STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	2/9/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

(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
F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 2/9/22. Intake #'s: MI00125868, MI00125932, MI00125956, MI00126041, MI00126225. Census=139	F0000		
F0580 SS= D	Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or	F0580	Resident #701 no longer resides at the facility. All residents have the potential to be affected. Licensed nurses were informed to notify the Director of Nursing or designee as soon as a change in residents condition is identified requiring a need to transfer the resident out to the hospital. The Director of Nursing will provide oversight to ensure that the nurses notify the physician and family/guardian of a change in residents condition and resident being transferred to the hospital. By 2/28/2022, Licensed Nurses will be educated by the DON/designee on the Change in Condition- Reporting Policy to ensure the attending physician and family/responsible party are notified when a resident experiences and change in condition and that there is appropriate documentation of this notification in the medical record. The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance maintained to ensure the licensed nurses notify the family/guardian and physician of a residents change in condition and resident being discharged to the hospital, with	2/28/2022

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

Electronically Signed | 02/22/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: This citation pertains to Intakes: MI00125868 and MI00126041 Based on interview and record review, the facility failed to inform the resident's physician and family/guardian of a change in condition for one (R701) of four resident reviewed for notifications, resulting in the physician and family/guardian not being notified of the resident being transferred to the hospital. Findings include: A complaint was filed with the State Agency that read in part, "...ER (emergency room) Doctor called me at 11:10 pm, stating that [R701], had been rushed in by the paramedic and was nonresponsive... She stated that they intubated him and upon attempting intubation they found a plastic bag in his airway... (the facility) did NOT contact me to tell me that (R701) was rushed to the hospital. By midnight I still hadn't received a call from them. I called (the facility) at 12:01a (1/6/22) and spoke with the staff member that called 911..." Review of the closed record revealed R701 was		documentation of notification of the resident□s attending physician and family/responsible party in the medical record. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 02/28/2022 and for sustained compliance thereafter.	

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	originally admitted into the facility on 11/5/18 and readmitted on 3/20/20 with diagnoses that included: stroke, dementia, and epilepsy. According to the Minimum Data Set (MDS) assessment dated 12/31/21, R701 had severely impaired cognition and required the extensive assistance of staff for all activities of daily living (ADL's). Review of R701's progress notes revealed a general note on 1/5/22 at 9:42 PM by Licensed Practical Nurse (LPN) "B" that read, "sent pt (patient) out to hospital apon [sic] observation pt was having trouble breathing and hard to arouse. stats (oxygen in blood) were low and 911 was called. EMS (Emergency Medical Services) arrived stats still were low so pt was transferred to [Name of Local Hospital]." This was the last progress note in the clinical record. On 2/8/22 at 8:57 AM, LPN "B" was interviewed by phone and asked about R701's status on the evening of 1/5/22. LPN "B" explained she had worked the midnight shift, 7:00 PM to 7:00 AM. She had just started her shift and was doing her rounds when she saw R701 having a difficult time breathing around 7:15 or 7:20 PM. LPN "B" continued that she had pulled R701 up in bed, but continued to breath "hard and fast", so she called 911 and they took him to the hospital. When asked if she had communication with the family/guardian, LPN "B" explained when she had talked to the family/guardian, they already knew about the plastic bag in the airway. Review of R701's clinical record did not reveal documentation that the physician or family/guardian was notified of the change in condition, or that R701 was transferred to the hospital. On 2/9/22 at 10:35 AM, Doctor (Dr.) "P", R701's			

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	attending physician, was interviewed by phone and asked if she had received notification of R701's change in condition, or that they had been transferred to the hospital on 1/5/22. Dr. "P" explained she had not received any notification that R701 was sent to the hospital but had been informed by another doctor at the hospital. On 2/9/22 at 2:56 PM, the Director of Nursing (DON) was interviewed and asked who should be notified if a resident needed to be sent to the hospital. The DON explained the nurse sending a resident should complete a transfer form and document on that form what time the physician, the family/guardian, and the DON/charge nurse were notified. Review of a facility policy titled, "Change in a Resident's Condition or Status" dated 7/11/18 read in part, "...The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): ...need to transfer the resident to a hospital/treatment center... a nurse will notify the resident's representative when: ...It is necessary to transfer the resident to a hospital/treatment center..."			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the	F0609	Resident #701 no longer resides at the facility. The injury of unknown origin was reported by the Administrator on 02/09/2022 to the appropriate state agencies after being reported by the state surveyors, the incident took place on 1/5/2022. After the investigation was completed the facility stopped the use of clear plastic bags for snacks/deserts and replaced them waxed paper bags. LPN “B” was given 1:1 education on reporting injuries of unknown origin immediately to the administrator, this includes information reported by an outside	2/28/2022

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	administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake # MI00125868 Based on interview and record review, the facility failed to report an injury of unknown origin for one (R701) of three residents reviewed for accidents. Findings include: A complaint was filed with the State Agency that read in part, "...ER (emergency room) Doctor called me at 11:10 pm, stating that [Name Redacted - R701], had been rushed in by the paramedic and was nonresponsive... She stated that they intubated him and upon attempting intubation they found a plastic bag in his airway." Review of the closed record revealed R701 was originally admitted into the facility on 11/5/18 and readmitted on 3/20/20 with diagnoses that included: stroke, dementia, and epilepsy. According to the Minimum Data Set (MDS) assessment dated 12/31/21, R701 had severely impaired cognition and required the extensive		agency/company/hospital to the facility regarding a resident All residents have the potential to be affected. The Director of Nursing or designee will review all resident discharges moving forward to ensure that there were no injuries of unknown origin or reportable events that occurred with the resident at the time of resident transfer/hospitalization. By 02/28/2022 the facility staff will be educated on the Abuse and Neglect Policy, specifically reporting injuries of unknown origin immediately to the administrator, this includes information reported by an outside agency/company/hospital to the facility regarding a resident. All staff will continue to receive this education bi-annually and as needed. New hires will be in service during orientation and bi-annually and as needed thereafter. The Administrator/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure resident injuries of unknown origin are immediately reported to the Administrator and reported to the appropriate state agencies timely. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator and DON will be responsible for assuring substantial compliance is attained through this plan of correction by 08/28/2022 and for sustained compliance thereafter.	

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	assistance of staff for all activities of daily living (ADL's). Review of R701's ADL care plan revealed an intervention initiated 2/22/19 that read, "EATING: The resident is able to feed himself with setup". Review of R701's progress notes revealed a general note on 1/5/22 at 9:42 PM by Licensed Practical Nurse (LPN) "B" that read, "sent pt (patient) out to hospital apon [sic] observation pt was having trouble breathing and hard to arouse. stats (oxygen in blood) were low and 911 was called. EMS (Emergency Medical Services) arrived stats still were low so pt was transferred to [Name of Local Hospital]." On 2/8/22 at 8:57 AM, LPN "B" was interviewed by phone and asked about R701 on 1/5/22. LPN "B" explained she had worked the midnight shift, 7:00 PM to 7:00 AM. She had just started her shift and was doing her rounds when she saw R701 having a difficult time breathing around 7:15 or 7:20 PM. LPN "B" continued that she had pulled R701 up in bed, but continued to breath "hard and fast", so she called 911 and they took him to the hospital. When asked if she had any communication with the emergency department (ED), LPN "B" explained the doctor called from the ED and wanted to know R701's medication list and that she had pulled a plastic bag from his airway. LPN "B" was asked if she had reported to anyone that there had been a plastic bag in R701's airway. LPN "B" explained she did not know she had to tell anyone. Review of R701's hospital records from [Name Redacted - Local Hospital] read in part, "...Procedure: Intubate... 1/6/22 12:44 AM... First intubation attempt revealed a foreign body in the airway protruding through the vocal cords. Mcgill			

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	forceps used to remove the foreign body, which looked like a bag of food... Pt arrived via EMS for respiratory distress... Pt was on NRB (non-rebreather mask) on arrival, altered in mentation... intubation completed with positive color change 23 [sic] at the lip..." On 2/9/22 at 8:03 AM, the Director of Nursing (DON) was interviewed and asked if she knew R701 had been sent to the hospital for respiratory distress and that the hospital had called the nurse to tell her they found a plastic bag in their airway. The DON explained she had not known anything like that had happened, but the nurse should have reported it immediately when the hospital had called. On 2/9/22 at 9:06 AM, the Administrator was interviewed and asked what the nurse should have done when informed by the hospital that a plastic bag with food in it was found in R701's airway. The Administrator explained without question she should have notified him or the DON so they could have done an investigation. Review of a facility policy titled, "Abuse and Neglect" revised 6/17/19 read in part, "...An injury should be classified as an "injury of unknown source" when both of the following conditions are met: a. The source of injury was not observed by any person or the source of injury could not be explained by the resident; and b. The injury is suspicious because of the extent of the injury or the location of the injury... All allegations and/or suspicious of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee..."			
F0622 SS= G	Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The	F0622	Resident #701 no longer resides at the facility. All residents have the potential to be affected	2/28/2022

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	facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this		by this citation. Facility discharge policy which included documentation was reviewed and deemed appropriate. PCC interact change of condition as well as e-interact discharge to hospital was reviewed and are appropriate. The facility printers at each nurse□s station were evaluated by the maintenance director for proper functioning. By 02/28/2022, Licensed Nurses will be educated by the DON/designee on the Discharge/Transfer Policy to ensure each resident has appropriate transfer/discharge details and forms completed and provided/conveyed to EMS/Hospital timely at the time of transfer/discharge. The DON/Designee will conduct random audits on 5 residents who discharged weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure appropriate transfer/discharge details and forms are completed and provided/conveyed to EMS/Hospital timely at the time of transfer/discharge. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator and DON will be responsible for assuring substantial compliance is attained through this plan of correction by 02/28/2022 and for sustained compliance thereafter.	

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	section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need (s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00125868			

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	Based on interview and record review, the facility failed to ensure documented details regarding a resident's hospital transfer for one (R701) of three residents reviewed for hospitalization, resulting in the delay of transportation to the hospital and essential health information not being conveyed to the emergency department for evaluation and continued treatment. Findings include: A complaint was filed with the State Agency that read in part, "...ER (emergency room) Doctor called me at 11:10 pm, stating that [R701], had been rushed in by the paramedic and was nonresponsive... She stated that they intubated him and upon attempting intubation they found a plastic bag in his airway. [Name of ER Doctor] stated that she was going to call the nursing home for more information..." Review of the closed record revealed R701 was originally admitted into the facility on 11/5/18 and readmitted on 3/20/20 with diagnoses that included: stroke, dementia, and epilepsy. According to the Minimum Data Set (MDS) assessment dated 12/31/21, R701 had severely impaired cognition and required the extensive assistance of staff for all activities of daily living (ADL's). Review of R701's progress notes revealed a general note on 1/5/22 at 9:42 PM by Licensed Practical Nurse (LPN) "B" that read, "sent pt (patient) out to hospital apon [sic] observation pt was having trouble breathing and hard to arouse. stats (oxygen in blood) were low and 911 was called. EMS (Emergency Medical Services) arrived stats still were low so pt was transferred to [Name of Local Hospital]." On 2/8/22 at 8:57 AM, LPN "B" was interviewed by phone and asked about R701 on 1/5/22. LPN "B" explained she had worked the midnight shift,			

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	7:00 PM to 7:00 AM. She had just started her shift and was doing her rounds when she saw R701 having a difficult time breathing around 7:15 or 7:20 PM. LPN "B" continued that she had pulled R701 up in bed, but continued to breath "hard and fast", so she called 911 and they took him to the hospital. When asked if she had any communication with the emergency department (ED), LPN "B" explained the doctor called from the ED and wanted to know R701's medication list and that she had pulled a plastic bag from his airway. Review of R701's record revealed no transfer or discharge form. On 2/8/22 at 12:46 PM, LPN "F" was interviewed and asked about transferring a resident to the hospital. LPN "F" explained there was a form in the computer charting record titled, "eInteract Transfer Form" that the nurse filled out when sending a resident to the hospital. On 2/8/22 at 12:49 PM, Registered Nurse "H" was interviewed and asked if there was a paper transfer form. RN "H" explained when transferring a resident to the hospital the only form was in the computer, the nurse filled it out and printed it along with the medication list and sent it with the resident. RN "H" continued that she usually sent the residents recent lab results also. Review of the EMS documentation by [Name of Local Fire Department] read in part, "Dispatched for a... patient in respiratory distress, upon arrival... patient is lying in bed responding only to pain, staff on scene states patient normally talking, patient tested positive for Covid 3 days ago...transport delay at (facility) due to staff having no patient info (information), once info was obtained patient was transported priority 1..."			

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	On 2/8/22 at 5:25 PM, LPN "B" was interviewed by phone again and asked about a transfer form. LPN "B" explained she had not done a transfer form because the computer in the COVID-19 unit where R701 was did not print, so another nurse not on the COVID-19 unit had to print out something for EMS. On 2/9/22 at 8:03 AM, the Director of Nursing (DON) was interviewed and asked what documentation should be sent when transferring a resident to the hospital. The DON explained the nurse sending a resident should complete a transfer form and send it along with a medication list. When asked if there was any review of discharges, the DON explained in clinical meeting the discharges are gone over to make sure all the documentation is in the record. Review of a facility policy titled, "Discharge or Transfer" updated 1/28/20 read in part, "...1. Transfer/Discharge: Emergency: a. Contact 911/EMS Transport; b. Contact primary physician; c. Complete transfer/discharge form and attach copies of: i. Face sheet, ii. Advance Directives, iii Current Physician's orders, H&P (health and physical), copies of pertinent labs/x-rays..."			
F0755 SS= D	Pharmacy Srvcs/Procedures/Pharmacist/Records §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 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing,	F0755	Resident #703 no longer resides in the facility. All like residents have the potential to be affected. The Medication Administration record was reviewed for the residing residents to ensure that medications are available from the pharmacy and being administered according to the physician orders. The policy on medication administration for	2/28/2022

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	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: This citation pertains to intake #MI00126041 and MI00126225. Based on interview and record review, the facility failed to ensure pharmacy services were provided to ensure prescribed medication was available for administration in accordance with physician orders for one (R703) of four residents whose medication was reviewed. Findings include: Review of a complaint reported to the State Agency on 1/27/22 included allegations that the facility failed to administer medication on time or as ordered. According to the facility's policy titled, "Medication Ordering and Receipt" dated		residents was reviewed and deemed appropriate. By 02/28/2022, licensed nurses will be educated on the Medication Administration policy which includes ordering of medication and medication changes to ensure medications are available and administered per physician order. The DON/designee will conduct random audits on 5 resident physician orders weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents medications are available from the pharmacy and administered as ordered by the attending physician. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator and DON will be responsible for assuring substantial compliance is attained through this plan of correction by 02/22/2022 and for sustained compliance thereafter.	

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	6/21/17: "...(Pharmacy Name) will dispense unit dose medications (tablets, capsules and similar forms) in individual unit dose packages in accordance with a delivery schedule agreed upon by the Facility and pharmacy...Resident supplies will be replenished in accordance with policies for reordering and refills...If the medication is needed before the next scheduled delivery, call the pharmacy before submitting the order...Check the order to see that the order is complete and legible before sending...Name of drug...Dose of drug...Times to be given...Duration, if limited...The nurse must specify the exact date and time the first dose of medication should be delivered from the pharmacy...For any non-daily medication order, the nurse must specify the days of administration and times...Be sure that the order is completely and accurately transcribed to all necessary medical records (MARs, TARs, etc.)...All orders requiring new dosage or directions are handled as a new drug order with the previous order being discontinued..." Review of the clinical record revealed R703 was admitted into the facility on 11/30/21, discharged to the hospital on 12/17/21, readmitted on 12/24/21 and discharged to another facility out of the country on 1/26/22. Diagnoses included: acute kidney failure, transplanted organ, and tissue status, MSSA (Methicillin-Susceptible Staphylococcus Aureus) and other bipolar			

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disorder.

Review of a hospital "After Visit Summary" dated 12/24/21 documented R703's reason for admission was "...Your primary diagnosis was: AKI (acute kidney injury)...Bipolar Disorder...".

Discharge medications to be continued included:

"darbepoetin 100 MCG (micrograms)/0.5ML (milliliter) Commonly known as: ARANESP (a bone marrow stimulant) inject 100 mcg into the skin every 7 days..."

Review of a progress note from Nurse Practitioner (NP 'JJ') on 12/27/21 at 8:07 PM documented, in part "...Readmission-stability visit, medication reconciliation...readmitted following send out to (name of local hospital) per wife stating his nephrologist wanted him seen in the hospital...from 12/17-12/24...MEDICATIONS: (home medications reviewed and reconciled with current medication)...Chronic hx (history) of organ transplant-NEW...Aranesp 100 mcg injected weekly on Wednesdays..."

Review of R703's physician orders and Medication Administration Records (MARs) since admission included:

An order dated 11/30/21 with a start date of 12/1/21 and end date of 12/20/21 (resident was in the hospital 12/17-12/24/21) for

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	"Aranesp (Albumin Free) Solution 100 MCG/0.5ML Inject 0.5 milliliter subcutaneously one time a day every 7 days (s) for anemia treatment". According to the MAR, R703 was due to receive this medication on 12/1 and 12/8, but both entries were coded as "9" (Other/See Nurses Notes). Review of these nurses' notes documented: on 12/1 at 3:57 PM "n/a (not available) at this time) and on 12/8 at 1:15 PM "medication not available awaiting delivery". Since admission on 11/30/21, the first time R703 received this medication was on 12/15/21. An order dated 12/24/21 with a start date of 12/25/21 and end date of 1/1/22 read, "Aranesp (Albumin Free) Solution 100 MCG/0.5ML Inject 100 mcg subcutaneously one time a day for anemia treatment for 7 days". According to the MAR, R703 was due to receive this medication on 12/25 (coded as "9"), 12/26 (coded as "9"), 12/27 (coded as "9"), 12/28 (received), 12/29 (coded as "9"), 12/30 (received) and 12/31 (coded as "5" which meant hold/see nurse notes). Review of these nurses' notes documented: on 12/25 at 10:32 AM "On order", on 12/26 at 10:37 AM "medication on order", on 12/27 at 10:04 AM "on order", on 12/29 at 11:02 AM "on order" and on 12/31 at 3:34 PM, "Called pharmacy to reorder medication for resident. Pharmacy states that they it ant <sic> be			

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	recorded <sic> due to script being expired. Writer explained medication was scheduled to be given this am but is not in facility. Pharmacy states to reenter it into (name of electronic medical record) fordelivery <sic>. Writer reenters medication into (name of electronic clinical record) for delivery.", and on 12/31/21 at 4:57 PM "called pharmacy in regards t o <sic> medication, pharmacy states medication will be delivered tomorrow. Medication rescheduled to giveon <sic> Sunday to ensure medication is available". Another order dated 12/31/21 with a start date of 1/2/22 and end date of 1/3/22 read, "Aranesp (Albumin Free) Solution 100 MCG/0.5ML Inject 100 mcg subcutaneously one time only for anemia for 1 Day". According to the MAR, R703 was due to receive this medication on 1/2/22 (coded as "9"). Review of the nurses' note for 1/2/22 at 9:53 AM documented, "on order". There were no additional orders for the Aranesp medication in the clinical record. Further review of the clinical record revealed no documentation that the facility physician/extenders were notified of the above missed medications, unavailability of medications, or clarification of orders. Further review of the physician/extender notes from readmission to discharge revealed no documentation that they had initiated			

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changes to the above medication.

On 2/8/22 at 10:20 AM, an interview was conducted with the Director of Nursing (DON) who reported they began this interim position last Tuesday (2/1/22). When asked about whether the facility had identified any concerns with medications not being administered, or available, the DON reported they had identified that not all nurses had access to the medication back-up system and was currently working with their contracted pharmacy staff to address this.

On 2/8/22 at 10:47 AM, the Pharmacy Consultant (Staff 'GG') was attempted to be contacted by phone and a voicemail message was left. An email request was also sent to Staff 'GG' requesting follow-up.

On 2/8/22 at 11:22 AM, Staff 'GG' responded back via email and indicated they would also be copying their Pharmacy General Manager (Staff 'HH') on this email thread and that they would follow-up.

On 2/8/22 at 1:15 PM, an interview was conducted with the DON. When asked to review the above medications/treatments concerns, the DON acknowledged the concerns and further reported they would have to follow up with the pharmacist and their Medical Director (Physician 'P') to try to get some answers. The DON was forwarded the same email message that was sent to Staff 'GG' and Staff 'HH'. When asked what

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processes were in place when medications were not available to be administered per physician orders, the DON reported the nurses should notify the physician of the missed dose, or it should be identified by pharmacy. When asked about the facility's process for ordering/re-ordering and receipt of medications, the DON reported the facility's pharmacy did not send blister packets, but instead delivered nightly medications for the next day which were pre-packaged in bags so that all scheduled medications were in the same bag to administer when due.

On 2/9/22 at 11:18 AM, an email response from Staff 'HH' included the following response in regard to R703's Aranesp medication:

"The 12/24/21 order of every 7 days we never received. We did receive an order for Aranesp on 12/24/21 with a start date of 12/25/21, to which we did process for daily x 7 days. We did send a request for approval for a High Dollar amount which was approved". There was indication the pharmacy identified any concern with this order which was incorrectly transcribed and changed for daily x seven days, instead of the initial order for once every seven days.

Regarding the expectation for turnaround time for when medications are ordered, delivered and whether available in the back-up medication machine, "These meds

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	(Aranesp) are not available in the Cubex machine...Cut off is at 5pm with an expectation to deliver that night. New admission cut off is at 9pm, again expectation to deliver that night..." On 2/9/22 at 3:45 PM, a phone interview was conducted with Nurse 'CC'. When asked if they could recall any information about R703's change in order for the Aranesp on 12/25/21 and 12/31/21, Nurse 'CC' reported they did recall and stated, "The medication was not available. Was supposed to have one more dose. When I called pharmacy, they said in order to deliver the medication that night, I had to go in to change the order." When asked to clarify whether the Physician or NP were contacted to change the order, Nurse 'CC' reported, "No. That was what the pharmacy told me to do." When asked if anyone from the facility had contacted them to discuss the order they had changed had not been transcribed correctly (put in as daily for seven days, instead of once every seven days), Nurse 'CC' reported they were not. When asked if a medication was not available for administration, or missed, what should they do, Nurse 'CC' reported "Normally when residents don't get meds should call. At that time was under impression the medication would come that evening if that was done." On 2/9/22 at 10:22 AM, a phone interview was conducted with Physician 'P'. When asked about the facility's process for what should occur if medications were missed or			

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	not administered due to not being available, Physician 'P' reported the nurse should explain to me or my NP. NP 'II' is my NP there 5 days a week and another NP (NP 'JJ') also rotates." When asked about R703's conflicting orders for Aranesp which had been put in as daily for seven days, Physician 'P' stated, "Cannot be daily!" When asked if they had been notified or aware of these orders, Physician 'P' reported they were not and further reported, "The nurses should have called myself or NP. It's a med error." Physician 'P' deferred to NP 'II' for further information about R703's medications as NP 'II' was at the facility five days a week. On 2/9/22 at 10:40 AM, a phone interview and electronic record review was conducted concurrently with NP 'II' and NP 'JJ'. NP 'II' reported they did not work at the facility from 1/11/22 to 1/31/22 as they were on medical leave and that NP 'JJ' had been covering during this time. When asked if they had been notified about R703's multiple missed medications, or that medications were not available to administer, NP 'II' reported they were not. NP 'II' further reported that they had similar, ongoing concerns and were usually discovered on their own during record reviews. When asked about the change in order for the Aranesp medication, and whether there was any documentation of their clinical rationale to change or stop this medication, NP 'II' reviewed their progress notes in			

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	addition to NP 'JJ' and Physician 'P' and reported "I don't see any adjustment in our notes. Those are posted (put into the electronic clinical record) the same day. If we stop, change or address a medication that would've been in our notes." NP 'II' further reviewed Physician 'P's notes and was unable to find any further documentation about R703's use of Aranesp as well. NP 'II' reported the order upon R703's readmission on 12/24/21 was correct and was to be administered once every seven days on Wednesdays. When asked if they were aware R703 received two doses of Aranesp on 12/28 and 12/30 and nothing further through discharge on 1/26/22, NP 'II' reported they were not notified of that medication error. NP 'II' further reported that they were able to identify the nurse that changed the order on 12/25 and 12/31 was Nurse 'CC' and that the order from 12/25 to 1/1 was wrong and should have been one time a week, not once daily as written. When asked if either had received notification from the pharmacy regarding identified irregularities or medication errors and both NP 'II' and NP 'JJ' reported they had not. When asked why R703 had not received Aranesp since the last documented administration on 12/30/21, both reported they were unable to offer any explanation other than the order had been changed on 12/25 and 12/31 and had been put into the computer incorrectly. NP 'II' and NP 'JJ' both reported they would not have been available			

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	on those dates to give any verbal ok to change this medication and further reported frustration as similar instances had occurred. When informed of the concerns with R703 not receiving the other above identified medications, NP 'II' reported they should have been notified to potentially adjust treatment accordingly, but that did not happen.			
F0760 SS= E	Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f) (2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00126041 and MI00126225. Based on interview and record review, the facility failed to ensure that one (R703) of four sampled residents reviewed for medications received medications as prescribed, resulting in significant medication errors and the potential for compromise in health status for a resident with a transplanted kidney, skin infection, and mental health concerns. Findings include: Review of a complaint reported to the State Agency on 1/27/22 included allegations that the facility failed to administer medication on time or as ordered.	F0760	Resident #703 no longer resides in the facility. All like residents have the potential to be affected by this citation. The Medication Administration record was reviewed for the residing residents to ensure that medications are available and being administered as prescribed according to the physician orders. The Administration of Drugs policy was reviewed and deemed appropriate. By 02/28/2022, licensed nurses will be educated on the Medication Administration policy including the Five Rights of medication pass (time, resident, med, dose, route, documentation) to ensure medications are administered as prescribed by the physician. The DON/designee will conduct random audits on 5 residents physician orders weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents medications are available and administered as prescribed by the attending physician.	2/28/2022

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	According to the facility's policy titled, "Medication Administration; Medication Errors" dated 7/11/18: "...Medication errors are generally defined as doses administered to a patient that deviates from the physician's orders. (Within the long-term care setting, medication errors are considered to include failure to accurately chart medications as administered...The staff nurse is responsible for completing a Medication Error Report and submitting the form to the Director of Nursing...All medication errors are to immediately be reported to the Physician and Director of Nursing...Any questions regarding medication administration or documentation will be directed to the Director of Nursing/designee...More than two medication errors per month are considered excessive and will result in disciplinary action and/or termination." Review of the clinical record revealed R703 was admitted into the facility on 11/30/21, discharged to the hospital on 12/17/21, readmitted on 12/24/21 and discharged to another facility out of the country on 1/26/22. Diagnoses included: acute kidney failure, transplanted organ, and tissue status, MSSA (Methicillin-Susceptible Staphylococcus Aureus) and other bipolar disorder. According to the Minimum Data Set (MDS)		The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator and DON will be responsible for assuring substantial compliance is attained through this plan of correction by 02/28/2022 and for sustained compliance thereafter.	

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assessment dated 12/3/21, R703 had minimal difficulty hearing but did not wear a hearing aid, had clear speech, had no concerns with understanding others, had intact cognition, required extensive assistance of two plus persons physical assist for bed mobility, dressing, personal hygiene, required extensive assistance of one person for bathing, toilet use, and limited assistance of two plus persons physical assist with transfers.

Review of the admission physician orders included an order dated 11/30/21 with a start date of 12/1/21 and end date of 12/20/21 (resident was in the hospital 12/17-12/24/21) for "Aranesp (Albumin Free) Solution 100 MCG/0.5ML Inject 0.5 milliliter subcutaneously one time a day every 7 days (s) for anemia treatment".

Review of a hospital "After Visit Summary" dated 12/24/21 documented R703's reason for admission was "...Your primary diagnosis was: AKI (acute kidney injury)...Bipolar Disorder...".

Further review of the Review of a hospital "After Visit Summary" dated 12/24/21 reavealed discharge medications to be continued included:

"cephalexin 250 MG (milligrams)/5ML (milliliters) Commonly known as: KEFLEX (an antibiotic) take 20 mL by mouth every 8 hours for 18 days...Last time this was given:

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	1,000 mg on December 24, 2021, 10:14 AM..." "darbepoetin 100 MCG (micrograms)/0.5ML Commonly known as: ARANESP (a bone marrow stimulant) inject 100 mcg into the skin every 7 days..." "Quetiapine 200 MG Tabs Commonly known as: SEROquel (an antipsychotic medication) take 1 Tablet by mouth once every night at bedtime...Last time this was given: 200 mg on December 23, 2021 9:14 PM..." "testosterone 12.5 MG/ACT (1%) Gel Commonly known as: ANDROGEL (a steroid hormone) place 50 mg onto the skin once every night at bedtime...Last time this was given: Ask your nurse or doctor..." (There was no further documentation of when this medication had last been administered prior to readmission to the facility.) Review of a progress note from Nurse Practitioner (NP 'JJ') on 12/27/21 at 8:07 PM documented, in part "...Readmission-stability visit, medication reconciliation...Wound cultures from left hand + for MSSA (a type of bacteria on the skin) and started on Keflex 100mg Q8hr (every eight hours) for 3 weeks...MEDICATIONS: (home medications reviewed and reconciled with current medication)...Cephalexin 250mg/5ml sus, 20ml PO Q8hr for 18 days...Aranesp 100mcg injected weekly on Wednesdays...Quetiapine 200mg PO QHS...Androgel 12.5mg/ACT, place 50mg onto the skin			

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	QHS...DIAGNOSIS/STATUS/PLAN...Acute kidney injury with hyponatremia-NEW...Acute MSSA bacteremia-NEW...Chronic hx (history) of organ transplant-NEW...Chronic personality disorder with depression-NEW...Seroquel increased from 50mg to 200 mg PO QHS..." Review of R703's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for December 2021 and January 2022 revealed: The antibiotic (Cephalexin/Keflex) was not administered on 1/8/22 at 9:00 PM, 1/9/22 at 6:00 AM, 1/9/22 at 9:00 PM, 1/10/22 at 6:00 AM and 1/10 at 9:00 PM. The last dose was administered on 1/11/22 at 3:00 PM. The antibiotic order had not been extended to ensure the intended complete course had been administered. R703 did not receive any additional doses of this medication through the remainder of their stay at the facility (through 1/26/22). The bone marrow stimulant (Darbepoetin/Aranesp) was due to be administered on 12/1 and 12/8, but both were noted as not available for administration. Additionally, upon readmission on 12/24, this medication was not administered until Tuesday 12/28/21 at 9:00 AM and a second administration was done on Thursday 12/30/21. A second order entry on the MAR for this medication identified a one-time only for one day order			

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	that had been entered on 12/31/21 by Nurse 'CC' (who was also the nurse that entered R703's readmission orders on 12/24/21). The entry on 1/2/22 was coded as a "9" (Other/See Nurse Notes). Review of the default MAR nurse note from 1/2/22 at 9:53 AM read, "on order". R703 did not receive any additional doses of this medication through the remainder of their stay at the facility (1/26/22). The antipsychotic (Quetiapine/Seroquel) was not administered on 1/13/22, 1/15/22 and 1/16/22. All three entries were coded "9". Review of the default MAR nurse notes for the entry on 1/13/22 read, "Medication not available for resident", on 1/15/22 read, "on order" and on 1/16/22 there was no note. The steroid hormone (Testosterone/Androgel) was never administered to R703 upon their readmission on 12/24/21 through their discharge on 1/26/22. Further review of the clinical record revealed no documentation that the facility physician/extenders were notified of the above missed medications, unavailability of medications, or clarification of orders. The antibiotic order had not been extended to ensure the intended complete dosage was administered. R703 did not receive any additional doses of this medication through the remainder of their stay at the facility (1/26/22).			

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Further review of the physician/extender notes from readmission to discharge revealed no documentation that they had initiated changes to the above medications.

On 2/8/22 at 9:43 AM, an interview was conducted with the Director of Nursing (DON) who reported they began this interim position last Tuesday (2/1/22). When asked about their facility's back-up medication process, the DON reported the facility utilized a machine that contained medication and would provide a list of the available medications.

On 2/8/22 at 10:20 AM, the DON provided a list of available medications which included 10 capsules of cephalexin 250 MG and 10 tablets of quetiapine 25 MG. When asked about whether the facility had identified any concerns with medications not being administered, or available, the DON reported they had identified that not all nurses had access to the medication back-up system and was currently working with their contracted pharmacy staff to address this.

On 2/8/22 at 10:47 AM, the Pharmacy Consultant (Staff 'GG') was attempted to be contacted by phone and a voicemail message was left. An email request was also sent to Staff 'GG' requesting follow-up.

On 2/8/22 at 11:22 AM, Staff 'GG' responded back via email and indicated they would also

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	be copying their Pharmacy General Manager (Staff 'HH') on this email thread and that they would follow-up. On 2/8/22 at 1:15 PM, an interview was conducted with the DON. When asked to review the above medications/treatments concerns, the interim DON acknowledged the concerns and further reported they would have to follow up with the pharmacist and their Medical Director (Physician 'P' to try to get some answers. The DON was forwarded the same email message that was sent to Staff 'GG' and Staff 'HH'. When asked what the facility's process was when medications were not administered per physician orders, the DON reported there were processes in place which included notifying the Physician of the missed dose or identified by pharmacy. When asked about the facility's process for ordering/re-ordering and receipt of medications, the DON reported the facility's pharmacy did not send blister packets, but instead delivered nightly medications for the next day which were pre-packaged in bags so that all scheduled medications were in the same bag to administer when due. On 2/9/22 at 11:18 AM, an email response from Staff 'HH' included the following responses to the above medication concerns: Regarding the testosterone gel, "Yes, Testosterone Gel is interchangeable with Androgel. We received an order on 1/26/22 at 11:15 am, then at 4:15 pm the facility			

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	updated the patient status to inactive". There was no further explanation as to why this medication was not available from 12/24/21 to 1/26/22. Regarding the Aranesp, "The 12/24/21 order of every 7 days we never received. We did receive an order for Aranesp on 12/24/21 with a start date of 12/25/21, to which we did process for daily x 7 days. We did send a request for approval for a High Dollar amount which was approved". Regarding the Keflex, "We received an order on 12/24 at 2:52 pm which was sent out that night but only for a 3 day supply. Facility ordered again on the 28th requested a refill, which we did not have the product and we owed and ordered it. Technician did not document who they would have spoken too <sic> at the facility. Product was sent and available from the 30th through the 4th of January. Facility requested a refill on 1/8/22 at 9:08 pm. Med was owed again. No documentation as to communication. On 1/11, 5:08 am the product was delivered with a supply through the 16th". Regarding the expectation for turnaround time for when medications are ordered, delivered and whether available in the back-up medication machine, "These meds are not available in the Cubex machine. There are Cephalexin capsules, however. Cut off is at 5pm with an expectation to deliver that night. New admission cut off is at 9pm, again			

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expectation to deliver that night..."

On 2/9/22 at 3:45 PM, a phone interview was conducted with Nurse 'CC'. When asked if they could recall any information about R703's change in order for the Aranesp on 12/25/21 and 12/31/21, Nurse 'CC' reported they did recall and stated, "The medication was not available. Was supposed to have one more dose. When I called pharmacy, they said in order to deliver the medication that night, I had to go in to change the order." When asked to clarify whether the Physician or NP were contacted to change the order, Nurse 'CC' reported, "No. That was what the pharmacy told me to do." When asked if anyone from the facility had contacted them to discuss the order they had changed had not been transcribed correctly (put in as daily for seven days, instead of once every seven days), Nurse 'CC' reported they were not. When asked if a medication was not available for administration, or missed, what should they do, Nurse 'CC' reported "Normally when residents don't get meds should call. At that time was under impression the medication would come that evening if that was done."

On 2/9/22 at 10:22 AM, a phone interview was conducted with Physician 'P'. When asked about the facility's process for what should occur if medications were missed or not administered due to not being available, Physician 'P' reported the nurse should explain to me or my NP. NP 'II' is my NP there 5 days a week and another NP (NP 'JJ') also

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	rotates." When asked about R703's conflicting orders for Aranesp which had been put in as daily for seven days, Physician 'P' stated, "Cannot be daily!" When asked if they had been notified or aware of these orders, Physician 'P' reported they were not and further reported, "The nurses should have called myself or NP. It's a med error." Physician 'P' further reported they had ongoing concerns that nurses did not call with concerns such as missed medications or delays and would normally find out by reviewing the clinical record. Physician 'P' further reported, "The only reason why a medication might be held up is if not available to sign a C2 (controlled substance) form." Physician 'P' deferred to NP 'II' for further information about R703's medications as NP 'II' was at the facility five days a week. On 2/9/22 at 10:40 AM, a phone interview and electronic record review was conducted concurrently with NP 'II' and NP 'JJ'. NP 'II' reported they did not work at the facility from 1/11/22 to 1/31/22 as they were on medical leave and that NP 'JJ' had been covering during this time. When asked if they had been notified about R703's multiple missed medications, or that medications were not available to administer, NP 'II' reported they were not. NP 'II further reported that they had similar, ongoing concerns and were usually discovered on their own during record reviews. When asked about the change in order for			

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	the Aranesp medication, and whether there was any documentation of their clinical rationale to change or stop this medication, NP 'II reviewed their progress notes in addition to NP 'JJ' and Physician 'P' and reported "I don't see any adjustment in our notes. Those are posted (put into the electronic clinical record) the same day. If we stop, change or address a medication that would've been in our notes." NP 'II' further reviewed Physician 'P's notes and was unable to find any further documentation about R703's use of Aranesp as well. NP 'II' reported the order upon R703's readmission on 12/24/21 was correct and was to be administered once every seven days on Wednesdays. When asked if they were aware R703 received two doses of Aranesp on 12/28 and 12/30 and nothing further through discharge on 1/26/22, NP 'II' reported they were not notified of that medication error. NP 'II' further reported that they were able to identify the nurse that changed the order on 12/25 and 12/31 Nurse 'CC' and that the order from 12/25 to 1/1 was wrong and should have been one time a week, not once daily as written. When asked why R703 had not received Aranesp since the last documented administration on 12/30/21, both reported they were unable to offer any explanation other than the order had been changed on 12/25 and 12/31 and had been put into the computer incorrectly. NP 'II' and NP 'JJ' both reported they would not have been available			

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	on those dates to give any verbal ok to change this medication and further reported frustration as similar instances had occurred. When informed of the concerns with R703 not receiving the other above identified medications, NP 'll' reported they should have been notified to potentially adjust treatment accordingly, but that did not happen.			
F0888 SS= F	COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility	F0888	No residents were identified in the 2567. All residents residing at the facility have the potential to be affected. On 2/8/22 and 2/10/22 all residents were tested via rapid test for COVID 19 and tested negative. Staff members identified as being exempt were assessed to ensure that they were wearing NIOSH approved N95 respirator while in patient care areas. By 02/28/2022, staff will be educated by the Administrator/DON/designee on the Staff-COVID 19 Vaccine Policy to ensure that exempt employees are wearing NISOH approved N95 respirators per the CDC guidelines/policy. The DON/Designee will conduct random audits on 5 staff whom receive COVID 19 Vaccine Exemptions weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the additional precautions are maintained specifically for staff members who work in direct patient care	2/28/2022

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	setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting		areas will utilize a NIOSH approved N95 respirator while in patient care areas. When in non-direct patient care areas, the staff member will utilize source control at all times while in the facility/company and/or within 6 feet of any other team members. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator/DON will be responsible for assuring substantial compliance is attained through this plan of correction by 02/28/2022 and for sustained compliance thereafter.	

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	information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facilitys COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for			

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	COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement their additional precautions for personal protective equipment (PPE) per their COVID-19 vaccination of facility staff policy for one (Certified Nursing Assistant - CNA "N") of two staff members reviewed for exempted COVID-19 vaccination status. Findings include: According to the facility's "Mandatory COVID-19 Vaccinations" policy revised 11/19/21, "...Accommodations Upon Receiving Exemption... Staff members who work in direct patient care areas will utilize a NIOSH approved N95 respirator while in patient care areas. When in non-direct patient care areas, the staff member will utilize source control at all times while in the facility/company and/or within 6 feet of any other team members..." Review of the facility's completed COVID-19 Vaccination Matrix identified there were a total of 167 staff members. 110 staff members were fully vaccinated, and 13 staff members, had exemptions (which included CNA "N"). On 2/8/22 at approximately 7:30 AM, the facility's front lobby was observed with several staff members being screened for COVID-19 and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	2/9/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	choosing masks from a box of surgical masks, or a box of N95 respirators. Both boxes were observed on the desk next to the screening form. On 2/8/22 at 9:37 AM, CNA "N" was observed on their assigned unit wearing a surgical mask. CNA "N" was asked what type of PPE they had been instructed to use. CNA "N" explained they only had to wear a surgical mask because they did not work on the unit with COVID-19 positive residents. On 2/8/22 at 12:45 PM, CNA "N" was observed sitting at the nurse station wearing a surgical mask underneath their nose, so only their mouth and chin were covered by the mask. On 2/8/22 at 3:07 PM, CNA "N" was observed wearing a surgical mask and walking with two other staff members into the lobby area. No social distancing was observed. On 2/8/22 at 3:19 PM, the Director of Nursing (DON) was interviewed and asked what type of PPE was required for an exempted non-vaccinated staff member. The DON explained anyone could wear a surgical mask in the facility except the COVID positive units. When informed that per the facility's policy, any non-vaccinated staff members were to wear N95 respirators, the DON explained she had only been DON for a week and did not know who the exempted non-vaccinated staff members were, but would get a list of non-vaccinated staff members to ensure they were wearing the N95 respirators.			