks of the hanger bar and the mounting brackets of the boom should be inspected every three months to	F 689	3. A. DON/Designee will Re-educate all CNAs and Licensed staff on ensuring the hoyer lift is safe for use and in proper working order, free of hazards prior to using it. B. DON/Designee will Re-educate staff on appropriate water temperatures and reporting any variances to an immediate supervisor. 4. The Maintenance Director/designee will complete an audit water temperature daily x 5 days for 7 weeks then weekly ongoing. Results of the audits will be submitted to the QAPI committee for compliance verification and ongoing audit process. Maintenance Director/ designee will audit hoyer lifts three times per week for seven weeks and ongoing to ensure safety clips are present and lifts are in proper functioning order.	

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F 689	Continued From page 10	F 689		

determine the extent of wear. If these parts become worn, replacement must be made. Casters and axle bolts require inspections every six months to check for tightness and wear.

After the first twelve months of operation, inspect the hanger bar and the eye of the boom (to which it attaches) for wear. If the metal is worn, the parts MUST be replaced. Make this inspection every six months thereafter. Regular maintenance of patient lifts and accessories is necessary to assure proper operation."

On 6/7/23 during the end of day meeting the Administrator was made aware of the finding and no further information was provided

2. The facility staff failed to maintain water temperatures in a range to mitigate burns, scalding and other injuries.

On the afternoon of 6/6/23, an interview was conducted with the maintenance director/Employee C. The maintenance director was asked if he checks water temperatures and the maintenance director stated, he checks temperatures weekly. Review of his water temperature logs revealed that temperatures are checked resident rooms routinely.

The maintenance director was asked to obtain his thermometer used to check water temperatures. When asked how often he calibrates the thermometer he uses to check temperatures, the maintenance director stated, "I haven't ever calibrated it". The maintenance director then

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F 689	Continued From page 11	F 689		

went and borrowed a digital thermometer from the kitchen as well.

The maintenance director accompanied Surveyor E to the room of Resident #4. The maintenance director used his thermometer to measure the water temperature and it was 118 degrees. The maintenance director then used the thermometer from the kitchen and the water measured 120.7 degrees. Both Surveyor E and the maintenance director did the same in 2 additional resident rooms and both measured 120.7-120.8 degrees on the digital thermometer. The maintenance director confirmed that this was too hot, and someone could get burned.

On the morning of 6/7/23, the maintenance director and vice president of plant operations (VPPO) confirmed that they had purchased a new thermometer and made adjustments to the water mixing valve to decrease the water temperature to safe range in Resident rooms. The maintenance director and VPPO accompanied Surveyor E to several rooms on each resident care hallway and verified water temperatures to be between 103-111 degrees. Both again confirmed that the temperature reading of 120 degrees the day prior, was too hot and could be a potential hazard to Residents.

On 6/7/23, the facility's corporate staff confirmed they were unable to pull a report of incident tracking via the electronic system used for incidents and would have to make a list manually. They further confirmed that no Residents had any incidents of burns within the past 3 months.

Review of the facility policy titled "water temperatures, safety of" was conducted. This

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

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F 689	Continued From page 12 policy read, "Tap water in the facility shall be kept within a temperature range to prevent scalding of residents. 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees Fahrenheit or the maximum allowable temperature per state regulation...4. If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor...". Access to water at 120 degrees in 5 minutes can cause 3rd degree burns, according to Moritz, A.R., Henriques F.C. Jr. (1947). Studies of Thermal Injury: 11. The Relative Importance of Time and Surface temperatures in the Causation of Cutaneous Burns. Am J Pathology, 23, 695-720. On 6/7/23 and again on 6/8/23, 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 provided.	F 689		
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,	F 695		7/15/23

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F 695	Continued From page 13 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure 1 resident (Resident # 1) in a survey sample of 26 residents received oxygen care in a manner to prevent the spread of infection. Findings included: 1. For Resident # 1, the facility staff failed to label and date the oxygen tubing. Resident # 1's clinical record was reviewed on 6/6/2023 and 6/7/2023. During the initial tour on 6/6/2023 at 11:40 AM, Surveyor C observed Resident # 1 lying in bed with oxygen, via nasal cannula, delivered by an oxygen concentrator located on the right side of the bed. The oxygen tubing was not labeled and dated. On 6/6/2023 at 12:45 p.m., Resident #3's oxygen tubing was observed again and noted to be without label or date. An interview was conducted with LPN (Licensed Practical Nurse) C who stated oxygen tubing should be labeled and dated. LPN C observed the tubing and stated there was no label on the tubing. LPN C stated she knew the tubing had been changed on the night shift on Sunday 6/4/2023 because she was the nurse who worked that night. LPN C stated she forgot to put the label and date on the tubing. LPN C stated it was important to change, label and date the tubing weekly to decrease the risk of infection.	F 695	1. On June 6, 2023 the oxygen tubing for resident # 1 was not dated or labeled. On 6/6/2023 resident # 1 oxygen tube was changed, labeled and dated by facility nursing staff. 2. All Current residents receiving oxygen have the potential to be affected by the deficient practice. DON/Designee to conduct a 100% audit of all residents receiving Oxygen ensuring tubing is labeled and dated. 3. DON/Designee will re-educate all licensed nursing staff on changing, labeling, dating, and storage of oxygen tubing. 4. DON/designee will audit O2 tubing daily 5 days a week x 2 weeks, 3 days a week x 2 weeks, 1 day a week x 3 weeks and ongoing. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 695	Continued From page 14	F 695		

During the end of day debriefing on 6/6/2023, an interview was conducted with the Interim Director of Nursing (DON) who stated, "Oxygen tubing should be labeled and dated and also changed weekly in order to prevent infections".

LPN B stated the facility staff should change the oxygen tubing weekly and staff should check the date on the tubing prior to using it to make sure it is not longer than a week due to potential for infection control problems.

Review of the Physicians Orders revealed the following orders for oxygen therapy: for Oxygen at 2 Liters per minute via nasal cannula every shift. There was an order revised on 5/10/2023 for "Oxygen Tubing, cannula / mask every _Sunday_____ and as needed when soiled. (every Sunday night shift)"

Review of the facility policy entitled Oxygen Therapy revealed no documentation of the policy on the frequency of changing oxygen tubing and humidifier or of labeling and dating the tubing. The policy did not state how often the tubing should be changed.

During the end of day debriefing on 6/6/2023, the Regional Administrative Consultant, Corporate Nurse Consultant and interim Director of Nursing were informed of the failure of the staff to change, label and date the oxygen tubing weekly. The Corporate Nurse Consultant stated the oxygen tubing should be changed weekly, labeled and dated.

No further information was provided.

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F 727	Continued From page 15	F 727		
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, and facility documentation the facility staff failed to maintain Registered Nurse coverage 7 days a week. This has the potential to affect Residents who need the services of a Registered Nurse (RN). The findings included: The facility staff failed to maintain RN coverage for at least 8 consecutive hours a day on 10/15/22. On 6/7/23 during entrance conference, the facility was asked if they had any kind of waivers and they stated that they did not. On 6/7/23, a review of Payroll Based Journal reports revealed that the facility lacked RN coverage on 10/8/22, 10/15/22, 10/22/22 and 10/23/22.	F 727	1. Payroll Based Journal reports identified there had been no RN coverage on October 15, 2022. The facility has hired more Registered Nurses for more thorough coverage. 2. Current residents have the potential to be affected. 3. LNHA/Designee will re-educate the Human Resources Director, Nursing Management, and Department Heads on the requirement to have 8 consecutive hours of RN coverage 7 days per week. Nursing Management and weekend Managers on Duty will verify RN coverage and make DON/Administrator aware of any discrepancies immediately. 4. The HR Director will keep a spreadsheet of RN coverage daily that will be reviewed in daily meeting and verified daily by DON/Administrator/designee. An	7/15/23

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F 727	Continued From page 16 On 6/7/23, the Human Resource director ran a report of the nursing staff scheduled for the months of September and October of 2022. A staffing schedule showed that on 10/8/22, 10/22/22, and 10/23/22, there appeared to be a Registered Nurse scheduled. However, on 10/15/22 the schedule appeared to be missing RN coverage. A request was made for timecard punches for 10/8/22, 10/15/22, 10/22/22, and 10/23/22 as credible evidence that the facility was staffed properly for those days. There was no time punch for an RN on 10/15/22. An interview with Employee H who stated that staffing the facility had been a challenging job at that time. She stated that they had been doing their best to ensure Registered Nurse coverage as well as floor staffing needs. She stated that they have finally gotten their staffing to where they are no longer using agency staff and going forward RN coverage should not be an issue. On 6/8/23 during the end of day meeting, the Administrator was made aware of the concerns and no further information was provided.	F 727	audit of this spreadsheet will be conducted weekly x 7 weeks. Nursing Management and weekend Managers on Duty will audit weekend RN coverage every weekend x 7 weeks ensuring appropriate coverage. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	
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 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		7/15/23

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F 755	Continued From page 17 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, interview, clinical record review, and facility documentation the facility staff failed to 1) ensure controlled substances were disposed of correctly and 2) failed to provide routine medications for 2 Residents (#28 and 16). The findings included: 1. The facility staff failed to ensure proper disposal of 24 controlled substances for Residents who no longer reside in the facility or who no longer use the controlled medication.	F 755	1. A. The facility staff failed to ensure proper disposal of 24 controlled substances for Residents who no longer reside in the facility or who no longer use the controlled medication. All unused controlled substances of residents that were discharged or no longer prescribed for use, were disposed of. B. The facility failed to provide routine medications for 2 Residents (#28 and 16). MD was notified and the pharmacy was called. Residents # 28 and 16 had no adverse side effects from not receiving	

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F 755	Continued From page 18 On 6/7/23 at approximately 8 AM, during the medication pass it was discovered that there were 24 controlled substances, in various bottles and cards, to include liquid morphine, liquid Ativan, oxycodone, hydrocodone, gabapentin, Vimpat, morphine ER, and Ambien for Residents who no longer reside in the facility or who no longer use the medication. A review of the facility's Policy entitled "Discarding and Destroying Medications," read: "Medications will be disposed of in accordance with federal, state and local regulations governing the management of nonhazardous pharmaceuticals, hazardous waste and controlled substances." "1. All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of." On 6/8/23 at approximately 11 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who stated that the policy was to destroy controlled substances with 2 RN's and since the Director of Nursing (DON) quit, she was the only Registered Nurse (RN). On 6/8/23 at approximately 1 PM, an interview was conducted with the Acting DON who stated she had only been in the facility since 6/5/23 and was unaware of the number of controlled substances being stored in the carts and in the refrigerator. When asked what the process was for disposal of controlled substances, she stated that 2 nurses had to waste controlled substances, but she was pretty sure the DON was responsible for disposal of controlled substances when the Residents were discharged or otherwise not using the medication. She further stated that	F 755	the medication. 2. A. Current residents have the potential to be affected by deficient practice. Audit of all medication carts and med room conducted ensuring controlled medication no longer in use was destroyed. B. All current residents have the potential to be affected by the deficient practice. 3. DON/Designee will re-educate all licensed nursing staff on the process for destruction of narcotics. DON/Designee will re-educate licensed nursing staff on the protocol to follow when medications are unavailable. 4. DON/Designee will audit medication cart and med rooms weekly x 7 weeks, ensuring unused narcotics are destroyed per facility protocol. DON/Designee will review the MAR daily x 5 days ensuring the proper med availability protocol is being followed. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 755	Continued From page 19	F 755		

going forward the disposal will happen weekly to rid the carts and refrigerators of any discontinued controlled substances.

On 6/8/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. During the medication administration observation, the facility staff did not have available medications ordered by the physician for Resident #28 and Resident #16.

On 6/7/23 at 8:18 AM, Licensed Practical Nurse C (LPN C) and LPN D were observed during the medication administration of Resident #28. LPN C mentioned that they did not have the MiraLax (Polyethylene Glycol 3350) to administer. LPN C said, "it [Polyethylene Glycol 3350] has been out for several days- we have had hard time getting it from the pharmacy, it is out of stock. Since it is OTC [over the counter], supply has to order it". The clinical record review revealed Resident #28 had an order for "GlycoLax Powder 17 GM/Scoop (Polyethylene Glycol 3350) Give 1 scoop by mouth one time a day for constipation", which was scheduled for a 9 am administration.

On 06/07/23 at 08:21 AM, LPN C and LPN D were observed during medication administration for Resident #16. Following the observation, Surveyor E reviewed the physician orders. This review revealed that Resident #16 had an order for "Refresh Tears Solution

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F 755	Continued From page 20 (Carboxymethylcellulose Sodium). Instill 2 drops in both eyes four times a day for dry eyes two drops in each eye four times per day". The eye drops had been signed off for the 9 am, administration, however they were not observed to be given. The facility policy titled, "Unavailable Medication" was received and reviewed. This policy read, "... 2. In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed [administered], nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication...". On 6/7/23, during an end of day meeting, the facility administrator, Director of Nursing (DON) and corporate staff were made aware of the above observations and medications not available for administration to Residents. The Regional Vice President stated that the concerns of the pharmacy had been brought to his attention and they had a meeting scheduled with their pharmacy. No further information was provided/received.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		7/15/23

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F 759	Continued From page 21 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 3 medication errors in 35 opportunities, resulting in an 8.57% error rate. The findings included: On 6/7/23 at 8:18 AM, Licensed Practical Nurse C (LPN C) and LPN D were observed during the medication administration of Resident #28. LPN C pulled Resident #28's medications which were a total of 10 pills (tablets and capsules). LPN C mentioned that they did not have the MiraLax to administer. LPN C said, "it [MiraLax] has been out for several days- we have had hard time getting it from the pharmacy, it is out of stock. Since it is OTC [over the counter], supply has to order it. Following the medication administration, LPN C continued with her medication pass and did not make any attempts to clarify that a supply had/had not come in, notify the physician, or take any other actions. On 06/07/23 at 08:21 AM, LPN C and LPN D were observed during medication administration. LPN C entered the room and administered Resident #16's medications, which included 10 pills and 1 inhaler. LPN D had obtained the Diclofenac gel, and waited until LPN C administered the medications and then she applied the Diclofenac gel to both of Resident #16's knees. Following the observation of medication administration, Surveyor E conducted a clinical	F 759	1. The facility staff failed to ensure the medication error rate was less than 5%. LPN C and LPN D noted resident # 28 was out of Glycolax Powder 17GM/Scoop (Polyethlene Glycol 3350) MiraLAX and didn□t follow facility protocol to obtain the medication. Resident # 16 had an order for Diclofenac gel to left knee and right shoulder topically. LPN C administered the gel to both of resident #16 knees. Resident #16 had an order for Refresh Tears Solution 2 drops in both eyes signed off by LPN C as given. LPN C communicated the medication wasn□t available to give. " LPN C and D were educated on June 7, 2023 on the process to follow when medications aren□t available and on ordering medications that are out of stock and following the rights of medication administration. " Resident # 28 continues to reside in the facility with no adverse effects noted from deficient practice. Nurse Practitioner was made aware of Miralax OTC medication not given. No new orders were given. " Resident # 16 continues to reside in the facility with no adverse effects noted from deficient practice. Nurse Practitioner was made aware of Diclofenac gel being administered to both knees and not to the right shoulder and left knee as ordered. NP was also made aware of the order for Refresh Tears eye drops not given as ordered. No new orders were given. 2. Current residents on Miralax,	

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F 759	Continued From page 22 record review of Resident #28 and #16's medication orders and medication administration record. This review revealed the following: a. Resident #28 had an order for "GlycoLax Powder 17 GM/Scoop (Polyethylene Glycol 3350) [MiraLax] Give 1 scoop by mouth one time a day for constipation", which was scheduled for a 9 am administration. b. Resident #16's order for the Diclofenac gel read, "Apply to left knee, right shoulder topically two times a day related to unilateral primary osteoarthritis left knee, apply 2 gm (grams)". This administration was not signed off as having been administered. c. Resident #16 had an order for the following: "Refresh Tears Solution (Carboxymethylcellulose Sodium). Instill 2 drop in both eyes four times a day for dry eyes two drops in each eye four times per day". The eye drops had been signed off for the 9 am, but were not given. Surveyor E then returned to the floor and interviewed LPN C. LPN C was asked about the administration of the Diclofenac gel being applied to both knees when the order was for the left knee and right shoulder. Surveyor E also notified LPN C the administration was not signed off. LPN C did not respond. Surveyor E then questioned the Refresh Tears eye drops that had been signed off and were not administered. LPN C confirmed the eye drops were not in-house and not available for administration. During the above interview, LPN C further confirmed that medications are to be signed off at the time of administration and only if they are	F 759	Diclofenac gel and Refresh Tears eyedrops have the potential to be affected. DON/Designee will conduct an audit of all residents receiving Miralax, Diclofenac gel and Refresh Tears eye drops to ensure compliance. An audit of all current residents medication orders and medication cart ensuring accuracy of orders to include correct dose (MAR/Cart Match). 3. DON/Designee will re-educate all license nursing staff on the process of ordering medications that are low and/or out of stock and the process for rights of medication administration and following medication orders. 4. DON/Designee will conduct a medication administration audit of 3 licensed nurses 1 x week x 7 weeks to ensure the process of rights of medication administration is being followed. DON/Designee will audit OTC meds 1x week x 7 weeks ensuring OTC meds are available for administration. DON/Designee will audit medication Cart for Refresh Tears 1x week x 7 weeks ensuring medication availability. DON/ designee will conduct MAR to cart match audits 1x weekly for 7 weeks. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 759	Continued From page 23 administered. Review of the facility policy titled; "Administering Medications" was conducted. This policy read, "...4. Medications are administered in accordance with prescriber orders, including any required time frame...10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication...". The facility policy titled, "Unavailable Medication" was received and reviewed. This policy read, "... 2. In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed [administered], nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication...". No further information was provided/received.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		7/15/23

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F 761	Continued From page 24 §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 for 1 of 2 medication carts inspected. The findings included: On 6/7/23 at 8:33 AM, while completing the medication storage tasks Surveyor E made the following observations of the medication cart for the 200 hall in the presence of LPN C and LPN D: 1. Resident #32 had a Lispro insulin pen that had an open date of 4/30/23, that was on the cart and available for use. Resident #32 also had a multi-use vial of Lantus, which had no date opened. 2. Resident #206, had an aspart insulin pen and a Degludec insulin pen that had no labeling for the date opened.	F 761	1. The facility staff failed to properly store medications for 1 of 2 carts inspected. " Resident # 32 had a Lispro insulin pen on the cart with open date of 4/30/23. Resident #32 had a multi-use vial of Lantus with no date opened, a Basaglar Kwik pen no open date, Novolog insulin pen open date 3/14/23. " Resident # 206 had an Aspart insulin pen and Degludec insulin pen no open date. Resident # 32 continues to reside in the facility. The MD was made aware, no new orders given. No adverse effects noted. Resident # 206 continues to reside in the facility. The MD was made aware, no new orders given. No adverse effects noted. On June 7, 2023, LPN C and D were educated on labeling and storage of medications. 2. All Current residents have the	

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F 761	Continued From page 25 3. Resident #32 had a Basaglar Kwik pen in the cart, which did not have an open date. A Novolog insulin pen which had an open date of 3/14/23, remained in the cart and available for use. LPN C confirmed all of the above findings and confirmed the date opened on the ones that had a date and commented, "They are only good for 28 days". LPN C also confirmed that she could not find a date opened on the other ones noted above. LPN C further added that, "He [Resident #32] isn't here anymore, he is deceased". A review of the facility policy titled; "Administering Medications" was reviewed. It read, "...12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container...". The facility policy regarding the storage of medications did not address the labeling of insulin or multi-use vials. An excerpt from the policy did read, "... Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed...". On the afternoon of 6/7/23, the director of nursing was asked about the storage of and labeling of insulin. The DON stated insulin is to be labeled when opened because it is only good for 28 days after being opened/accessed. The DON also confirmed that medications that are not in use or if the resident is no longer at the facility should be removed from the cart. On 6/7/23 during the end of day meeting the Administrator was made aware and no further information was provided.	F 761	potential to be affected by deficient practice. DON/Designee conducted a 100% audit of med carts ensuring medications were dated and expired meds removed from the cart. 3. DON/Designee will re-educate all Licensed nursing staff on labeling and storage of medications. 4. DON/Designee will audit medication carts 5 x week x 2 weeks, 3 x week x 2 weeks, 1 x week x 7 weeks ensuring insulin pens are dated and not expired. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		7/15/23

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F 842	Continued From page 27 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, interview, clinical record review and facility documentation the facility staff failed to ensure the medical record was accurate for 1 Resident (#32) in a survey sample of 26 Residents. The findings included: For Resident #32 the facility staff failed to ensure that his clinical record contained only his information.	F 842	1. Facility staff failed to ensure the medical record was accurate for resident # 32, 33 PASARRs including his own was noted in resident□s medical records. The LNHA re-educated the admissions director on June 8, 2023, on correctly scanning in documents to the resident□s electronic medical records and the importance of maintaining HIPPA for all residents. 2. Current residents have the potential to	

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F 842	Continued From page 28 On 6/8/23 when the electronic medical record was accessed for Resident #32 to view the Pre-Admission Screening And Resident Review (PASARR) screening, a tab that said PASARR was clicked and what opened up was a document containing 33 PASARR's. Resident #32's PASARR was among the 33 PASARRs. On 6/8/23 at approximately 2PM, an interview was conducted with Employee N who was asked how assessments and records get put in the EHR (electronic health record), she stated that they are scanned and uploaded into the system. When asked if they do one chart at a time, she indicated that they did. When asked if a document is scanned into the wrong person's chart what happens, she stated that when they are aware of it, they immediately correct it. When asked why this is important, she stated because it's a Health Information Portability and Accountability Act violation. On 6/8/23 at approximately 4:15 PM, an interview was conducted with the DON, Corporate VP and Administrator who were made aware of the finding of 33 PASARR's in Resident #32's chart. The Corporate VP stated that it must have been when medical records scanned it in incorrectly and attached the entire file instead of only Resident #32's. On 6/8/23 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 842	be affected. A review of all current residents Electronic Health Records will be conducted. 3. DON/LNHA/Designee will re-educate medical records on how to properly scan documents to the electronic health record and to ensure all documents are filed under the appropriate resident□s file. 4. DON/Designee will conduct an audit 1 x week for 7 weeks to ensure all documentation is filed under the correct resident. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/10/23

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F 880	Continued From page 29	F 880		

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

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

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation,

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F 880	Continued From page 30 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to maintain an infection control and prevention program to help prevent the development and transmission of infections, which has the ability to affect all Residents residing at the facility. The findings included: 1. The facility staff failed to develop and implement a water management plan for Legionella with regards to a risk assessment to	F 880	1. Infection Prevention and Control " The facility staff failed to develop and implement a water management plan for Legionella and other waterborne bacteria. " The facility staff failed to maintain an infection control program that included a system of infection surveillance. a. Facility Specific Plan for Legionella developed by Regional Director of Maintenance. b. Facility IP to re-initiate the Infection control program for Infection Surveillance	

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F 880	Continued From page 31 identify where Legionella and other waterborne bacteria could grow. On 6/7/23, during review of the facility water management program the facility Maintenance Director of Vice President of Plant Operations were present. When asked for their facility risk assessment with regards to water management, which used to identify where Legionella and other waterborne bacteria could grow and spread in the facility water system, the facility had nothing to provide. On the morning of 6/8/23, the Corporate VP of Plant Operations (VPPO) stated they had been unable to locate any type of risk assessment with regards to water management and had nothing to submit. The facility Administrator was made aware of the lack of a water management program on 6/8/23, during the end of day meeting. No further information was provided. 2. The facility staff failed to maintain an infection control program that included a system of infection surveillance. On the afternoon of 6/8/23, Surveyor E met with the Director of Nursing (DON) and Infection Preventionist (IP) to review documents. The IP had a line listing of facility staff who displayed signs of infections from March and April 2023. The IP had no evidence of any infection surveillance/tracking, etc. for facility staff prior to March 2023 to submit.	F 880	system. ADON/IP was re-educated by the Regional Director of Infection Prevention on June 20, 2023 on the facility□s infection prevention, surveillance and control protocol. 2. Current residents have the potential to be affected by deficient practice. No residents were identified as being affected by deficient practices. 3. LNHA/Director of Maintenance will educate facility staff on the facility□s water management plan to prevent Legionella and other waterborne bacteria. DON/Designee will re-implement facility staff on Infection Control, infection prevention and surveillance. 4. DON/Designee will audit the infection control/surveillance/prevention process in clinical meeting daily x 5 days x 2 weeks, daily x 3 days x 2 weeks, 1 x week x 2 weeks, 1 x month x 1 month to ensure compliance. Maintenance Director will audit the Legionella process weekly x 7 weeks ensuring compliance. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 880	Continued From page 32	F 880		

Review of the surveillance of Resident infections was reviewed and revealed that the tracking and trending was inaccurate and incomplete. The evidence included:

a. For the month of June 2022, the facility noted 15 Resident infections. Of the 15 infections, 6 were UTI's (urinary tract infections). On the facility floor plan where they monitor for trends of infections, no UTI's were noted.

b. For the month of January 2023, the facility noted 2 UTI infections, 5 COVID infections and 2 with pneumonia. Of these, only the pneumonia infections were noted on the facility floor plan, which is used to monitor for trending and potential spread of infection.

c. For the month of February 2023, the facility noted 2 infections with pneumonia, either of which were noted on the floor plan for trending.

None of the infection control documents submitted had any evidence of the evaluation of the data or any trends noted and the facility's response.

On 6/8/23, the DON and IP were present for the above review and noted the same findings. When a discussion was held, both said they understood and agreed that the current infection control program was inadequate and missing a lot of information. The DON said, the reason infection surveillance is important is, "To monitor for any best practices and to monitor for patterns or issues, where we are causing the infection through breaches in infection control and tracking it room to room. It allows us to take the best care

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F 880	Continued From page 33 of our residents. especially with flu and cold seasons". Review of the facility's infection control policy was conducted. The policy titled, "Surveillance for Infections" read, "1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and healthcare-associated infections, to guide appropriate interventions, and to prevent further infections". Another excerpt read, "...3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment; ... c. clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C. Difficile) .... During the end of day meeting held on 6/8/23, with the facility administrator, director of nursing and corporate staff, they were made aware of the above findings. No further information was provided.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 881		7/15/23

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F 881	Continued From page 34 Based on staff interview and facility documentation review, the facility staff failed to maintain an ongoing antibiotic stewardship program to monitor the use of antibiotics which had the ability to impact numerous Residents throughout the facility on all nursing units/resident care units. The findings included: On 6/8/23 at 11:42 AM, an interview was conducted with the facility's Infection Preventionist (IP)/Employee J, and the Director of Nursing. Review of the infection surveillance revealed that the facility uses an electronic form to review antibiotic usage to determine if McGreer criteria was met. Several Residents were noted to be prescribed and receiving antibiotics and the assessment indicated antibiotic use was not warranted. The assessment read, "Does not meet criteria" and "Does not meet requirements". The Director of Nursing stated when this happens the facility staff are to talk with the physician and document the conversation about antibiotic use not being warranted and note any new orders received. In each of the instances reviewed where the Resident was noted to not meet criteria for antibiotic usage, the facility had no evidence of a conversation being held with the prescriber/physician to see if they wanted to discontinue the antibiotic. Each of the Resident's completed a full course of antibiotics. During the above interview, the Director of Nursing discussed that the risk of antibiotic use when it was not warranted leads to antibiotic	F 881	1. Facility staff failed to maintain an ongoing antibiotic stewardship program. " IP/ADON was re-educated on the antibiotic stewardship program and the full use of surveillance tracker in PointClickCare by the Regional Infection Preventionist. IP to re-implement the Antibiotic Stewardship program to include the use of the McGeer□s criteria. 2. Current residents have the potential to be affected. No residents were identified as being affected by deficient practice. 3. DON/Designee will re-educate all licensed nursing staff on the McGeer□s criteria for antibiotic stewardship. 4. DON/Designee will review/audit the process for antibiotic stewardship daily x 5 days for 7 weeks. Results of the audits will be submitted to the QAPI committee for compliance verification and ongoing audit process.	

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F 881	Continued From page 35 resistance. Review of the facility policy titled, "Antibiotic Stewardship", was conducted. This policy read, "Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. 1. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. 2. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community...". On 6/8/23, the facility Administrator, Director of Nursing and Corporate staff were made aware that the facility had failed to provide evidence of an ongoing antibiotic stewardship program. No further information was provided.	F 881		
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	F 883		7/15/23

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F 883	Continued From page 36	F 883		

has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative 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.

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F 883	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to determine the Resident's immunization status and offer influenza and pneumonia vaccines for 2 Residents (Resident #255 & #48) in a survey sample of 5 residents reviewed for immunizations. The findings include: 1. The facility staff failed to determine Resident #255's current immunization information and offer any immunizations the Resident was eligible. A clinical record review was performed on 6/7/23. Resident #255's clinical record revealed, under the immunization tab, that the flu vaccine and pneumococcal immunizations were, "historical". The record had no information to support where the facility obtained this data. On 6/8/23, an interview was conducted with the facility's Director of Nursing (DON) who accessed the clinical record for Resident #255 and verified the findings. The DON further confirmed there was no Virginia Immunization Information System (VIIS) uploaded into the record as evidence that the facility had attempted to obtain the Resident's current immunization status. 2. The facility staff failed to identify/assess Resident #48's current immunization status so that they could offer any immunizations the Resident was eligible for.	F 883	1. The facility staff failed to determine Residents #255 and #48 immunization status and offer influenza and pneumonia vaccines. " Resident # 255 continues to reside in the facility and #48 has discharged from the facility. " Resident # 255 received the pneumococcal vaccine on April 19, 2023 and received the flu vaccine on October 23, 2022. MD made aware of vaccination record. " Resident # 48 was discharged from the facility on June 8, 2023. " The facility gained access to the Virginia Immunization Information System and the admissions director was educated on how to use and pull vaccination information. Pneumonia and influenza vaccinations were ordered and due to arrive at the facility on June 27, 2023. 2. Current residents have the potential to be affected. A 100% audit was conducted to verify any residents that needed pneumonia and/or influenza vaccinations. Pneumonia and influenza vaccinations were ordered and due to arrive at the facility on June 27, 2023. All residents who need pneumonia or influenza vaccination will be offered to any residents identified as not having received them. 3. DON/Designee will re-educate all licensed staff on offering vaccinations upon admission that have not yet been received or are due. DON/Designee will re-educate licensed staff on documenting	

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F 883	Continued From page 38 A clinical record review was performed on 6/7/23. Resident #48's clinical record revealed, under the immunization tab, that there was no information with regards to flu vaccine and pneumococcal immunizations. Nor was there any evidence that facility staff had offered education or the vaccines to Resident #48. On 6/9/23, an interview was conducted with the facility's Director of Nursing (DON) who accessed the clinical record for Resident #48 and confirmed the above findings. The DON further confirmed there was no Virginia Immunization Information System (VIIS) uploaded into the record as evidence that the facility had attempted to obtain the Resident's current immunization status. The DON stated that the facility's process is for admissions to check the VIIS and upload it into the clinical record and then nursing will educate and offer any immunizations the Resident is eligible to receive. She said the importance of immunization is, "we are trying to help the community be healthier and safer". Following the above interview, the DON advised Surveyor E that "no one in the facility has access to the VIIS system". Review of the facility policy entitled, "Pneumococcal Vaccinations", was conducted. This policy read, "1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine within (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated...".	F 883	in the immunization tab on Point-Click-Care to ensure that documentation for vaccinations are completed in each resident□s electronic health record. 4. DON/Designee will audit new admission charts and 5 random charts daily x 5 days x 7weeks ensuring immunizations are up-to-date and documented in the medical records. Results of the audits will be submitted to the QAPI committee monthly for compliance verification and ongoing audit process.	

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F 883	Continued From page 39 The facility policy titled, "Influenza, Prevention and Control of Seasonal" was reviewed. An excerpt from this policy read, "...Vaccination: 1. The infection preventionist organizes and oversees an annual influenza campaign. 2. All residents and staff are offered the vaccine at or before the onset of the influenza season. 3. All residents and staff are encouraged to receive the vaccine unless there is a medical contraindication...". On 6/8/23 during the end of day meeting, the Facility Administrator, DON, and corporate staff were made aware of the findings. No further information was provided.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination	F 887		7/10/23

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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 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

1. * Facility staff failed to determine resident #255 current immunization status

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F 887	Continued From page 41 failed to offer COVID-19 immunizations for 2 Residents (Resident #255 and 48) in a survey sample of 5 Residents reviewed for COVID-19 immunizations. The findings include: 1. The facility staff failed to determine Resident #255's current immunization status and offer any COVID-19 immunizations the Resident was eligible for. A clinical record review was performed on 6/7/23. Resident #255's clinical record revealed, under the immunization tab, that the Resident had only received a primary vaccination series for COVID-19 and had not received any booster doses. Therefore, the Resident was eligible to receive the bivalent COVID-19 booster. On 6/8/23, an interview was conducted with the facility's Director of Nursing (DON) who accessed the clinical record for Resident #255 and verified the above findings. The DON further confirmed there was no evidence that Resident #255 had received education or been offered the COVID-19 bivalent booster. 2. The facility staff failed to identify/assess Resident #48's current COVID-19 immunization status so that they could offer any COVID-19 immunizations for which the Resident was eligible. A clinical record review was performed on 6/7/23. Resident #48's clinical record revealed, under the immunization tab, that there was no information	F 887	and offer the eligible immunizations. " Facility staff failed to identify/assess resident #48 current Covid-19 immunization status. " Resident # 255 was offered the Bivalent COVID-19 Booster. Resident declined. " Resident #48 was discharged from the facility on June 8, 2023. 2. All Current residents have the potential to be affected. 100% audit on all current residents COVID-19 immunization status. 3. DON/Designee will re-educate all licensed nursing staff on verifying and offering the Covid-19 vaccination upon admission and again during their quarterly care plan meeting. 4. DON/Designee will conduct audits daily x 5 days x 7 weeks of all new admissions ensuring that vaccinations have been offered, given or declined and the documentation added to the resident□s electronic health record.	

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with regards to COVID-19 immunizations. Nor was there any evidence that facility staff had offered education or been offered any COVID-19 vaccines to Resident #48.

On 6/9/23, an interview was conducted with the facility's Director of Nursing (DON) who accessed the clinical record for Resident #48 and confirmed the above findings. The DON further confirmed there was no evidence that Resident #48 had been educated on or been offered any COVID-19 immunizations.

The DON stated that the facility's process is for admissions to check the Virginia Immunization Information System (VIIS) and upload it into the clinical record and then nursing will educate and offer any immunizations the Resident is eligible to receive. She said the importance of immunization is, "we are trying to help the community be healthier and safer".

Following the above interview, the DON advised Surveyor E that "no one in the facility has access to the VIIS system".

Review of the facility policy entitled; "COVID-19 Vaccination" was conducted. This policy read, "Eligible staff members and residents who meet eligibility criteria will be offered the COVID-19 vaccine... 2. Prior to offering the vaccine, individuals will be screened for prior immunization, medical precautions, and contraindications to determine if they are appropriate candidates for vaccination...Documentation: 1. The facility will document the following in the resident's medical record: a. That the resident (or representative) was provided education regarding the benefits

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F 887	Continued From page 43 and potential side effects of the COVID-19 vaccine, including the date the education, and offering took place...". On 6/8/23 during the end of day meeting, the Facility Administrator, DON, and corporate staff were made aware of the findings. No further information was provided.	F 887		