STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495150	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on staff interview, clinical record review and facility document review, the facility staff failed to notify the physician and/or responsible party of missed COVID-19 vaccination for Resident #24 and failed to notify the resident's representative of weight loss for Resident #22 in a survey sample of 42 residents. The findings included: 1. Resident #24 was originally admitted to the nursing facility on 07/15/21. Diagnosis included but not limited to Chronic Obstructive Pulmonary Disease (COPD). The most recent Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date (ARD) of 09/14/21 coded Resident #24 with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The MDS coded Resident #24 total dependence of two with transfer and total dependence of one with dressing, bathing and personal hygiene and extensive assistance of two with bed mobility and toilet use and supervision with limited assistance of one with eating for Activities of Daily Living (ADL) care. Resident #24's comprehensive care plan with a revision date of 08/10/20 document resident at risk for alteration in psychosocial well-being related to restrictions on visitation due to COVID-19. The goal set for the resident by the staff the resident will not experience any adverse effects. Some of the intervention/approaches to manage goal include but not limited resident is on droplet isolation precautions related to dialysis, encourage alternative communication with visitors and provide opportunities for expression of feelings related to situational stressors. Review of Resident #24's clinical record revealed a COVID-19 vaccination consent form signed and dated by the resident's representative (RR) on 12/18/20. The document was also signed and dated by Registered Nurse (RN) #1 on 01/21/21. Review of Resident #24's clinical record did not reveal evidence that the COVID-19 vaccination was either offered or declined. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, RN #1 and Infection Preventionist/Staff Development Coordinator. RN #1 said Resident #24 refused the COVID-19 vaccination but it's wasn't documented in the nurses note or clinical record. RN #1 stated, I should have written a nurse's note of the refusal and the clinical record should have been updated under vaccination to include Resident #24 refused the COVID-19 vaccination. An interview was conducted with the Administrator on 09/30/21 at approximately 2:27 p.m., who stated, If Resident #24 refused the COVID-19 vaccination when offered, the nurse should have attempted again, and if the resident still refused, the refusal should have been documented in the nurse's note or someone where in his clinical record. The Administrator said the physician and the resident's (RR) should have been notified Resident #24 did not receive the COVID-19 vaccination. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. The facility's policy titled: Charting and Documentation - revision date 07/2017. Policy statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation read in part: 7. Documentation of procedures and treatments will include care-specific details, including: e. Whether the resident refused the procedure/treatment. f. Notification of family, physician or other staff, if indicated; and the signature and titles of the individual documenting. 40711 2. The facility staff failed to notify the resident representative of a significant weight loss for Resident #22 in the survey sample. Resident #22 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In section G(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing. The Care Plan dated 5/23/21 reads: FOCUS: The resident has nutritional problems or potential nutritional problems r/t Diet restrictions, mechanically altered diet, weight loss. Goals: The resident will tolerate diet and have no significant gain/loss through review date. Interventions: Observe/report to MD (Medical Doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition: Emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, greater than 10% in 6 months. MAR (Medication Administration Record) reads: weekly weights one time a day every Wed -Start Date 10/14/2020 at 9:00 AM. MAR (11/2020). Weights not recorded. MAR (12/2020) Weights not recorded. The following weights were recorded in the clinical record under weights. 10/7/2020 152.8 1bs. 11/15/20 135 lbs. 12/03/20 135.2 lbs. 12/8/21 135.2 lbs. The above recorded weights were not consistent with the ordered weekly weights). A review of resident's weight from October 7, 2020 (152.8 lbs) to November 15, 2020 (135.0 lbs.) Resident has lost 17.8 lbs. According to the complainant the resident had a significant amount of weight loss. The weekly ordered weights were not consistent from 10/07/20-11/15/20 Resident lost 17.8 lbs. A review of clinical progress notes show no documentation proving the POA (Power of Attorney) or family member were notified of the 17.8 lbs. weight loss. Review of progress note dated on 11/20/2020 at 9:43 AM from NP (Nurse Practitioner) reads: CC: Weight loss. This is an [AGE] year old who is residing on Memory Unit for LTC (Long Term Care). She was seen recently due to report of abnormal weight loss and poor appetite. Her weight is down to 135# this month, 152. 8 # in October. She is seen today to follow up on lab results. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of progress notes dated 11/18/2020 13:09 (1:09 PM). Progress Notes reads: CC: Weight loss. She is seen today due to report of abnormal weight loss. Her weight is down to 135# this month, 152.8 # in October. Staff report poor intake, about 25% at meals. No report of diarrhea or GI symptoms. She is a poor historian due to dementia. She says she is alright and denies pain or difficulty breathing. She is c/o feeling cold. Weight loss: possible etiologies-thyroid dysfunction, progressing dementia, or depression. Start Eldertonic 15 ml BID. Monitor weight. Weight warning trigger: 11/16/2020 15:31 Nutrition Note Text: WEIGHT WARNING: 135 lbs. A review of Progress notes dated 11/15/2020 read: RD (Registered Dietician) weight review; resident displays significant weight loss; Re-weigh to verify weight; weekly weights x 1 mo, RD to f/u PRN; RDN. A review of the clinical record dated 11/24/2020 at approximately 9:27 AM reveal that Resident's daughter spoke to staff about concerns about her mother's/resident's condition days after she was noted to have significant weight loss. On 9/23/21 at approximately 2:00 PM an interview was conducted with the District Dietary Manager/OSM (Other Staff Member) #6. He stated, A lot of it has to do with her decline with dementia. Her weight has been stable through 6 months. They had a staff member not putting down the proper weights. We found out that she wasn't weighing the resident. Nursing should notify the family of weight loss issues. Quarterly nutrition report completed. On 9/23/21 at approximately 12:10 PM an interview was conducted with resident's daughter. She stated, We received no calls about her weight loss or her not being able to walk. I spoke to the DON (Director of Nursing) and explained the weight concern she stated they would call me every Monday with weights. On 9/23/21 at approximately 12:00 PM a telephone interview was conducted with the Registered Dietician/OSM #2 concerning Resident # 22. She stated, The weights aren't consistent especially since COVID19. I brought it up a few times with the dietary managers. They had gotten better since the new DON came. Mostly from staff shortage. In my note she stabilized (weight) and was at a relative stable weight. I recommended fortified foods because sometimes her po (by mouth) intake is poor. She's now on weekly weights. She was on Remeron for a while for her appetite. House shakes 3 times a day. I also recommended they give her calorie dense snacks. Usually the DON's would call the family members. On 9/23/21 at approximately 2:00 PM an interview was conducted with the District Dietary Manager/OSM (Other Staff Member) #6. He stated, A lot of it has to do with her decline with dementia. Her weight has been stable through 6 months. They had a staff member not putting down the proper weights. We found out that she wasn ' t weighing the resident. Nursing should notify the family of weight loss issues. Quarterly nutrition report completed. On 9/23/21 at approximately 12:10 PM an interview was conducted with resident ' s daughter. She stated, We received no calls about her weight loss or her not being able to walk. I spoke to the DON (Director of Nursing) and explained the weight concern she stated they would call me every Monday with weights. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/21 at approximately 12:00 PM a telephone interview was conducted with the Registered Dietician/OSM #2 concerning Resident # 22. She stated, The weights aren't consistent especially since COVID19. I brought it up a few times with the dietary managers. They had gotten better since the new DON came. Mostly from staff shortage. In my note she stabilized (weight) and was at a relative stable weight. I recommended fortified foods because sometimes her po (by mouth) intake is poor. She's now on weekly weights. She was on Remeron for a while for her appetite. House shakes 3 times a day. I also recommended they give her calorie dense snacks. Usually the DON's would call the family members. On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. This is a complaint deficiency

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 37828 Based on clinical record review, staff interview and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 2 residents (Resident #5 and Resident #80) in the survey sample. The findings included: 1. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #5 who was discharged from skilled services with Medicare days remaining. Resident #5 was admitted to the nursing facility on 07/16/20. Diagnosis for Resident #5 included but not limited to Muscle Weakness. Resident #5's Minimum Data Set (MDS) a Medicare/5 day assessment with an Assessment Reference Date (ARD) date of 09/06/21 coded Resident #5 a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated no cognitive impairment. Review of the SNF Beneficiary Notification provided by the facility was noted that Resident #5 was not issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage). Resident #5 started Medicare Part A stay on 08/31/21 and the last covered day was on 09/17/21. Resident #5 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #5 had only used 21 days of his Medicare Part A services with 79 days remaining. Resident #5 should have been issued a SNF ABN and an NOMNC. A phone interview was conducted with the Social Worker (SW) on 09/23/21 at approximately 9:00 a.m. The SW said only the NOMNC was issued when Resident #5 was discharged from Medicare A services that ended on 09/20/21. She said I should have issued an ABN letter along with the NOMNC letter. 2. Resident #80 was admitted to the nursing facility on 12/07/17. Diagnosis for Resident #80 included but not limited to Lack of Coordination. Resident #80's Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) date of 09/01/21 coded Resident #14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated no cognitive impairment. Review of the SNF Beneficiary Notification was noted that Resident #80 was not issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice.) The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage). Resident #80 started a Medicare Part A stay on 09/07/21, and the last covered day of this stay was 09/20/21. Resident #80 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #80 only used 77 days of her Medicare Part A services with 23 days remaining. Resident #80 should have been issued a SNF ABN and an NOMNC. The resident was only issued an NOMNC. A phone interview was conducted with the Social Worker (SW) on 09/23/21 at approximately 9:00 a.m. The SW said only the NOMNC was issued when Resident #5 was discharged from Medicare A services ended on 09/17/21. She said I should have issued an ABN letter along with the NOMNC letter. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the above findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. The facility's policy titled: Advance Beneficiary Notices, revision date: 11/01/20. Policy: It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage. Policy Explanation and Compliances Guidelines included but not limited to: 1. The Business Office Manager (BOM) is the contact person for information regarding Medicare eligibility, coverage, and applying for benefits. 5. The current CMS-approved revision of the forms shall be used at all time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. A. For Part A times and services, the facility shall us the Skilled Nursing facility Advance Beneficiary Notice (SNF ABN). Form CMS-10055.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observation, resident interview, staff interviews, clinical record review, the facility's staff failed to ensure personal privacy of a resident's physical body during personal care for 1 of 42 residents (Resident #90), in the survey sample. The findings included: Resident #90 was originally admitted to the facility 5/14/19 and readmitted [DATE] after an acute care hospital stay, returning to the facility 9/9/21. The current diagnoses included; SARS-CoV-2 infection and Multiple Sclerosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/16/21 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview was coded for intact long and short term memory as well as modified independence with daily decision making. In section G (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of one person with bed mobility, transfers, dressing, toileting, and personal hygiene, limited assistance of one person with transfers, and supervision after set-up with eating. Upon entering Resident # 90's room on 9/23/21 at approximately 9:45 a.m., a sheet was observed on the floor and on top of the sheet were elimination saturated towels, a gown and used gloves. Resident #90; a SARS-CoV-2 infected resident; was in bed uncovered and without clothing. The resident stated he no longer felt sick and presented without shortness of breathe, cough, diaphoresis or fatigue. Resident #90 stated CNA #5 was obtaining towels for him to use for incontinence wear, afterwards she would dress him. The resident stated use of towels was his method of staying dry for it takes the staff too long to provide assistance when he rings the call bell. The resident's window was opened and he was viewable as staff passed by the window. The resident stated when he gets up he closes the blinds but he hadn't been up for a few days and no one had closed the blinds on his behalf. An interview was conducted with CNA #5 on 9/23/21 at approximately 9:53 a.m. CNA #5 stated she forgot to close the window prior to beginning care for the resident was in a private room. She also stated she should have covered the resident before she stepped out to get towels, it was an oversight. An interview was conducted with the DON on the COVID-19 positive unit on 9/23/21 at approximately 10:05 a.m. The DON stated her expectation of the CNA is to close doors, privacy curtains and window coverings before personal care is started and that no more of the resident's body be exposed than the area care is being rendered. On 9/30/21 at approximately 6:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. An opportunity was offered to the facility's staff to present additional information or comment but no additional information was provided.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide reasonable care for the protection of residents' property from loss for 2 of 42 residents (Resident #7 and #22) in the survey sample. The findings included: 1. Resident #7 was originally admitted to the facility on [DATE]. Diagnoses for Resident #7 included but not limited to COVID-19 and Cognitive Communication Deficit. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/18/21 coded Resident #7 as not having the ability to complete the Brief Interview for Mental Status (BIMS). A review of the complaint/grievance report dated 2/06/20 filed by POA (Power of Attorney) Reads: Resident is missing significant amount of personal items: Clothes, burgundy/beige comforter, white watch and a gold bracelet. Sister sews name on garments. Resolution reads items returned on 2/21/20. A review of complaint document/grievance dated 1/01/21 filed by POA reads: Other residents clothing found in the laundry bin when sister picks up residents laundry. Resident is missing her gold chain. Findings of Investigation: Gold chain was not able to be located. Residents on unit 5 are in and out of each other's rooms/closets. Plan to resolve complaint: Speak with CNAs on Unit 5 about consolidating resident's clothing only for sister to retrieve every week. Results of action taken: Will continue to look for gold chain. Advised sister of facility policy on missing items. Resolution: Ongoing: Hopes that gold chain will turn up soon. Received document on 9/27/21(dated 9/24/21) from Social Worker (OSM/Other Staff Member) #8 concerning misplaced items. The document reads: Laundry/Housekeeping recovered burgundy/beige comforter (Initials in the corner) and other items. (Five pairs of pants, four shirts and two bras). Signed laundry personnel. [NAME] watch and gold bracelet was not found. The writer (OSM#8) spoke to POA on 9/25/21 to inform her of items found. POA very thankful for call and information via this writer. During the initial tour on 9/21/21 at approximately 2:25 PM Resident #7 was observed Resting in bed. An interview was attempted with Resident #7 but due to her cognitive communication deficit an interview was not successful. On 9/23/21 an interview was conducted at 8:25 AM with CNA (Certified Nursing Assistant) #10 concerning Resident #7. She stated, Her sister did her laundry at first but wasn't coming frequently enough so the resident would run out of clean laundry so we started washing it here. I don't know anything about the resident having a gold chain or remember seeing her wearing a watch. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/21 at approximately 10:30 a.m., an interview was conducted with the Laundry Supervisor. He stated they had a staff member out of work therefore the laundry services were backed-up but it was their intention to get the three large bins of resident personal belongings sorted, folded or hung and returned to the residents very soon. The Laundry Supervisor stated no resident will be without needed personal items affecting their care as a result of the back-up On 9/23/21 at approximately 1:00 PM a phone call was made to Resident #7's sister concerning her lost belongings. She stated, The jewelry is at our own risk. She had a gold chain, gold bracelet and a watch when she first came in. It was hard getting things from her. The facility told me I shouldn't leave valuable things here. She lost glasses and they said they would refer her. She's lost wigs. The former Social Worker said they don't replace items. The Laundry wasn't available to me for pick up. Due to resident's incontinence the clothes were sent to laundry. She's lost many clothes and a comforter set that she liked. On 9/24/21 at approximately 12:20 p.m., the Laundry Supervisor stated he recruited assistance of a previous laundry employee and they managed to get all resident personal laundry sorted and returned to the rightful owners. On 9/28/21 at 3:45 PM an interview was conducted with Social Worker (OSM/Other Staff Member) #8 concerning Resident #7. She stated, I didn't locate the resident's watch or bracelet. From the policy we don't reimburse for such items. I didn't see an inventory list in her chart. We informed the POA (Power of Attorney). I will see if we have a policy. 2. For Resident #22, the facility staff failed to replace a lost hearing aid and assist a hearing impaired resident's hearing aid and dentures needed to hear and eat foods. Per physicians order Resident #22 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). In section G(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing. Reveiwed complaint/grievance report dated 3/23/21 filed by son and communicated to Social Services. Concern: During last recent in person visits on 3/19/21 and 3/20/21 resident had no dentures or hearing aid. Family requested resident to have daily. Findings: Hearing aids were being kept on medication cart when not in use. Dentures and hearing aids have been missing for an unknown amount of time. Plan: Facility to acquire contract with senior well that offers dental and audiology services for residents. Resolution: Follow-up needed. Remarks: Missing items are a continious issue for this family and son is weery about replacement dentures. A review of the MAR (Medication Administration Record) reveal the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/10/2021: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime. No dentures in the nursing cart. 9/9/2021: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired. due to behavior of taking them out and putting them in random places only one remains. 7/8/2020: Medication Administration Note Note Text: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired. 12/4/2020: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime Only top denture collected from resident. No bottom denture. A review of progress notes read: On 11/27/2020 at 11:47 AM Nursing Progress Note: CNA placed residents upper and lower dentures in her mouth this shift. Resident removed her bottom dentures/misplaced them. Hearing aids are in place. Resident met with family this shift through window visit. No concerns noted at this time. Will inform oncoming staff of misplaced bottom dentures. 11/24/2020 at 9:27 AM Progress Note: This Lpn (Licensed Practical Nurse) spoke with daughter, her concerns was resident didn't have dentures, hearing aids, hair and nail cut. Also not knowing her mother is w/c bound and incontinent. I reeducated her on resident condition and that we will make sure on her mother is will groom on a daily basis. 11/21/2020 at 10:53 AM-Medication Administration Note: Place bilateral hearing aids in resident ears every morning. On 9/22/21 at approximately 10:25 AM., Surveyor observed Resident without dentures and hearing aides as she was sitting at the table in the activities room. No dentures intact. No hearing aide intact. Her CNA stated, She will take out her own dentures. On 9/22/21 at approximately 7:10 PM- an interview was conducted with LPN (Licensed Practical Nurse) #6 concerning Resident #22's dentures. She stated, I haven't seen her dentures in her mouth in a couple of weeks. On 9/23/21 at approximately 8:25 AM an interview was conducted with CNA (Certified Nursing Assistant) #10 concerning Resident #22. He stated, Her dentures should be taken out at night and soaked. They should be left on the sink. Her hearing aid should be locked in the medication cart before she goes to bed. On 9/23/21 at approximately 9:35 AM an interview was conducted with CNA (Certified Nursing Assistant) #1 concerning Resident #22. She stated, She doesn't have any dentures. When she did she would take them out. On 9/23/21 Resident observed in Activity room at 9:40 AM. No dentures intact. (continued on next page)

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Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/21 at approximately 12:44 PM an interview was conducted with Resident #22's son concerning her dentures and weight loss. He stated, I never saw her pull them out (her dentures) nor the hearing aids. Not wearing the dentures makes her face sunken in. Constant lack of not shaving her.(Whiskers on her face). The dietician would talk about her weight loss at the quarterly meetings. Received Investigation document dated on 9/24/21 on 9/27/21 from Social Worker (OSM/Other Staff Member) #8. It reads as follows: During investigation one hearing aid is in place. No dentures found. Appointment was scheduled October 7, 2021 @10:00 AM with Affordable Dentures. Resident's son was called and informed of upcoming appointment. Reached out to ENT (Ear, Nose and Throat) on 9/24/21 office was closed. Will follow up on Monday September 27, 2021 to schedule an appointment. On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. This is a complaint deficiency

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan for 3 out of 42 residents (Resident #33, Resident #42 and Resident #21) after being transferred to the hospital. The findings included: 1. The facility staff failed to ensure Resident #33's Plan of Care Summary to include her care plan goals was sent upon or shortly after transfer/discharge to the hospital on 07/15/21. Resident #33 was originally admitted to the facility on [DATE]. Diagnosis for Resident #33 included but not limited to Anxiety disorder. Resident #33's Minimum Data Set (MDS-an assessment protocol) a significant change MDS with an Assessment Reference Date of 07/28/21 coded Resident #33 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The Discharge MDS assessments was dated for 07/15/21 - discharged with return anticipated. A nurse's note entered on 07/15/21 at approximately 8:02 a.m., revealed the following documentation: Resident observed in supine position, not easily aroused, eyes unresponsive to light and sternal rub given in order to be aroused. The note included the physician was notified of change in condition with Resident #33 with new orders to start Intravenous (IV) fluids and send to the emergency room (ER) for evaluation and treatment. The nurse's note indicated the vital signs were but not limited to the following: (BP) 95/60 - (hypotension) (P) 105 - (tachycardia) (R) 12 and oxygen saturation levels at 98%-on room air. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care. 2. The facility staff failed to ensure Resident #42's Plan of Care Summary to include his care plan goals was sent upon or shortly after transfer/discharge to the hospital on 09/04/21. Resident #42 was originally admitted to the facility on [DATE]. Diagnosis for Resident #42 included but not limited to Dementia without behavioral disturbance. Resident #42's Minimum Data Set (MDS-an assessment protocol) a quarterly Medicare 5-day assessment with an Assessment Reference Date of 09/06/21 coded Resident #42 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The MDS assessment was dated for 09/06/21 - discharged with return anticipated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note entered by on 09/04/21 at approximately 9:13 a.m., revealed the following documentation: Resident #42 noted with cough and congestion; lungs sounds noted with crackles in the left upper lobe. The note included resident refusing all medications, fluids and breakfast at this time. The nurse's note indicated the vital signs were but not limited to the following: (BP) 158/92 - (hypertension) (P) 102 - (tachycardia) (R) 20, (T) 100.9 and oxygen saturation levels at 94% on room air. On the same day at approximately 4:28 p.m., the nurse's note indicated the resident was in the emergency room (ER). On 09/05/21 at approximately 7:58 p.m., the nurse's note revealed a note that read, Resident in hospital. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the above findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. The facility policy titled Transfer and Discharge including Against Medical Advice (AMA) revised on 10/20/20. 7. Emergency Transfer/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Section D. Complete and send with the resident or provide as soon as practical) a Transfer Form which documents: Comprehensive care plan goals. 34896 3. The facility staff failed to ensure that Comprehensive Care Plan Goals were sent upon transfer to the hospital on 4/26/21 and 8/22/21 for Resident #21. Resident #21 was admitted on [DATE] with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, Psychosis and Difficulty Swallowing. Resident #21's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making. Resident #21's Clinical Census was reviewed and revealed the resident was discharged on [DATE] and 8/22/21. Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows: (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/26/2021 17:12 (5:12 p.m.), eINTERACT SBAR(Situation, Background, Assessment, Recommendations) Summary: The Change In Condition/s reported are/were: Functional decline (worsening function and/or mobility) - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: SEND OUT VIA 911. 4/26/2021 21:32 (9:39 p.m.), Nursing Progress Note: Nurse was notified by CNA(certified nursing assistant) that patient had been acting different than usual today and has not got up out of bed. This nurse went to assess pt(patient) and noted pt to be having seizure-like movements. Pt was able to respond to verbal stimuli by lifting his head up and looking towards nurse. Pt was non-vocal at this time with grunting noises noted NP(nurse practitioner)/MD(medical doctor) notified, 911 called, pt sent out to hospital. Unit Manager and ADON(assistant director of nursing), were notified. Called the hospital for an update and the ER(emergency room) Nurse stated pt was intubated and being admitted for AMS(altered mental status), Seizures, and Renal Failure. MD(medical doctor)/NP(nurse practitioner) and ADON(assistant director of nursing) made aware. 8/21/2021 19:24 (7:24 p.m.), Nursing Progress Note: Resident noted to have extreme lethargy and weakness and frequent jerking of BUE(bilateral upper extremities) and BLE(bilateral lower extremities) noted and resident extremely pale. Resident pocketing food and difficulty swallowing food and liquids. B/P-83/53. MD on call made aware and new order to send patient to hospital to be evaluated for altered mental status. 8/21/2021 19:44 (7:44 p.m.), eINTERACT SBAR Summary: The Change In Condition/s are/were: Altered mental status - Blood Pressure: BP 83/53 - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) - Functional Status Evaluation: Swallowing difficulty. - Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Nursing observations, evaluation, and recommendations are: Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Send resident to ER(emergency room) to be evaluated. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/22/2021 06:25 a.m. Nursing Progress Note: Call placed to ED(emergency department) for admitting diagnosis. Informed there was no admitting diagnosis only that resident was admitted to the ICU(intensive care unit) for further treatment. There was no documentation in Resident #21's clinical record to indicate that the resident's comprehensive care plan goals were sent with the resident upon transfer from the facility to the hospital on 4/26/21 or 8/22/21. On 9/28/21 at 10:40 a.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #21's hospital transfers on 4/26/21 and 8/22/21 and if comprehensive care plan goals were sent with him. The DON stated, I couldn't find no documentation that the care plan goals were sent to the hospital with him for 4/26/21 or 8/22/21. They should have been sent with him so the hospital staff would know specific information about him and about the care he required. On 9/29/21 at 4:10 p.m., an interview was conducted with the Regional Director of Clinical Services regarding what was expected to be sent with resident's upon transfer to the hospital. The Regional Director of Clinical Services stated, The care plan goals should go with the resident because the receiving provider needs to know the person-centered care required for the resident. It should also be documented in the resident's medical record that it was sent. The facility policy titled Transfer and Discharges dated 11/1/20 was reviewed and is documented in part, as follows: 7. Emergency Transfer/Discharges: d. Complete and sent with the resident: viii. Comprehensive care plan goals. On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on resident record review, staff interviews and facility document reviews, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of discharges for two residents (Resident #22, #21) in the sample of 42 residents. The findings included: 1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #22's transfer to the local hospital on 07/10/20. Resident #22 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. Diagnosis for Resident #22 include but not limited to Unspecified Intracapsular Fracture of the Left Femur, Sequela. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). On 7/10/20, according to the facility's documentation, a change in condition was reported concerning resident's skin color. An X-ray was ordered and showed an acute left hip fracture. Resident was picked up via transportation services and taken to the local ER (emergency room). On 7/14/20, according to the facility's documentation, Resident returned from the hospital. Resident has a Honeycomb dressing at the left hip over incision to repair fracture. On 9/29/21 at approximately 3:00 PM an interview was conducted with ASM (Administrative Staff Member) #7. She stated, We don't have a record of an Ombudsman notification being sent. On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. 34896 2. The facility staff failed to ensure the local State Long-Term Care Ombudsman was notified that Resident #21 was discharged to the hospital on 4/26/21 and 8/22/21. Resident #21 was admitted on [DATE] with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, Psychosis and Difficulty Swallowing. Resident #21's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making. Resident #21's Clinical Census was reviewed and revealed the resident was discharged on [DATE] and 8/22/21. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows: 4/26/2021 21:32 (9:39 p.m.), Nursing Progress Note: Called the hospital for an update and the ER(emergency room) Nurse stated pt(patient) was intubated and being admitted for AMS(altered mental status), Seizures, and Renal Failure. MD(medical doctor)/NP(nurse practitioner) and ADON made aware. 8/22/2021 06:25 a.m. Nursing Progress Note: Call placed to ED(emergency department) for admitting diagnosis. Informed there was no admitting diagnosis only that resident was admitted to the ICU(intensive care unit) for further treatment. On 9/22/21 at 11:00 a.m., the facility Social Worker was asked for documentation to show that the local State Long-Term Care Ombudsman was notified that Resident #21 was discharged to the hospital on 4/26/21 and 8/22/21. On 9/22/21 at 1:00 P.M. an interview was conducted with the facility Social Worker regarding documentation that the State Long-Term Care Ombudsman was notified by the facility that Resident #21 was discharged to the hospital on 4/26/21 and 8/22/21. The Social Worker stated, I was not here in April and can not find any documentation that the ombudsman was notified of that discharge. Also I can not find documentation that I notified the ombudsman of the 8/22/21 discharge. I should have sent that at the beginning of September. On 9/22/21 at 2:00 p.m., an interview was conducted with the Regional Director of Clinical Services regarding when and who should notify the State Long-Term Care Ombudsman of discharges. The Regional Director of Clinical Services stated, The Social Worker should notify the ombudsman at least monthly of all discharges. The facility policy titled Transfer and Discharges dated 11/1/20 was reviewed and is documented in part, as follows: 7. Emergency Transfer/Discharges: k. Social Services Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list. On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37828 Based on staff interview, facility documentation review and clinical record review the facility staff failed send a copy of the Bed-Hold Policy upon discharge/transfer for 4 of 42 resident's (Resident #33, Resident #42, Resident #21 and Resident #92) after being transferred to the hospital. The findings included: 1. The facility staff failed to ensure that Resident #33 or his resident's representative was provided a copy of the bed hold policy upon discharge/transfer to the hospital on 07/15/21. Resident #33 was originally admitted to the facility on [DATE]. Diagnosis for Resident #33 included but not limited to Anxiety disorder. Resident #33's Minimum Data Set (MDS-an assessment protocol) a significant change MDS with an Assessment Reference Date of 07/28/21 coded Resident #33 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The Discharge MDS assessments was dated for 07/15/21 - discharged with return anticipated. A nurse's note entered on 07/15/21 at approximately 8:02 a.m., revealed the following documentation: Resident observed in supine position, not easily aroused, eyes unresponsive to light and sternal rub given in order to be aroused. The note included the physician was notified of change in condition with the Resident #33 with new orders to start Intravenous (IV) fluids and send to the emergency room (ER) for evaluation and treatment. The nurse's note indicated the vital signs were but not limited to the following: (BP) 95/60 - (hypotension) (P) 105 - (tachycardia) (R) 12 and oxygen saturation levels at 98%-on room air. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident #33 care plan after being transferred to the hospital. The facility staff failed to ensure Resident #33's Plan of Care Summary to include her care plan goals was sent upon or shortly after transfer/discharge to the hospital on 07/15/21. Resident #33 was originally admitted to the facility on [DATE]. Diagnosis for Resident #33 included but not limited to Anxiety disorder. Resident #33's Minimum Data Set (MDS-an assessment protocol) a significant change MDS with an Assessment Reference Date of 07/28/21 coded Resident #33 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The Discharge MDS assessments was dated for 07/15/21 - discharged with return anticipated. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's note entered on 07/15/21 at approximately 8:02 a.m., revealed the following documentation: Resident observed in supine position, not easily aroused, eyes unresponsive to light and sternal rub given in order to be aroused. The note included the physician was notified of change in condition with Resident #33 with new orders to start Intravenous (IV) fluids and send to the emergency room (ER) for evaluation and treatment. The nurse's note indicated the vital signs were but not limited to the following: (BP) 95/60 - (hypotension) (P) 105 - (tachycardia) (R) 12 and oxygen saturation levels at 98%-on room air. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care. 2. The facility staff failed to ensure Resident #42's Plan of Care Summary to include his care plan goals was sent upon or shortly after transfer/discharge to the hospital on 09/04/21. Resident #42 was originally admitted to the facility on [DATE]. Diagnosis for Resident #42 included but not limited to Dementia without behavioral disturbance. Resident #42's Minimum Data Set (MDS-an assessment protocol) a quarterly Medicare 5-day assessment with an Assessment Reference Date of 09/06/21 coded Resident #42 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The MDS assessment was dated for 09/06/21 - discharged with return anticipated. A nurse's note entered by on 09/04/21 at approximately 9:13 a.m., revealed the following documentation: Resident #42 noted with cough and congestion; lungs sounds noted with crackles in the left upper lobe. The note included resident refusing all medications, fluids and breakfast at this time. The nurse's note indicated the vital signs were but not limited to the following: (BP) 158/92 - (hypertension) (P) 102 - (tachycardia) (R) 20, (T) 100.9 and oxygen saturation levels at 94% on room air. On the same day at approximately 4:28 p.m., the nurse's note indicated the resident was in the emergency room (ER). On 09/05/21 at approximately 7:58 p.m., the nurse's note revealed a note that read, Resident in hospital. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. Corporate said the care plan should have been sent when discharge to the new provider (acute care setting). She said the care plan ensures the new provider knows what kind of care the resident needs to maintain continuity of care. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the above findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Transfer and Discharge including Against Medical Advice (AMA) revised on 10/20/20. 7. Emergency Transfer/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Section D. Complete and send with the resident or provide as soon as practical) a Transfer Form which documents: Comprehensive care plan goals. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations, Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. 2. The facility staff failed to ensure that Resident #42 or his resident's representative was provided a copy of the bed hold policy upon discharge/transfer to the hospital on 09/04/21. Resident #42 was originally admitted to the facility on [DATE]. Diagnosis for Resident #42 included but not limited to Dementia without behavioral disturbance. Resident #42's Minimum Data Set (MDS-an assessment protocol) a quarterly Medicare 5-day assessment with an Assessment Reference Date of 09/06/21 coded Resident #42 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The MDS assessment was dated for 09/06/21 - discharged with return anticipated. A nurse's note entered by on 09/04/21 at approximately 9:13 a.m., revealed the following documentation: Resident #42 noted with cough and congestion; lungs sounds noted with crackles in the left upper lobe. The note included resident refusing all medications, fluids and breakfast at this time. The nurse's note indicated the vital signs were but not limited to the following: (BP) 158/92 - (hypertension) (P) 102 - (tachycardia) (R) 20, (T) 100.9 and oxygen saturation levels at 94% on room air. On the same day at approximately 4:28 p.m., the nurse's note indicated the resident was in the emergency room (ER). On 09/05/21 at approximately 7:58 p.m., the nurse's note revealed a note that read, Resident in hospital. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. The Administrator said the bed is hold policy should have been sent when discharged to the hospital. He said the bed hold policy informs the resident of their rights when returning back to the facility along with the bed hold requirement. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations, Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. (continued on next page)

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	495150	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Transfer and Discharge including Against Medical Advice (AMA) revised on 10/20/20. 7. Emergency Transfer/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified). Section I. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer. 34896 3. The facility staff failed to ensure that a Bed Hold Notice was provided or sent upon transfer to the hospital on 4/26/21 and 8/22/21 for Resident #21. Resident #21 was admitted on [DATE] with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, Psychosis and Difficulty Swallowing. Resident #21's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making. Resident #21's Clinical Census was reviewed and revealed the resident was discharged on [DATE] and 8/22/21. Resident #21's Nursing Progress Notes were reviewed and are documented in part, as follows: 4/26/2021 17:12 (5:12 p.m.), eINTERACT SBAR(Situation, Background, Assessment, Recommendations) Summary: The Change In Condition/s reported are/were: Functional decline (worsening function and/or mobility) - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: SEND OUT VIA 911. 4/26/2021 21:32 (9:39 p.m.), Nursing Progress Note: Nurse was notified by CNA(certified nursing assistant) that patient had been acting different than usual today and has not got up out of bed. This nurse went to assess pt(patient) and noted pt to be having seizure-like movements. Pt was able to respond to verbal stimuli by lifting his head up and looking towards nurse. Pt was non-vocal at this time with grunting noises noted NP(nurse practitioner)/MD(medical doctor) notified, 911 called, pt sent out to hospital. Unit Manager and ADON(assistant director of nursing), were notified. Called the hospital for an update and the ER(emergency room) Nurse stated pt was intubated and being admitted for AMS(altered mental status), Seizures, and Renal Failure. MD(medical doctor)/NP(nurse practitioner) and ADON(assistant director of nursing) made aware. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/21/2021 19:24 (7:24 p.m.), Nursing Progress Note: Resident noted to have extreme lethargy and weakness and frequent jerking of BUE(bilateral upper extremities) and BLE(bilateral lower extremities) noted and resident extremely pale. Resident pocketing food and difficulty swallowing food and liquids. B/P-83/53. MD on call made aware and new order to send patient to hospital to be evaluated for altered mental status. 8/21/2021 19:44 (7:44 p.m.), eINTERACT SBAR Summary: The Change In Condition/s are/were: Altered mental status - Blood Pressure: BP 83/53 - Mental Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) - Functional Status Evaluation: Swallowing difficulty. - Neurological Status Evaluation: Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) Nursing observations, evaluation, and recommendations are: Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: Send resident to ER to be evaluated. 8/22/2021 06:25 a.m. Nursing Progress Note: Call placed to ED(emergency department) for admitting diagnosis. Informed there was no admitting diagnosis only that resident was admitted to the ICU(intensive care unit) for further treatment. There was no documentation in Resident #21's clinical record to indicate that a bed hold notice was provided or sent with Resident #21 upon transfer from the facility to the hospital on 4/26/21 or 8/22/21. On 9/28/21 at 10:40 a.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #21's hospital transfers on 4/26/21 and 8/22/21 and if a bed hold notice was sent with him. The DON stated, I couldn't find no documentation that a bed hold notice was sent to the hospital with him for 4/26/21 or 8/22/21. On 9/29/21 at 4:10 p.m., an interview was conducted with the Regional Director of Clinical Services regarding what was expected to be sent with resident's upon transfer to the hospital. The Regional Director of Clinical Services stated, The bed hold notice should go with the resident each time they go out. It should also be documented in the resident's medical record that it was sent. The facility policy titled Transfer and discharge date d 11/1/20 was reviewed and is documented in part, as follows: (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Emergency Transfer/Discharges: d. Complete and sent with the resident: i. Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer. The facility policy titled Bed Hold Notice Upon Transfer dated 11/1/20 was reviewed and is documented in part, as follows: Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. Policy Explanation and Compliance Guidelines: Bed Hold Notice Upon Transfer. 1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. b. The reserve bed payment policy. c. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. d. Conditions upon which the resident would return to the facility. 2. In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan. On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. 09546 4. The facility staff failed to provide Resident #92 with a Notice on Bed - Hold Policy and Readmission before transfer. Resident #92 had an original admitted [DATE]. Diagnoses included schizophrenia, anxiety, traumatic brain injury, benign prostatic hyperplasia, dementia, mood disorder, seizures, hypertension,muscle weakness, dysphagia. This resident was assessed on a quarterly Minimum Data Set (MDS) in the area of Cognitive Patterns as 15 on the BIMS assessment. This resident was assessed as requiring one person physical assist in the area of Activities of Daily Living (ADL's) in the area of transfer, dressing, personal hygiene and toileting. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Care plan dated 01/15/20 indicated: Focus- No plans to discharge. Goal- Participate in care decisions for long term stay. Interventions- Monitor for signs and symptoms of anxiety, distress, withdrawal or depression relating to not return to previous home environment. A Nursing Note dated 02:35 on 08/10/20 indicated: Resident became combative around 0145 threatening roommate waving walking cane in his roommates face. Turning up his radio loud, treating other residents and staff members. Resident went to another unit and called 911. Officers came to the facility. Resident stated he wanted to go to jail and continued to open lobby door. Police officer called medical transport and resident was sent to ER. RP and NP were notified. A Social Service note dated 13:39 on 08/10/20 indicated: IDT met to discuss resident's possible re-admission to facility and decided that a 30 day notice would be the safest option for the facility. Hospital notes indicate that resident is still exhibiting dangerous behaviors and psych concerns still persist even after medication adjustment. Resident made some alarming threats and put both himself and others in danger. 30 day notice was sent to the hospital, and two agency's. A Social Service note dated 13:39 on 08/10/20 indicated: IDT met to discuss resident's possible re-admission to facility and decided that a 30 day notice would be the safest option for the facility. Hospital notes indicate that resident is still exhibiting dangerous behaviors and psych concerns still persist even after medication adjustment. Resident made some alarming threats and put both himself and others in danger. 30 day notice was sent to the hospital, and two agency's. During an interview on 09/22/21 at 11:10 a.m. with the administrator he was asked why Resident #92 was not permitted to return to the facility? The Administrator stated, Resident #92 was a danger to himself and other residents. The Administrator stated, Resident #92 had attempted to set fire to the curtains in his room. When asked for documentation of Resident #92 attempting to set fire to the curtains, the administrator stated, he did not have any documentation to support the allegation. When asked for documentation of the Bed-Hold Notice provided to Resident #92, the administrator stated the resident voluntarily discharged himself from the facility and was not provided a Bed Hold Notice. During an interview on 9/22/21 at 11:29 a.m. with the Complainant, she stated, Resident #92 had appealed the facility's ruling and the facility still refused to re admit him. A review of Department of Medical Assistance Services Appeal Decision dated February 5, 2021 indicated the following: Issue - Nursing Home Discharge- Endangerment of Staff and Residents; Bed Hold Policy - Appeal filed August 14, 2020 Hearing Date December 16, 2020. Bed Hold - Notice on Bed Hold Policy and Readmission- Notice before transfer. Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning re-admittion to the facility immediately upon the first availability of a bed in a semiprivate room in the facility. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 10, 2020, the Appellant was involuntarily discharged from the Nursing Facility to the hospital for a psychiatric evaluation. As a Medicaid recipient who was discharged to a hospital for medical treatment, the Nursing Facility was required by law to provide the Appellant with bed hold policy and the opportunity to retain his bed at the Nursing Facility for re-entry. The evidence and testimony in the record shows that the Nursing Facility did not do so and never intended to allow the Appellant's readmission back into the Nursing Facility. This is evidenced by the fact that the Nursing Facility Representatives testified that the Appellant's readmission was denied due to his endangerment of the nursing facility staff and residents. There was evidence provided to show that the Appellant was in fact a danger to the nursing facility staff and residents in this matter. The facility did not comply with the required Bed hold regulations, and refused to the Appellant's lawful readmission into the Nursing Facility. The facility staff failed to provide Resident #92 with a Bed Hold policy or readmission to the facility. Compliant deficiency

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09546 Based on a closed record review, staff interviews, and a complaint investigation, the facility staff failed to re-admit one resident Resident # 92 in the survey sample of 42 residents after they were hospitalized . The findings included: Resident #92 had an original admitted [DATE]. Diagnoses included schizophrenia, anxiety, traumatic brain injury, benign prostatic hyperplasia, dementia, mood disorder, seizures, hypertension,muscle weakness, dysphagia. This resident was assessed on a quarterly Minimum Data Set (MDS) in the area of Cognitive Patterns as 15 on the BIMS assessment. This resident was assessed as requiring one person physical assist in the area of Activities of Daily Living (ADL's) in the area of transfer, dressing, personal hygiene and toileting. A Care plan dated 01/15/20 indicated: Focus- No plans to discharge. Goal- Participate in care decisions for long term stay. Interventions- Monitor for signs and symptoms of anxiety, distress, withdrawal or depression relating to not return to previous home environment. A Nursing Note dated 02:35 on 08/10/20 indicated: Resident became combative around 0145 threatening roommate waving walking cane in his roommates face. Turning up his radio loud, treating other residents and staff members. Resident went to another unit and called 911. Officers came to the facility. Resident stated he wanted to go to jail and continued to open lobby door. Police officer called medical transport and resident was sent to ER. RP and NP were notified. A Social Service note dated 13:39 on 08/10/20 indicated: IDT met to discuss resident's possible re-admission to facility and decided that a 30 day notice would be the safest option for the facility. Hospital notes indicate that resident is still exhibiting dangerous behaviors and psych concerns still persist even after medication adjustment. Resident made some alarming threats and put both himself and others in danger. 30 day notice was sent to the hospital, and two agency's. During an interview on 09/22/21 at 11:10 a.m. with the administrator he was asked why Resident #92 was not permitted to return to the facility? The Administrator stated, Resident #92 was a danger to himself and other residents. The Administrator stated, Resident #92 had attempted to set fire to the curtains in his room. When asked for documentation of Resident #92 attempting to set fire to the curtains, the administrator stated he did not have any documentation to support the allegation. During an interview on 9/22/21 at 11:29 a.m. with the complainant, she stated, Resident #92 had appealed the facility's ruling and the facility still refused to re admit him. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Department of Medical Assistance Services Appeal Decision dated February 5, 2021 indicated the following: Issue - Nursing Home Discharge- Endangerment of Staff and Residents - Appeal filed August 14, 2020 Hearing Date December 16, 2020. The Notice of Discharge stated a reason for discharge that was not supported by the evidence in the record, and it did not provide the required 30 days of notice for transfer or discharge. The Notice of Discharge states that discharge was for the health and safety of the residents and staff. That is not one of the permissible basis for discharge provided in the applicable regulation. Code of Federal Regulations, 42 CFR 483.15 (c) 1 (C) and (D). The transfer or discharge must documented in the resident's medical record by a physician and must include the basis for the discharge. 42 CFR 483.15 (c) (2). The Nursing Facility Representatives did not provide any evidence or testimony to show that the Appellant's attending physician or Nursing Facility's medical director had evaluated the Appellant and determined that discharge was necessary based on the reason for discharge stated in the Notice of Discharge. There was no signed medical records to establish whether the requirement for such documentation had been met. There was no evidence provided to show that the Appellant's attending physician or the Nursing Facility's medical director had evaluated the Appellant for his potential discharge, notated the Appellant's medical records, drafted medical orders for potential discharge. Accordingly, the Hearing Officer finds that the Nursing Facility's proposed discharge of the Appellant was not in compliance with the applicable law and policy requiring a physician's approval. The Nursing Facility failed to follow applicable law and policy for an involuntary discharge/transfer from the Nursing Facility. The Nursing Facility did not provide evidence to show a valid reason for involuntary discharge/transfer, did not provide adequate notice of discharge, did not provide evidence that the Appellant's physician or Nursing Facility's medical director had made a notation in the Appellant's record approving the discharge, and did not conduct a formal discharge planning meeting with the Appellant. Therefore, the Nursing Facility's proposal to involuntarily transfer/discharge the Appellant on August 10, 2020 was not in compliance with the applicable law and regulations. Complaint deficiency

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34896 Based on clinical record review, facility document review and staff interviews the facility staff failed to initiate a Level II Preadmission Screening and Annual Resident Review (PASARR) after a positive Level I PASARR screening was completed for 2 of 42 residents in the survey sample, Resident #21 and Resident #71. The findings included: 1. The facility staff failed to initiate a Level II PASARR for Resident #21 after a positive Level I PASARR screening was completed on 4/19/2017 Resident #21 was originally admitted to the facility on [DATE] with diagnoses to include but not limited to Dementia, Paranoid Schizophrenia, and Psychosis. Resident #21's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 9/7/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 00, indicating severe cognitive impairment and the inability to perform daily decision making. Resident #21's last comprehensive MDS was a Significant Change with an ARD of 5/21/21. Under Section A1500 Preadmission Screening and Resident Review (PASRR): Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? Resident #21 was coded as No. Resident #21's Level I PASARR screening completed on 4/19/2017 was reviewed and is documented in part, as follows: 2. Does this individual have a current serious mental illness? YES. a. Is this major mental disorder diagnosable under DSM-IV (Diagnostic and Statistical Manual of Mental Disorders); (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; personality disorder; other psychotic disorder; or mental disorder that may lead to chronic disability)? YES. b. Has the disorder resulted in functional limitations in major activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace: and adaptation to change? YES. c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? YES. 5. Recommendation: a; refer for secondary assessment. (NF(nursing facility) Placement =(equals) Level II refer to ASCEND. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Ascend: Company that provides onsite, independent PASARR level II mental health and intellectual/development evaluations. (https://www.dmas.virginia.gov/media/1294/virginia-pasrr-training). Resident #21's Progress Notes were reviewed and are documented in part, as follows: 9/22/2021 17:15 (5:15 p.m.), Social Service Progress Note: Documentation for PASARR update faxed to Name at Ascend this date. SS (Social Services) will assist as needed. 9/24/2021 14:02 (2:14 p.m.), Social Service Progress Note: Call rec'd (received) from VA(virginia) PASARR assessment screener requesting a Sunday at 10:00 a.m. visit for Name (Resident #21). Unit manager and Nurse on duty today made aware of tentative visit for resident Sunday. Contact information also provided in writing to nurse on duty this date. On 9/24/21 at 2:55 p.m., an interview was conducted with the facility Social Worker regarding Resident #21's Level I PASARR completed on 4/19/2017 and if a Level II PASARR was indicated. The Social Worker stated, Name (Resident #21) readmitted to the facility on [DATE]. I completed a Level I PASARR on 6/4/21 that indicated no Level II PASARR was required. However, during a re-audit of the resident's chart on 7/31/21 I found the PASARR dated 4/19/17 indicating a Level II. I did another Level I PASARR on 7/21/21 which also indicated a Level II needed to be completed. Name (Resident #21's) medical records were faxed to Ascend on 9/23/21. The Social Worker was asked why Ascend was just being notified on 9/23/21 when she found the Level I PASARR dated 4/19/17 on 7/21/21 indicating a Level II PASARR was needed. The Social Worker stated, I just got busy with other things that needed my attention and hadn't gotten back to working on it. On 9/30/2021 at 1:10 p.m., during an interview the Social Worker was asked what was the importance of the PASARR screening. The Social Worker stated, The PASARR ensures that individuals are provided with the disability services that they need, including rehabilitative and specialized services. The goal of the PASARR is to optimize each individual placement success, treatment and ultimately, the individual's quality of life. The facility policy titled Resident Assessment-Coordination with PASARR Program was reviewed and is documented in part, as follows: Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I-initial pre-screening that is completed prior to admission. ii. Positive Level I Screen-necessitates a PASARR Level II evaluation prior to admission. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. PASARR Level II- a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has mental disorder, intellectual disabilities, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority. On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. 2. The facility staff failed to initiate a Level II PASARR for Resident #71 after a positive Level I PASARR screening was completed on 7/16/2021 Resident #71 was admitted to the facility on [DATE] with diagnoses to included but not limited to Dementia, Bipolar Disorder, Anxiety Disorder and Dementia. Resident #71's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/27/21. Resident #71's Brief Interview for Mental Status (BIMS) was coded as a 01, indicating severe cognitive impairment and the inability to perform daily decision making. Resident #71's Level I PASARR screening completed on 7/16/2021 by the current Social Worker was reviewed and is documented in part, as follows: 2. Does this individual have a current serious mental illness? YES. a. Is this major mental disorder diagnosable under DSM-IV (Diagnostic and Statistical Manual of Mental Disorders); (e.g., schizophrenia, mood, paranoid, panic, or other serious anxiety disorder; personality disorder; other psychotic disorder; or mental disorder that may lead to chronic disability)? YES. b. Has the disorder resulted in functional limitations in major activities within the past 3-6 months, particularly with regard to interpersonal functioning; concentration, persistence, or pace: and adaptation to change? YES. c. Does the treatment history indicate that the individual has experienced psychiatric treatment more intensive than outpatient care more than once in the past 2 years or the individual has experienced within the last 2 years an episode of significant disruption to the normal living situation due to the mental disorder? NO. 5. Recommendation: a; refer for Level II evaluation (NF Placement = Level II refer to ASCEND. Resident #71's Social Service Progress Notes were reviewed for any entries regarding a Level I PASARR, a Level II PASARR, or any notification to Ascend. No entries were identified in Resident #71's clinical record. (continued on next page)

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Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/21 at 2:55 p.m., an interview was conducted with the facility Social Worker regarding Resident #71's Level I PASARR completed on 7/16/2021 and if a Level II PASARR was indicated. The Social Worker stated, Name (Resident #71's) chart was audited on 7/16/21 and I discovered there was no Level I PASARR uploaded in the clinical record. I completed a Level I PASARR on 7/16/21 that indicated a Level II PASARR was required. During a re-audit of the Name (Resident #71's) chart on 7/23/21 I noted that the medical records had not been sent to Ascend. Name (Resident #71's) medical records were faxed to Ascend on 9/23/21. The Social Worker was asked why Ascend was just being notified on 9/23/21 when the Level I PASARR she completed on 7/16/21 indicated that a Level II PASARR was needed. The Social Worker stated, I just got busy with other things that needed my attention and hadn't gotten back to working on it. On 9/30/2021 at 1:10 p.m., during an interview the Social Worker was asked what was the importance of the PASARR screening. The Social Worker stated, The PASARR ensures that individuals are provided with the disability services that they need, including rehabilitative and specialized services. The goal of the PASARR is to optimize each individual placement success, treatment and ultimately, the individual's quality of life. On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34896 Based on clinical record review, facility document review and staff interviews the facility staff failed to revise a care plan to include an indwelling foley catheter upon re-admission for 1 or 42 residents in the survey sample, Resident #21. The findings included: The facility staff failed to revise Resident #21's care plan upon re-admission to the facility on [DATE] for 21 days to include an indwelling foley catheter. Resident #21 was readmitted to the facility on [DATE] with diagnoses to include but not limited to Urinary Tract Infection, and Stage 3 Chronic Kidney Disease. Resident #21's most recent comprehensive Minimum Data Set (MDS) was a Significant Change with an Assessment Reference Date (ARD) of 5/21/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 02, indicating severe cognitive impairment and the inability to perform daily decision making. Under Section H - Bladder and Bowel H0100 Appliances; A. Indwelling catheter (including suprapubic catheter and nephrostomy tube), Resident #21 was coded as: Yes. H0300. Urinary Continence; Urinary continence - Select the one category that best describes the resident. Resident #21 was coded as: 3. Always incontinent. The following observations were made of Resident #21's indwelling foley catheter: On 09/20/21 at 8:00 p.m., Resident noted to have intact foley catheter, draining clear yellow urine. On 09/21/21 at 10:38 a.m., Resident has indwelling foley catheter in place and covered with privacy bag, Catheter care being performed by Certified Nursing Assistant with no issues noted. On 09/22/21 at 1:00 p.m., Resident's indwelling foley catheter in place, privacy maintained, and draining clear urine. Resident #21's Admission/Re-Admission Screening Assessment completed By Licensed Practical Nurse (LPN) #4 dated 9/1/21 at 3:53 p.m., was reviewed and is documented in part, as follows: SECTION I. Bladder/Bowel 34. Bladder: a. Residents Continence Status: 7. admitted with Catheter. CATHETER d. Catheter Type/Size: foley 16fr (french) 10cc. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #21's Progress Notes were reviewed and are documented in part, as follows: 9/1/2021 15:58(3:58 p.m.) Nursing Progress Note: Patient admitted to facility from Hospital dx (diagnosis): septic shock d/t (due to) complicated UTI (urinary tract infection). Patient has a 16fr 10cc foley catheter r/t (related to) urinary retention. All orders verified by provider. On 9/23/21 at 12:28 p.m., an interview was conducted with LPN #4, who was the admitting nurse for Resident #21 on 9/1/21. LPN #4 was asked is she updated/revised Resident #21's care plan to include the indwelling foley catheter that was present on re-admission. LPN #4 stated, No, I have never been educated on who does or that I was to update the care plan. I really thought management would follow-up with the foley and add it to his care plan. Resident #21's comprehensive care plan was reviewed and is documented in part, as follows: Focus: The resident has Indwelling Catheter: related to obstructive uropathy and places him at risk for complications. Date Initiated: 9/22/2021 Created on: 9/22/2021 Interventions: Check tubing for kinks each shift and as needed. Date Initiated: 9/22/2021. Foley cath care as needed and ordered including positioning and securing. Date Initiated: 9/22/2021. Monitor/document for pain/discomfort due to catheter. Date Initiated: 9/22/2021. Monitor/record/report to Medical Doctor for signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated: 9/22/2021. On 9/23/21 at 2:00 p.m., an interview was conducted with the Regional Director of Operations. The Regional Director of Operations was asked who in the facility is responsible for revising a resident's care plan if there is a change upon re-admission. Regional Director of Operations stated, The Charge Nurse should update the care plan if there are changes. On 9/29/21 at 4:11 p.m. an interview was conducted with the Regional Director of Clinical Services and the above information was share. The Regional Director of Clinical Services was asked when should a resident care plan be revised and who in the facility was responsible to revise it if there is a change upon re-admission. The Regional Director of Clinical Services stated, The care plan should be revised whenever there is a change with the resident, quarterly and annually. Upon re-admission the clinical staff should update the care plan within 24 hours. Name (Resident #21's) foley catheter should have been updated on his care plan when he was recently readmitted . The facility policy provided for Care Plan Revision is the Resident Assessment Instrument (RAI) 4.7: The RAI and Care Planning which was reviewed and is documented in part, as follows: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving. On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to monitor daily weights per physician's orders for 1 of 42 residents (Resident #22) in the survey sample. The findings included; Resident #22 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). In section G(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing. The Care Plan dated 5/23/21 reads: FOCUS: The resident has nutritional problems or potential nutritional problems r/t Diet restrictions, mechanically altered diet, weight loss. Goals: The resident will tolerate diet and have no significant gain/loss through review date. Interventions: Observe/report to MD (Medical Doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition: Emaciation, muscle wasting, significant weight loss: 3lbs in 1 week, greater than 5% in 1 month, greater than 7.5% in 3 months, greater than 10% in 6 months. MAR (Medication Administration Record) reads: weekly weights one time a day every Wed -Start Date 10/14/2020 at 9:00 AM. MAR (11/2020). Weights not recorded. MAR (12/2020) Weights not recorded. The following weights were recorded in the clinical record under weights. 10/7/2020 152.8 1bs. 11/15/20 135 lbs. 12/03/20 135.2 lbs. 12/8/21 135.2 lbs. The above recorded weights were not consistent with the ordered weekly weights. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of resident's weight from October 7, 2020 (152.8 lbs) to November 15, 2020 (135.0 lbs.) Resident has lost 17.8 lbs. According to the complainant the resident had a significant amount of weight loss. The weekly ordered weights were not consistent from 10/07/20-11/15/20 Resident lost 17.8 lbs. A review of clinical progress notes show no documentation proving the POA (Power of Attorney) or family member were notified of the 17.8 lbs. weight loss. Review of progress note dated on 11/20/2020 at 9:43 AM from NP (Nurse Practitioner) reads: CC: Weight loss. This is an [AGE] year old who is residing on Memory Unit for LTC (Long Term Care). She was seen recently due to report of abnormal weight loss and poor appetite. Her weight is down to 135# this month, 152. 8 # in October. She is seen today to follow up on lab results. A review of progress notes dated 11/18/2020 13:09 (1:09 PM). Progress Notes reads: CC: Weight loss. She is seen today due to report of abnormal weight loss. Her weight is down to 135# this month, 152.8 # in October. Staff report poor intake, about 25% at meals. No report of diarrhea or GI symptoms. She is a poor historian due to dementia. She says she is alright and denies pain or difficulty breathing. She is c/o feeling cold. Weight loss: possible etiologies-thyroid dysfunction, progressing dementia, or depression. Start Eldertonic 15 ml BID. Monitor weight. Weight warning trigger: 11/16/2020 15:31 Nutrition Note Text: WEIGHT WARNING: 135 lbs. A review of Progress notes dated 11/15/2020 read: RD (Registered Dietician) weight review; resident displays significant weight loss; Re-weigh to verify weight; weekly weights x 1 mo, RD to f/u PRN; RDN. A review of the clinical record dated 11/24/2020 at approximately 9:27 AM reveal that Resident's daughter spoke to staff about concerns about her mother's/resident's condition days after she was noted to have significant weight loss. On 9/23/21 at approximately 2:00 PM an interview was conducted with the District Dietary Manager/OSM (Other Staff Member) #6. He stated, A lot of it has to do with her decline with dementia. Her weight has been stable through 6 months. They had a staff member not putting down the proper weights. We found out that she wasn't weighing the resident. Nursing should notify the family of weight loss issues. Quarterly nutrition report completed. On 9/23/21 at approximately 12:10 PM an interview was conducted with resident's daughter. She stated, We received no calls about her weight loss or her not being able to walk. I spoke to the DON (Director of Nursing) and explained the weight concern she stated they would call me every Monday with weights. On 9/23/21 at approximately 12:00 PM a telephone interview was conducted with the Registered Dietician/OSM #2 concerning Resident # 22. She stated, The weights aren't consistent especially since COVID19. I brought it up a few times with the dietary managers. They had gotten better since the new DON came. Mostly from staff shortage. In my note she stabilized (weight) and was at a relative stable weight. I recommended fortified foods because sometimes her po (by mouth) intake is poor. She's now on weekly weights. She was on Remeron for a while for her appetite. House shakes 3 times a day. I also recommended they give her calorie dense snacks. Usually the DON's would call the family members. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. This is a complaint deficiency

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, staff interview, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain assistive devices to include hearing aids and dentures for 1 of 42 residents (Resident #22) in the survey sample. Resident #22 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Diagnosis for Resident #22 included but not limited Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/17/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). In section G(Physical functioning) the resident was coded as extensive assistance of one person with bed mobility, dressing and locomotion on and off the unit. Requiring extensive assistance of two persons transfers. Requiring supervision set-up help with eating and requiring totals dependence of one person with toileting, personal hygiene and bathing. The careplan dated 01/09/20 Reads: ADL (Activity of Daily Living) self-care performance deficit relating to dementia. Goals: The resident will maintain current level of function through the review date. Interventions: Honor resident's preference for rising, going to bed, bathing/showering. The resident is totally dependent on staff for bathing needs. Physician Order Summary dated 1/09/20 reads: Place bilateral hearing aids in resident ears every morning. Physician's Order Summary Dated 1/08/20 reads: Remove Dentures (top & bottom) at bedtime & lock in nurse cart. MAR (Medication Administration Record) reads: Place bilateral hearing aids in resident ears every morning. One time a day for hearing impaired -Start Date 01/09/2020 0900 (9:00 AM.) A review of the MAR for November 2020 reads: Place bilateral hearing aids in resident ears every morning. One time a day for hearing impaired. A review of the MAR for September show that staff placement of the hearing aids were completed. The date in question 11/23/21 when family visited was also checked off as completed. MAR for November 2020 reads: Performed Oral & Denture (top & bottom denture) care every morning. A review of the September 2021 MAR reveal that staff checked off Yes for placement of hearing aids on the following dates: 9/05/21 and 9/06/21. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MAR reads: Performed Oral & Denture (top & bottom denture) care every morning in the morning -Start Date 01/09/2020 0800 (8:00 AM). A review of the September 2021 MAR reveal that staff performed oral and denture care every day except on 9/25/21. A review of the MAR notes reveal the following: 9/25/2021 23:24 (11:24 PM) Medication Administration Note: Remove bilateral hearing aid out of resident in ear at bedtime & lock in nursing cart at bedtime for hearing impaired. N/A (Not Applicable). 9/25/2021 10:32 AM Medication Administration Note: Performed Oral & Denture (top & bottom denture)care every morning. Unable to locate dentures. 9/24/2021 22:29 (10:29 AM) Medication Administration Note: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime No denture in resident's mouth. 9/24/2021 22:27 (10:27 PM) Medication Administration Note: Remove bilateral hearing aid out of resident in ear at bedtime & lock in nursing cart at bedtime for hearing impaired one hearing in the narcotic box. 9/24/2021 9:51 AM-Medication Administration Note: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired not available. 9/10/2021 10:24 PMMedication Administration Note Text: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime. No dentures in the nursing cart. 9/9/2021 10:02 AM Medication Administration Note: Place bilateral hearing aids in resident ears every morning. one time a day for hearing impaired. due to behavior of taking them out and putting them in random places only one remains. 12/4/2020 11:31 PM -Medication Administration Note Text: Remove Dentures (top & bottom) at bedtime & lock in nurse cart at bedtime. Only top denture collected from resident. No bottom denture. A review of the Complaint/Grievance Report dated 3/23/21 reads: During the last recent in person visits on 3/19/21 and 3/20/21 resident had no dentures or hearing aid. Family requested resident to have daily. Family upset. No management to assist with concerns. Investigations: Hearing aides were being kept on medication cart when not in use. Dentures and hearing aids have both been missing for an unknown amount of time. Reviewed complaint/grievance report dated 3/23/21 filed by son and communicated to Social Services. Concern: During last recent in person visits on 3/19/21 and 3/20/21 resident had no dentures or hearing aid. Family requested resident to have daily. Findings: Hearing aids were being kept on medication cart when not in use. Dentures and hearing aids have been missing for an unknown amount of time. Plan: Facility to acquire contract with senior well that offers dental and audiology services for residents. Resolution: Follow-up needed. Remarks: Missing items are a continuous issue for this family and son is weary about replacement dentures. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of progress notes read: 11/27/2020 11:47 Nursing Progress Note: CNA placed residents upper and lower dentures in her mouth this shift. Resident removed her bottom dentures/misplaced them. Hearing aids are in place. Resident met with family this shift through window visit. No concerns noted at this time. Will inform oncoming staff of misplaced bottom dentures. 11/24/2020 09:27 Progress Note: This LPN (Licensed Practical Nurse) spoke with daughter, her concerns was resident didn't have dentures, hearing aids, hair and nail cut. Also not knowing her mother is w/c (wheel chair) bound and incontinent. I re-educated her on resident condition and that we will make sure on her mother is will groom on a daily basis. On 09/21/21 at approximately 2:12 PM Resident #22 was observed sitting in her wheel chair in the activity room. Well groomed, hair combed, finger nails trimmed and clean, clothing clean and without body odor. CNA #1 was asked if Resident was wearing her dentures at the moment. She stated, She's not wearing her dentures. On 9/22/21 at approximately 10:25 AM., Resident #22 was observed sitting at the table in the activities room engaged in activity. No dentures were intact. No hearing aids was intact. Resident was well groomed, wearing clean clothing, hair combed, finger nails clean. No body odor was present. On 9/22/21 at approximately 10:30 AM an interview was conducted with CNA #1 concerning Resident #22. She stated, She will take out her dentures. On 9/22/21 at approximately 7:10 PM- an interview was conducted with LPN (Licensed Practical Nurse) #6 concerning Resident #22's dentures. She stated, I haven't seen her dentures in her mouth in a couple of weeks. A medication cart audit was conducted by LPN #6. No dentures were found. She was able to locate 1 hearing aide. On 9/23/21 at approximately 8:25 AM an interview was conducted with CNA (Certified Nursing Assistant) #10 concerning Resident #22. He stated, Her dentures should be taken out at night and soaked. They should be left on the sink. Her hearing aid should be locked in the medication cart before she goes to bed. On 9/23/21 at approximately 9:35 AM an interview was conducted with CNA (Certified Nursing Assistant) #1 concerning Resident #22. She stated, She gets her hair washed on shower days. She doesn't have any dentures. When she did she would take them out. She gets her showers on the 3-11 shift when she doesn't refuse them. She's a picky eater on a puree diet. On 9/23/21 Resident observed in Activity room at 9:40 AM. No dentures intact. A review of Social worker progress notes dated 9/28/21 at 12:22 PM reads: Called son to inform of Ear, Nose, Throat appointment for Resident's hearing aids. No answer. Message left on VM (Voice Mail)to return call back re: appointment. Medical Records called to schedule transportation for appointment. To soon to schedule transportation. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/23/21 at approximately 12:44 PM an interview was conducted with Resident #22's son concerning her dentures and weight loss. He stated, I never saw her pull them out (her dentures) nor the hearing aids. Not wearing the dentures makes her face sunken in. Constant lack of not shaving her.(Whiskers on her face). The dietician would talk about her weight loss at the quarterly meetings. Received Investigation document dated on 9/24/21 on 9/27/21 from Social Worker (OSM/Other Staff Member) #8. It reads as follows: During investigation one hearing aid is in place. No dentures found. Appointment was scheduled October 7, 2021 @10:00 AM with Affordable Dentures. Resident's son was called and informed of upcoming appointment. Reached out to ENT (Ear, Nose and Throat) on 9/24/21 office was closed. Will follow up on Monday September 27, 2021 to schedule an appointment. On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, and Corporate Staff Members. An opportunity was offered to the facility's staff to present additional information but no additional information was provided. This is a complaint deficiency

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34896 Based on clinical record review, facility document review and staff interviews the facility staff failed to obtain physician orders upon re-admission for an indwelling foley catheter for 1 or 42 residents in the survey sample, Resident #21. The findings included: The facility staff failed to obtain physician orders for an indwelling foley catheter for Resident #21 for 21 days upon re-admission to the facility on [DATE]. Resident #21 was readmitted to the facility on [DATE] with diagnoses to include but not limited to Urinary Tract Infection, and Stage 3 Chronic Kidney Disease. Resident #21's most recent comprehensive Minimum Data Set (MDS) was a Significant Change with an Assessment Reference Date (ARD) of 5/21/21. Resident #21's Brief Interview for Mental Status (BIMS) was coded as a 02, indicating severe cognitive impairment and the inability to perform daily decision making. Under Section H - Bladder and Bowel H0100 Appliances; A. Indwelling catheter (including suprapubic catheter and nephrostomy tube), Resident #21 was coded as: Yes. H0300. Urinary Continence; Urinary continence - Select the one category that best describes the resident. Resident #21 was coded as: 3. Always incontinent. The following observations were made of Resident #21's indwelling foley catheter: On 09/20/21 at 8:00 p.m., Resident noted to have intact foley catheter, draining clear yellow urine. On 09/21/21 at 10:38 a.m., Resident has indwelling foley catheter in place and covered with privacy bag, Catheter care being performed by Certified Nursing Assistant with no issues noted. On 09/22/21 at 1:00 p.m., Resident's indwelling foley catheter in place, privacy maintained, and draining clear urine. Resident #21's Admission/Re-Admission Screening Assessment completed By Licensed Practical Nurse (LPN) #4 dated 9/1/21 at 3:53 p.m., was reviewed and is documented in part, as follows: SECTION I. Bladder/Bowel 34. Bladder: a. Residents Continence Status: 7. admitted with Catheter. CATHETER d. Catheter Type/Size: foley 16fr (french) 10cc. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/22/21 Resident #21's clinical record was reviewed. During the clinical record review no physician orders for Resident #21's indwelling foley catheter or the care of the indwelling catheter were identified. Resident #21's Progress Notes were reviewed and are documented in part, as follows: 9/1/2021 15:58(3:58 p.m.) Nursing Progress Note: Patient admitted to facility from Hospital dx (diagnosis): septic shock d/t (due to) complicated UTI (urinary tract infection). Patient has a 16fr 10cc foley catheter r/t (related to) urinary retention. All orders verified by provider. 9/2/2021 06:49 a.m. Nursing Progress Note: Foley cath (catheter) intact, draining clear yellow urine. Output 700ml (milliliters). 9/3/2021 14:13 (2:13 p.m.), Nursing Progress Note: Foley draining clear, straw-colored urine. No foul odor or sediment noted. Urine output this shift 750mls. 9/8/2021 11:41 a.m., Nursing Progress Note: Foley draining clear, straw-colored urine. 9/15/2021 22:50 (10:50 p.m.), Nursing Progress Note: Resident foley catheter patent and flowing clear yellow, odorless urine. 9/21/2021 13:27 (1:27 p.m.), Nursing Progress Note: Foley draining clear, straw-colored urine with small amounts of sediment. On 9/23/21 at 12:28 p.m., an interview was conducted with LPN #4, who was the admitting nurse for Resident #21 on 9/1/21. LPN #4 was asked if Resident #21 was readmitted on [DATE] with an indwelling foley catheter and if so did she obtain physician orders for the catheter. LPN #4 stated, Yes, I put that he had a foley on the admission assessment and I documented the foley in my admission nurses note. I assessed the patient upon admission and then I check the discharge summary for the orders. The foley was not mentioned in the discharge orders, but I knew he had a foley before looking at them. I remember telling the Nurse Practitioner (NP) that he had a foley. I just forgot to write the order for the foley. This was my first time doing an admission here and I wasn't sure how the foley orders were to be written. I called the NP and put the catheter orders in today. Resident #21's Physician Orders were reviewed and are documented in part, as follows: Order Date: 9/22/21 Order Summary: Foley catheter used for obstructive uropathy 16 Fr 10 cc balloon. On 9/29/21 at 4:10 p.m. an interview was conducted with the Regional Director of Clinical Services regarding what the expectation was for staff when verifying and transcribing admission orders. The Regional Director of Clinical Services stated, After doing the physical assessment and reviewing the discharge summary the nurse is expected to enter the orders accurately after verifying them with the physician. If a foley catheter was noted upon assessment the nurse needs to contact the physician to see if the foley is necessary and write the order. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy titled Admission Orders dated 11/1/21 was reviewed and is documented in part, as follows: Policy: A physician, physician assistant, nurse practitioner or clinical nurse specialist must provide orders for the residents' immediate care and needs. Policy Explanation and Compliance Guidelines: 1. The written orders should include at a minimum: c. Routine care orders. 2. The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission. On 9/30/21 at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09546 Based on record review and staff interviews the facility staff failed to provide physician services for two residents in the survey sample (Residents #28 and #83) of 42 residents. The findings included: 1. Resident #83 was admitted to the facility on [DATE] with diagnoses which included atherosclerotic heart disease, benign prostatic hyperplasia, transient cerebral ischemic attack, dysphagia, muscle weakness and dementia. A 9/2/21 Quarterly Minimum Data Set (MDS) indicated this resident was not able to be coded in the Cognitive Pattern area for Brief Interview for Mental status. This resident required extensive assistance in all areas of Activities of Daily Living. A review of a Care Plan dated 08/02/21 indicated: Focus- Resident is on antibiotic therapy due to infection. Goal- Resident will be free of any discomfort or adverse side effects of antibiotic therapy. Interventions- Administer Antibiotic medication as ordered by physician. Monitor/document side effects and effectiveness Q-shift. Focus- Resident has dehydration or potential fluid deficit r/t- Goal- The resident will be free of symptoms of dehydration and maintain moist mucous membranes, good skin turgor. Interventions- Administer medications as ordered. Monitor/document for side effects and effectiveness. Monitor vital signs as ordered/per protocol and record. Notify MD of significant abnormalities. A review of the clinical records indicated the physician's last visited Resident #83 on 5/14/21. During an interview on 09/30/21 at 7:15 P.M. with Regional Nurse Consultant she stated, the physician's Nurse Practitioner had been visiting the resident. The facility staff failed to ensure physician visits were conducted in a time manner. 40711 2. For Resident #28, the facility staff failed to provide physician visits in a timely manner during the month of June 2021. Resident #28 was originally admitted to the facility 9/14/17 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified and Muscle Weakness. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 07/18/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #28 cognitive abilities for daily decision making were intact. In section G(Physical functioning) the resident was coded as requiring supervision after set-up only with bed mobility, transfers, locomotion, dressing, eating, toileting, personal hygiene and bathing June 2021. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's clinical record show that NP (Nurse Practitioner) visits were conducted on the following dates: 5/05/21, 6/14/2021, 6/18/21. A review of the clinical record show that Physician visits were conducted on the following dates: 7/08/21, 7/27/21, 8/03/21 and 9/23/21. A review of the clinical record showed that no physician visits were conducted for the month of June 2021. On 09/30/21 at approximately 6:20 p.m., the above findings were shared with the Administrator, The Interim Director of Nursing, The Regional Director of Clinical Services and The Regional Director of Operations. The Regional Director of Operations stated, The Physician Visits are still under a waiver.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37828 Based on staff interviews and facility information, the facility staff failed to staff a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The findings included: During review of the facility's staffing for RN coverage in a 60-day lookback revealed the facility did not provide 8 consecutive hours of RN coverage on the following days: 08/07/21, 08/08/21, 08/21/21, 08/22/21 and 09/18/21. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator who were informed that the facility did not have 8 consecutive hours of RN coverage on the days mentioned above. The administration team did not have any further questions or present any information about the findings. An interview was conducted with the Administrator on 09/30/21 at approximately 2:27 p.m., who stated, I expect RN coverage 8 hours a day, 7 days a week. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the pre-exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. The facility's policy titled Nursing Services-Registered Nurse (RN) revision date: 10/28/20. Under policy included the intent of the facility to comply with Registered Nurse staffing requirements. Policy Explanation and Compliance Guidelines: 1. The facility will utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days per week.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 37828 Based on extended survey task, staff interview and documentation review the facility staff failed to ensure 3 out of 3 Certified Nursing Assistant (CNA) received their required 12 hours of mandatory annual competencies and 1 out of 3 CNA's completed her mandatory Dementia training. The findings included: On 09/22/21 at approximately 8:58 a.m., the surveyor requested evidence that CNA #7, CNA #11 and CNA #12 received their required 12 hours of mandatory annual competencies to include abuse and dementia training. The Admission Coordinator presented the list of Yearly Competency Training completed on 08/17/21. The training showed zero (0) hours. The competency training consisted of the following training: -Shower/Tub Bath -Nail Grooming -Oral Care -Elastic Stocking (Ted Hose) -Height & Weight -Vital Signs -Sit to Stand Lift / bedside to wheel chair -Positioning -SWAT-Full Body Lift (bed to wheel chair) -Catheter care -Perineal Care Male and Female -Heimlich maneuver -Hand washing -Intake/output -Personal protective equipment (PPE) (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/29/21 at approximately 1:16 p.m., an phone interview was conducted with the Staff Development Coordinator who said she was not able to locate the 12 hours of mandatory annual competencies on the three (3) CNA's requested and was not able to provide the mandatory dementia training for CNA #12. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the pre-exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. The facility's policy titled Continuing Education - revision date 10/28/20. Compliance with the facility's standards, policies, and procedures is a condition of employment. This includes compliance with the policies and procedures of the facility's training program. Policy Explanation and Compliance Guidelines: 1. All levels of employees are expected to complete required training within designated time frames.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09546 Based on facility policy, and staff interview, the facility staff failed to have a governing body of persons to ensure policies regarding the management and operations of the facility during COVID-19 outbreak. The findings included: The facility staff failed to conduct and document a facility wide assessment to determine what resources were necessary to assist in the prevention of the spread of COVID -19. The facility staff failed to use outside resources including the Local Health Department during a Major COVID-19 outbreak in the facility. During interaction with the Administrator and Infection Preventionist from [DATE] through [DATE] resulted in the facility's inability to provide COVID-19 cumulative data (total of COVID-19 positive residents/staff, number of residents/staff hospitalized COVID-19 related, number of resident/staff deaths, current number of quarantined resident/staff and number of affected residents/staff that were vaccinated since the outbreak began and currently) for the facility. A review of the data presented to the survey team on [DATE] indicated: 53 residents were identified with COVID-19. No information was provided as to how many residents were sent to the hospital. Nine residents were identified who expired from COVID-19. Eight staff were identified as COVID-19 positive. One staff was identified as out of work on quarantine. One resident was identified as never returned to work. One resident was identified who expired from COVID-19. During an interview on [DATE] at 3:30 P.M. with the Administrator and Infection Preventionist they were asked if the facility staff had reached out to the local Health Department for assistants and guidance. The Administrator stated, the facility had not. A [DATE] Local Health Report on the facility after an unannounced visit indicated: As of 9:30 am [DATE] we have had notification form the local hospital of 11 total admissions since [DATE] and 4 known deaths among patients arriving from the facility. A determination was made for an immediate visit was necessary to: 1. Assess status of patients regarding numbers currently ill 2. Determine vaccination status of patients and staff 3. Assess staffing and medical coverage 4. Explore PPE use and availability; assist with procuring additional if needed (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Based on the number of patients ill, determine what, if any cohorting possibilities there are within the facility that could help limit transmission 6. Look at any other mitigation strategies the IP and epi team believe could help It was also determined that Local Health Department staff touch base with the facility's corporate office to let them know of our concerns and request their engagement. A CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes dated [DATE] indicated: Notify HCP (Health Care Professionals), Residents, and families about Outbreaks, and Report SARS-COV-2 Infections, Facility staffing, Testing, and Supply Information to Public Health Authorities Notify the health department promptly about the following: c 1 residents or HCP with suspected or confirmed SAR-Cov-2 infection c Resident with severe respiratory infection resulting in hospitalization or death c 3 residents or HCP with acute illness compatible with COVID-19 with onset within 72 hour period. Find the contact information for the healthcare-associated infections program in your state health department, as well as your local health department. Notify HCP, residents and family's promptly about identification of SARS-Cov-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions. Report SARS-Cov-2 infections, facility staffing and supply information, and point of care testing data to the National HealthCare Safety Network (NHSN) Long term Care Facility (LTCF) COVID-19 Module weekly. CDC NHSN provides long term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way. Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements. Professional Resources: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html A review of the Facility Assessment policy dated [DATE] indicated: 2. The facility assessment is completed at the facility level utilizing the following individuals: a. Administrator b. A representative from the governing body c. The Medical Director d. The Director of Nursing A review of the Governing Body Policy dated [DATE] indicated: (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The governing body is responsible and accountable for the Quality Assurance and Performance Improvement (QAPI) program/Quality Assurance (QA).

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09546 The facility staff failed to conduct and document a facility wide assessment to determine what resources were necessary to assist in the prevention of the spread of COVID -19. The findings included: The facility staff failed to use outside resources including the Local Health Department during a Major COVID-19 outbreak in the facility. The level of Community Transmission was noted to be high (Red). Upon entering the facility the Director of Nursing stated the facility was experiencing a major COVID outbreak. During the entrance conference the Administrator was asked how many COVID -19 positive residents and staff did the facility have. The Administrator stated there were 36 residents in the facility with COVID-19. On [DATE] the survey team was present with the 802 Resident matrix that coded three residents with COVID in the Infections section. On [DATE] the Infection Preventionist presented to the survey team with a list of residents on the 802 Resident matrix that totaled 21 residents with COVID -19. On [DATE] the Administrator presented to the survey team an 802 Resident matrix with 24 residents. During interaction with the Administrator and Infection Preventionist from [DATE] through [DATE] resulted in the facility's inability to provide COVID-19 cumulative data (total of COVID-19 positive residents/staff, number of residents/staff hospitalized COVID-19 related, number of resident/staff deaths, current number of quarantined resident/staff and number of affected residents/staff that were vaccinated since the outbreak began and currently) for the facility. A review of the data presented to the survey team on [DATE] indicated: 53 residents were identified with COVID-19. No information was provided as to how many residents were sent to the hospital. Nine residents were identified who expired from COVID-19. Eight staff were identified as COVID-19 positive. One staff was identified as out of work on quarantine. One resident was identified as never returned to work. One resident was identified who expired from COVID-19. A review of the facility's COVID-19 Action Plan stated there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an Isolation/Hot Unit for COVID-19 positive Unit. The facility had only one general well unit, one well memory unit, one well/COVID-19 positive memory unit and a full COVID-19 positive unit. The facility staff failed to follow CDC guidance to ensure Health Care Personal (HCP) to include contract, agencies and vendors required COVID-19 testing was completed based on the level of community transmission and the results of each test was documented. As a result of the non-compliance with testing while the facility was in a major COVID-19 outbreak there had been further transmission, hospitalization s and deaths. (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE], staff testing was observed and the documentation of the testing was reviewed. The Infection Preventionist stated testing for staff was two times weekly (Tuesday and Thursday). Review of those listed as tested revealed no documentation of their test results. The Infection Preventionist stated that indicated the results were negative. The results remained undocumented. The Infection Preventionist was not able to provide how the facility HCP's met the requirements to be tested based on the level of community transmission. In accordance to CDC guidance the Facility's Assessment Program failed infection control measures and practices during a major outbreak to prevent further transmission of COVID-19: 1. Entry Notification/Visitation 2. PPE usage during major outbreak 3. COVID-19 surveillance plan 4. Unit set up in accordance with CDC Guidelines and facility policies and procedures During an interview on [DATE] at 3:30 P.M. with the Administrator and Infection Preventionist they were asked if the facility staff had reached out to the local Health Department for assistants and guidance. The Administrator stated, the facility had not. A [DATE] Local Health Report on the facility after an unannounced visit indicated: As of 9:30 am [DATE] we have had notification form the local hospital of 11 total admissions since [DATE] and 4 known deaths among patients arriving from the facility. A determination was made for an immediate visit was necessary to: 1. Assess status of patients regarding numbers currently ill 2. Determine vaccination status of patients and staff 3. Assess staffing and medical coverage 4. Explore PPE use and availability; assist with procuring additional if needed 5. Based on the number of patients ill, determine what, if any cohorting possibilities there are within the facility that could help limit transmission 6. Look at any other mitigation strategies the IP and epi team believe could help It was also determined that Local Health Department staff touch base with the facility's corporate office to let them know of our concerns and request their engagement. A CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes dated [DATE] indicated: Notify HCP (Health Care Professionals), Residents, and families about Outbreaks, and Report SARS-COV-2 Infections, Facility staffing, Testing, and Supply Information to Public Health Authorities (continued on next page)

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	495150	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Notify the health department promptly about the following: c 1 residents or HCP with suspected or confirmed SAR-Cov-2 infection c Resident with severe respiratory infection resulting in hospitalization or death c 3 residents or HCP with acute illness compatible with COVID-19 with onset within 72 hour period Find the contact information for the healthcare-associated infections program in your state health department, as well as your local health department. Notify HCP, residents and family's promptly about identification of SARS-Cov-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions. Report SARS-Cov-2 infections, facility staffing and supply information, and point of care testing data to the National HealthCare Safety Network (NHSN) Long term Care Facility (LTCF) COVID-19 Module weekly. CDC NHSN provides long term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way. Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements. A review of the facility's COVID-19 Action Plan dated [DATE] indicated: COVID Response Plan 1. There will be 3 units set for resident populations in accordance with CDC Guidelines 2. Well/Cool Unit 3. Quarantine/Warm Unit- for new admission and readmissions 4. Isolation/Hot Unit-COVID-19 Positive Residents 5. Goals: All residents will remain free from complications related to the COVID-19 pandemic Reduce the transmission of the COVID-19 Virus A Facility assessment dated [DATE] indicated: The facility must conduct and document a facility -wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for any changes that would require a substantial modification to any part of this assessment. The facility assessment must address or include: (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. The facility's resident population, including, but not limited to, (ii) The care required by the resident's population considering the type of diseases 2. The facility's resources\, including but not limited to, (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; Additional References to the Facility Assessment: Infection Control- 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: (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 and following accepted national standards. In the area of Special Treatments/Resident Care Needs: Special Services- Transmission Based Precautions (Isolation) zero (0) was indicated in the average number of resident's per-month column. In the Facility Assessment Section 3.11- indicated: The facility's infection control program is monitored and reviewed at the monthly QAPI meeting. The QAPI team reviews metrics and trends to evaluate the infection prevention and control program as well as monitor effective systems for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, volunteers, and visitors. During an interview at 2:21 PM on [DATE] with the Administrator he was asked for the facility's Risk Assessment and Patient Population Emergency Preparedness Plan including policy's and procedures. The Administrator provided a Facility Assessment Tool 2021. A Facility and Community Risk Assessment - Hazard and Vulnerability Tool for Naturally Occurring Events 2021 was provided. When asked how many residents were identified with COVID-19 and had been hospitalized the Administrator stated he did not know. A review of the facility's COVID-19 Action Plan stated there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an isolation/Hot Unit for COVID-19 positive Unit. The facility had only one general well unit, one well memory unit, one well/COVID-19 positive memory unit and a full COVID-19 positive unit.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09546 The facility staff failed to utilize outside resource to assist in the prevention of the spread of COVID -19 which resulted in hospitalization s and deaths. The findings included: The facility staff failed to use outside resources including the Local Health Department during a Major COVID-19 outbreak in the facility. The outbreak started on 08/28/21 according to the facility's records. During entrance to the facility on [DATE] signage on the front door at the visitor's entrance read face mask required at all times. The signage lacked clear information/alerts to visitors. Review of other visitor entrances (kitchen, construction unit and the laundry door connecting with Unit 1 revealed no signage). Upon entering the facility, staff members stated screening was a self-performed task. After multiple days of reviewing the screening logs the team was unable to account for many on duty staff. Multiple attempts between 09/21/21 and 09/23/21 were made with the infection Preventionist to review the facility's COVID-19 system for capturing COVID-19 cases. Upon entrance on 09/20/21 the Administrator stated there were 36 incidences of COVID-19 in the facility and two staff. A review of the facility's 802 Resident Matrix as presented to the survey team identified (3) residents with COVID-19. Each interaction with the Administrator and Infection Preventionist resulted in the facility's inability to provide COVID-19 cumulative data (total of COVID 19 positive residents/staff, number of residents/staff hospitalized COVID-19 related, number of resident/staff deaths, current number of quarantined resident/staff and number of affected residents/staff that were vaccinated since the outbreak began and currently) for the facility. A review of the facility's COVID-19 Action Plan stated there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an isolation/Hot Unit for COVID-19 positive Unit. The facility had only one general well unit, one well memory unit, one well/COVID-19 positive memory unit and a full COVID-19 positive unit. Various types of mask were observed donned by the facility staff but regardless of the type of mask worn most staff were observed not appropriately positioned to cover the nose and mouth. The facility staff failed to follow CDC guidance to ensure Health Care Personal (HCP) to include contract, agencies and vendors required COVID-19 testing was completed based on the level of community transmission and the results of each test was documented. As a result of the non-compliance with testing while the facility was in a major COVID-19 outbreak. On 09/21/21 staff testing was observed and the documentation of the testing was reviewed. The Infection Preventionist stated testing for staff was two times weekly (Tuesday and Thursday). Review of those listed as tested revealed no documentation of their test results. The Infection Preventionist stated that indicated the results were negative. The results remained undocumented. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/23/21 at 2:15 P.M. with the administrator he was asked had the Local Health Department been contacted to assist the facility in assessing the status of residents and the number of resident who have been hospitalized . The Administrator, stated, No the facility had not contacting the Local Health Department for that purpose. The administrator was asked if the facility had outside resources whom he could consult regarding the COVID-19 outbreak. The administrator stated, corporate office had sent several regional staff including a Regional Corporate Nurse to assist with the outbreak. A 09/17/21 Local Health Report on the facility after an unannounced visit indicated: As of 9:30 am September 17, 2021 we have had notification form the local hospital of 11 total admissions since [DATE] and 4 known deaths among patients arriving from the facility. A determination was made for an immediate visit was necessary to: 1. Assess status of patients regarding numbers currently ill 2. Determine vaccination status of patients and staff 3. Assess staffing and medical coverage 4. Explore PPE use and availability; assist with procuring additional if needed 5. Based on the number of patients ill, determine what, if any cohorting possibilities there are within the facility that could help limit transmission 6. Look at any other mitigation strategies the IP and epi team believe could help It was also determined that Local Health Department staff touch base with the facility's corporate office to let them know of our concerns and request their engagement. A CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-COV-2 Spread in Nursing Homes dated 09/10/21 indicated: Notify HCP (Health Care Professionals), Residents, and families about Outbreaks, and Report SARS-COV-2 Infections, Facility staffing, Testing, and Supply Information to Public Health Authorities Notify the health department promptly about the following: -1 residents or HCP with suspected or confirmed SAR-Cov-2 infection -Resident with severe respiratory infection resulting in hospitalization or death -3 residents or HCP with acute illness compatible with COVID-19 with onset within 72 hour period. Find the contact information for the healthcare-associated infections program in your state health department, as well as your local health department. Notify HCP, residents and family's promptly about identification of SARS-Cov-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report SARS-Cov-2 infections, facility staffing and supply information, and point of care testing data to the National Healthcare Safety Network (NHSN) Long term Care Facility (LTCF) COVID-19 Module weekly. CDC NHSN provides long term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way. Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements. Professional source: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html An Administration Facility policy revised 10/22/20 Indicated: The facility will provide polices and systems that it is administered in a manner that will focus on attaining and maintaining the highest practicable physical, mental and psychosocial well-being of each resident. Policy Explanation and Compliance Guidelines: The facility will follow the accepted professional standards and principles of the various practice acts and regulations for the various licensed personnel within the facility. The facility will employ professionals necessary to carry out the provisions of requirements.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34896 Based on a clinical record review, staff interviews, facility document review and during the course of a complaint investigation the facility staff failed to ensure a complete and accurate clinical record for 2 of 42 residents in the survey sample, Resident #8 and Resident #93. The findings included: 1. The facility staff failed to ensure Resident #8's clinical record documentation was complete to include a fall, nursing fall assessment, physician notification and physician order follow-up during the 11-7 shift on 10/23/20. Resident #8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include but not limited to Right Femur Fracture and Dementia. Resident #8's most recent Minimum Data Set (MDS) was a quarterly with an Assessment Reference Date (ARD) of 9/22/21. Resident #8's Brief Interview for Mental Status (BIMS) was not attempted because the resident was coded as rarely or never understood. Resident #8 was also coded as having long and short term memory recall. On 9/22/21 at 10:00 a.m., the facility Administrator was asked if he had information about a fracture for Resident #8. The Administrator stated, Yes, I have a FRI(facility reported incident), a follow-up and statements regarding the incident with him for October 2020. The Administrator provided the surveyor with all of the above documents for review. The Facility Reported Incident dated 10/29/20 was reviewed and is documented in part, as follows: Residents involved: Name (Resident #8). Incident Type: Injury of Unknown origin. Describe incident, including location, and action taken: Resident Name (Resident #8) was noted to have bruising and leg pain. Order for x-ray revealed fracture. Resident sent out 911. Name of employee involved and their position: Name, (Certified Nursing Assistant #13 (CNA). Employee action initiated or taken: Employee suspended based on statements from nurse on duty. The facility 5-day follow-up to the FRI submitted on 10/29/20 dated 11/3/2020 was reviewed and is documented in part, as follows: Situation: This is a follow-up to the initial FRI sent on October 29, 2020 concerning an injury of unknown origin for fracture to Name (Resident #8). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation: Based on review of the written statements and interviews with employees it was determined that the CNA (CNA #13) on 11-7 did report a fall to an agency nurse. The agency nurse failed to complete documentation concerning the fall and to notify nursing management of a fall. All notifications have been made and the resident is currently in acute care receiving treatment for his injury. Conclusion: This injury is, in fact, attributed to a fall. -CNA returned back to work after the internal investigation. -100% re-education to all nurses on notification and documentation of falls in Name(electronic medical record). -100% re-education of notification to DON(Director of Nursing)/Administrator with falls with major injuries. The facility staff interviews obtained during the investigation of Resident#8's injury of unknown injury were reviewed and are documented in part, as follows:: Statement from CNA #13 who worked 11/7 on 10/23/20: Accident date: 10/24/20 This morning I was with Name (Resident #8), I directed him to his room. As I was standing in the hall at his (Resident #8's) door, he got up and walked to the sink, got on the floor. I yelled to them (Registered Nurse(RN) #2 and Licensed Practical Nurse #5) Name (Resident #8) is on the floor. I said Name (Resident #8) get up, he did. Then he walked out to the hall, holding on to the rail, then he fell on the floor in the hall. The 2 nurses (RN #2 and LPN #5) came to him. It was change of shift. My relief came, I told her what was going on and I left the floor. Statement from LPN #5 who worked 7-3 on 10/24/20: On 10/24/2020 I came on shift at 7 a.m., Name (Resident #8) was in his room. Night shift CNA came to desk saying that patient was crying out in pain. Night shift nurse and I went down to see patient and he was crying that his right knee was hurting. Patient was given as needed tylenol throughout the day. patient was limping throughout the hall and I kept redirecting him to sit down and not walk on injured leg. X-ray was done on my shift. Statement from RN #2 who worked 11-7 on 10/23/20: Dated 10/29/20 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/21 at around 0400(4:00 a.m.), I noticed resident walking out of his room, Name (CNA #13) was redirecting him back to his room. I continued doing my rounds. When I walked past the resident's room I saw the CNA sitting in a wheelchair watching over him. She said she was making sure that the resident will stay in bed and would not fall. I went to see the resident and asked how's he doing. He said his right knee hurts. I asked him if he fell , he said no. I asked him what happened, he said, I don't know. I asked him to flex his leg, he said it hurts. I assessed for any visible trauma, there was none. CNA was in the room all this time. So I emailed the MD (medical doctor) requesting for a stat x-ray related to right knee pain, placed the order to Name (mobile x-ray company) and endorsed the incident to the incoming LPN. CNA #13 is no longer employed with the facility, the Director of Nursing provided the employee's phone number to surveyor. This surveyor attempted to call CNA #13 on 9/22/21 a total of 8 times. With each call the phone was answered by someone briefly speaking Spanish, them the call was immediately disconnected. No opportunity was given for a voice message to be left. On 9/21/21 at 12:06 p.m., a phone interview was conducted with LPN #5. LPN #5 was asked to explain her involvement with Resident #8 on the morning of 10/24/20. LPN #5 stated, I was the 7-3 nurse that morning and I was relieving Name (RN #2). Name (RN #2) and I were at the nurses desk and the CNA (CNA #13) came up right around 7 because it was shift change and said Name (Resident #8) had fallen in the hall. We (RN #2) and I got up and went to his room. Name (RN #2) assessed him. When she assessed him, he complained of right leg pain. She said she would call the doctor and for me to give him some tylenol. Name (RN #2) told me before she left that she called the doctor and got an order for an x-ray of the right knee. She said she put the order in and for me to watch for them (mobile x-ray) to come. The x-ray was done on my shift. When I left, I told the next shift what happened and that we were waiting on the x-ray results. LPN #5 was asked if she documented anything about the resident's fall or the assessment oh her shift. LPN #5 stated, No, I thought she (RN#2) was going to document everything that happened and that she called the doctor. On 9/23/21 at 3:06 p.m., an interview was conducted with RN #2. RN #2 was asked to review her written statement dated 9/29/20 and asked if her incident date of 10/21 was correct. RN #2 stated, No, the date on the statement should have been 10/23/20, the 10/21 was the wrong date. RN #2 was asked to explain what care she provided to Resident #8 on the morning of 10/24/20. RN #2 stated, It was around 3 am, Name (Resident #8) is an early riser and he is in and out of his room all day. Name (CNA #13) redirected him back to his room. I was walking back to the nurses station and I saw Name (CNA #13) and Name (Resident #8) in his room. When I walked by Name (CNA #13) said Name (Resident #8) was complaining of pain in his right or left knee, I can't remember which one. I went into the room and pulled down his pants, there was no bruising. I asked him where the pain was, he said his knee. I asked him if he fell and he said no, I asked Name (CNA #13) if he fell and she said no. I did range of motion on the leg and he said, oh that hurts. I told him I would email the doctor and get an x-ray. I let the oncoming nurse know that the mobile x-ray had been called to do the x-ray. RN #2 was asked if CNA #13 came to the nurses station that morning around the change of shift and alerted her and LPN #5 that Resident #8 had fallen in the hall. RN #2 stated, No he didn't fall in the hall. I did tell the oncoming nurse about what had happened, that he had knee pain and I assessed him. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent Minimum Data Set (MDS - an assessment protocol) a Medicare 5-day assessment with an Assessment Reference Date (ARD) of 09/18/19 coded Resident #93 with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. The MDS coded Resident #93 with total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene and supervision with set-up help only with eating for Activities of Daily Living (ADL) care. During the review of Resident #93's clinical record revealed the following documents: Vital signs, progress notes and daily skilled notes since admission, pain, mobility and skin assessment dated [DATE] and an incomplete list of physician orders. There were no other documents located in the resident's clinical record under their current software program Point Click Care (PCC). On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist/Staff Development Coordinator. The MDS Coordinator reviewed Resident #93's clinical record then stated, His clinical record is not complete, the clinical record is missing the Hospital Discharge Summary, Admission Agreement, hospital Medication Administration Record (MAR) and hospital Treatment Administration Record (TAR), hospital progress notes, insurance information, admission paperwork etc. The Regional Director of Clinical Services said when Resident #93 was admitted to the facility on (09/11/19) the facility was not completely integrated with the software program Point Click Care (PCC) and that paper charting was still being utilized. The Administration team said they will reach out to the Regional [NAME] President of Clinical Services for assistance. On 09/30/21 at approximately 1:44 p.m., the Regional [NAME] President of Clinical Services provided a letter that read: Resident #93 was admitted to the facility on [DATE] and was discharged from the facility on 9/20/2019. During that time period the facility used PCC as the Electric Medical Record (EMR). The PCC was not fully integrated at the time nor did the facility use all the functions of PCC. The facility was acquired on 7/1/2019 from (name of previous nursing home). The facility transitioned the EMR from American HealthTech (AHT) to PCC over the following weeks and much of the medical records during that timeframe would have been completed on paper. These records would have included physician orders, Medication Administration Records, Treatment Administration Records, Care Plans, and paper medical records being scanned into the Documents tab. The facility medical records department has reached out to Iron Mountain (offsite document storage) in an attempt to locate the paper medical record, in addition reached out to (name of pharmacy) to get copies of any documents, physician orders, or hospital records that may have been sent to the pharmacy. If we are able to obtain these records we will reach out to the survey team and provide them with the requested medical records. On 09/30/21 at approximately 2:03 p.m., an email was received from the Regional [NAME] President of Clinical Services that read in part: The only additional documents obtained were the admission physician orders that were faxed to the pharmacy and the manifest. The documents have been uploaded in Resident #93's record and can now can be viewed in PCC. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. COMPLAINT DEFICIENCY

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	495150	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37828 Based on deficiencies determined during this survey the QAA (Quality Assessment and Assurance) and Quality Assurance and Performance Improvement (QAPI) committee failed to develop and implement corrective plans of action and monitoring to ensure the necessary systems were in place and correct identified quality deficiencies during a major outbreak of SARS-CoV-2 in the facility beginning 08/28/2021. Immediate Jeopardy to the resident health and safety was identified on 09/23/21 in the area of Infection Control at (F-880 and F886) at a scope and severely level 4 Widespread (L) which constituted Substandard Quality of Care. The findings included: On 9/23/21 at 8:37 p.m., the facility Administrator, Director of Nursing and three Corporate Consultants were informed of the above Immediate Jeopardy concerns at F-880; Infection Prevention and Control Program secondary to an outbreak of SARS-CoV-2 infections within the facility. On the same day and at the same time, the Administrator, Director of Nursing and three Corporate Consultants were also informed of the above Immediate Jeopardy concerns at F-886; COVID-19 Testing; during an outbreak of SARS-CoV-2 infections within the facility. Observations were made of staff non-compliance with screening, improper use Personal Protective Equipment (PPE), no post visual signs at the entrance and/or in strategic places with instructions about current Infection Prevention Control recommendations related to SARS-CoV-2, staff's inability to provide documentation of staff and resident vaccination status, cumulative clinical data of cases of SARS-CoV-2 infections, and measures/practices and the necessary systems were in place and correct identified quality deficiencies to protect the health and safety of the residents during a major outbreak of SARS-CoV-2 in the facility. The QAPI document was received via email from the Admission Coordinator on 09/21/21 at approximately 2:52 p.m. The most recent QAPI meeting was held on 09/14/21, when the facility was already in a major outbreak of SARS-CoV-2. The facility also provided the attendance sheet which showed all the required members were present. Review of the facility's QAPI for 09/14/21 did not provide any evidence a system in place for routine monitoring of managing residents with suspected or confirmed SARS-CoV-2, screening of visitors and healthcare personnel, monitoring of unvaccinated employees, improper wear of Personal Protective Equipment (PPE), cumulative clinical data of cases of SARS-CoV-2 infections and unit set up in accordance with CDC Guidelines. On 09/29/21 at approximately 10:30 a.m., a phone interview was conducted with the Administrator, Regional Director of Clinical Services, MDS Coordinator and Infection Preventionist (IP)/Staff Development Coordinator (SDC). The IP said the issues related to the most recent outbreak was discussed and acted upon during the QAPI meeting held on 09/14/21. IP stated, I will get that information to you right away. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	After several attempts to reach the IP via phone on 09/29/21, the IP was reached on 09/30/21 at approximately 8:43 a.m., who stated, I' not able to provide evidence that the issues that were discussed during the QAPI meeting held on 09/14/21 related to the recent outbreak of COVID-19 on 08/28/21 was every addressed by me or the QAA committee. A phone interview was conducted with the Administrator on 09/30/21 at approximately 2:27 p.m., who stated, The COVID-19 outbreak started in the facility on 08/28/21 and we had our QAPI meeting on 09/14/21. He said IP should have started COVID education once we (QAA meeting) realized there was an outbreak on 08/28/21 and that training and education should have continued until everyone were reeducated and the QAA committee should have put the necessary steps inn place to identify the cause and correct the issue (outbreak of COVID-19) in the building. A phone interview was conducted with the Administrator on 09/30/21 at approximately 2:27 p.m., who stated that the facility had a QAPI meeting on 09/14/21 but did not address the issues related to the recent outbreak of COVID-19 within the facility. He said an action plan should have been put in place to address the recent outbreak but that did not occur. The QAA committee is responsible for identify and correcting identified quality deficiencies. The facility was not able to provide evidence that the facilities QAA meeting had a systematic plan in place to maintain and improve the safety and quality in the facility involving the resident and staff and took the necessary steps to identify the cause and correct the problem. The Administrator, Interim Director of Nursing, Chief Operating Officer, Regional Director of Operations and Regional Director of Clinical Services was informed of the findings during the exit meeting on 09/30/21 at approximately 7:40 p.m. The facility did not have any further questions or present any further information about the findings. The facility's policy titled Quality Assessment and Assurance Committee (QAA) - revision date 10/22/20. This facility will maintain a (QAA) Committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies through an interdisciplinary approach. Policy Explanation and Compliance Guidelines include but not limited to: 4. The QAA committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAA program. The committee will: -Meet at least quarterly and as needed. -Provide oversite of the QAPI program. -Identify and respond to quality deficiencies throughout the facility. -Develop and implement corrective plans of action, and monitor to ensure performance goals or targets are achieved and sustained. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy titled Quality Assurance and Performance Improvement (QAPI) - revision date 12/22/20. It is the policy of the facility to develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Policy Explanation and Compliance Guidelines include but not limited to: -Develop and implement appropriate plans of action to correct identified quality deficiencies. 3. The QAPI plan will address the following elements: -Process for addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: Tracking and measuring performances, establishing goals and thresholds for performance improvements, identifying and prioritizing quality deficient, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities and a process to ensure care and services delivered meet acceptable standards of quality.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observations, resident interviews and staff interviews on all four resident living areas, and review of facility documentation, the facility's staff failed to follow Centers for Disease Control and Prevention (CDC) guidance to establish an infection control program to ensure SARS-CoV-2 infection control measures/practices were in place during a major SARS-CoV-2 outbreak and to prevent further transmission, severe infections, hospitalization s and deaths which constituted immediate jeopardy at F880 (L) in the following specific areas: The facility failed to provide accurate documentation of their COVID-19 surveillance and data analysis including line listings of infections and vaccination status of resident and HCP; which was necessary for early detection to enable a response to a SARS-CoV-2 outbreak and to report SARS-CoV-2 infections information to Public Health Authorities. The facility failed to post visual signs at the entrance and/or in strategic places with instructions about current Infection Prevention Control recommendations related to SARS-CoV-2. The facility failed to adhere to the CDC recommended screening process to identify anyone entering the facility who was positive for SARS-CoV-2 or with symptoms of COVID-19. The facility failed to quarantine residents with suspected or confirmed SARS-CoV-2 infection including new admissions and re-admissions during an outbreak for 6 residents (Resident #21, #73, #90, #53, #16, and #65) of 42 residents in the survey sample. The facility staff failed to ensure facemasks were well-fitting and worn to cover the nose and mouth, and ensure that HCP caring for SARS-CoV-2 positive residents are using full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). On [DATE] at 8:37 p.m., the facility Administrator, Director of Nursing and three Corporate Consultants were informed that the above non-compliance constituted Immediate Jeopardy at F-880; Infection Prevention and Control Program secondary to an outbreak of SARS-CoV-2 infections within the facility at a scope and severity level 4 widespread (L) which constituted Substandard Quality of Care. The survey team validated the plan of removal through observations, interviews and review of facility documents and the Immediate Jeopardy was removed on [DATE] at 4:25 p.m. The deficient practice was decreased to an F (potential for more than minimal consequence). The facility's final cumulative of data provided on [DATE] disclosed from [DATE] through [DATE]; there were fifty-three SARS-CoV-2 positive residents, nineteen were hospitalized , one remained in the hospital and nine died . The cumulative of SARS-CoV-2 positive staff was six, one staff was hospitalized and died , four staff returned to work and no staff was still in quarantine. The facility stated they felt this was accurate but was unable to attest it was one hundred percent accurate. The findings included: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1A. The facility staff failed to provide accurate documentation of their COVID-19 surveillance and data analysis including line listings of infections and vaccination status of resident and HCP; which was necessary for early detection to enable a response to a SARS-CoV-2 outbreak. Multiple times on [DATE] interviews were attempted with the Infection Preventionist (IP) to review the line listing of SARS-CoV-2 cases in the facility including residents and staff. Each time the IP would leave for she desired to review the documents on her computer. Even after bringing in the computer to review the line listing she was unable to definitely provide the requested numbers. She stated the cases are not adding up correctly. The IP stated the outbreak began [DATE] when an alert and oriented resident (Resident #90) tested positive after a Rapid test. She was not certain of the symptoms the resident presented with prior to the test but she stated the resident was symptomatic and a PCR test was performed as a result of the positive Rapid test. The PCR test results were also positive. Another interview was attempted with the IP on [DATE] at approximately 10:10 a.m., to obtain a cumulative of SARS-CoV-2 cases since the beginning of the pandemic was requested as well as the number of cases in-house on [DATE], when the survey team entered the facility. The IP stated she thought there were 36 in-house cases on [DATE] but the numbers still weren't adding up therefore; she needed to review the line listing to get an official count. The IP was also asked to provide the number of hospitalized residents/staff, number of deceased residents/staff, and the number/name of residents/staff who were vaccinated. On [DATE] at approximately 3:15 p.m., the IP stated she believed there were 19 SARS-CoV-2 cases in the facility when the survey team arrived on [DATE] but she still wasn't sure of the cumulative since the pandemic began. At approximately 4:15 p.m., the Regional Clinical Reimbursement Consultant (RCRC) stated the IP wasn't able to assist further with the SARS-CoV-2 statistics because she would be rendering direct care therefore; she would be calculating the numbers. On [DATE] at approximately 11:20 a.m., the RCRC provided the following numbers as an accurate cumulative of the facility SARS-CoV-2 cases and the disposition of the affected residents/staff. The cumulative of Residents who tested positive for SARS-CoV-2 was forty-eight. Seven of the forty-eight resident died including one in the facility, seventeen of the cumulative residents were admitted to the hospital, three of the cumulative residents remained in the hospital and thirty-six of the cumulative residents were quarantined in the facility. The cumulative of staff who tested positive for SARS-CoV-2 was eight, one staff died , one staff was hospitalized , no staff remained in the hospital, one staff remained quarantined and six staff had returned to work. On [DATE] at approximately 3:15 p.m., the facility stated they had made additional changes to the cumulative number of residents and staff to account for all affected since the outbreak beginning [DATE]. The cumulative of SARS-CoV-2 positive residents was fifty-three, nineteen were hospitalized , one remained in the hospital and nine died . Six new resident cases were identified [DATE] - [DATE]. The cumulative of SARS-CoV-2 positive staff was six, one staff was hospitalized and died , four staff returned to work and no staff were still in quarantine. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Three pages of emails were provided to the survey team along with documentation of the cumulative data and line listings. An email dated [DATE] at 6:02 a.m., stated; we have eight more staff and two staff members who tested positive for SARS-CoV-2. At 7:47 a.m., an email read; another one just tested positive. Its nine now. Another email dated [DATE] read; we have two more residents who tested positive for COVID today. An email dated [DATE] read; we have two COVID positive residents who expired at the hospital. We also have some new residents who tested positive. I will send an updated line listing later this evening. Another email dated [DATE] at 6:04 p.m. read; Attached is a copy of the COVID-19 line list. It seems like 75% of my September positives are residents who are vaccinated. On [DATE] an email read A COVID positive staff death at (name of the facility). Have you done the Occupational Safety and Health Administration investigation to determine work relatedness? We need to document thoroughly. B. The facility staff failed to report SARS-CoV-2 infections information to Public Health Authorities. The three pages of email chains above revealed the facility staff had a situation too overwhelming for then to manage, yet they failed to notify the health department promptly of the first positive case of SARS-CoV-2, each suspected or confirmed SARS-CoV-2 infection and of additional cases, including residents with severe respiratory infection resulting in hospitalization or death, three residents or HCP with acute illness compatible with COVID-19 with onset within a 72-hour period.An interview was conducted with the Infection Preventionist on [DATE] at approximately 3:20 p.m. The Infection Preventionist stated she had not contacted the local Health Department and/or the Epidemiologist in reference to the facility's outbreak or to ask for assistance in managing their rapid increasing number of SARS-CoV-2 positive cases. The Infection Preventionist further stated approximately one week ago the Local Health Department came in on their own to conduct a site visit and offer assistance. 2. The facility failure to post visual signs at the entrance and/or in strategic places with instructions about current Infection Prevention Control recommendations related to SARS-CoV-2. On [DATE] at approximately 7:05 p.m., upon arriving to the facility the only signage at the visitor's entrance read face mask required at all times. This signage was located to the sides of the door and at a low position. There was no entrance door signage with clear information/alerts to visitors. Review of other visitor entrances (kitchen, construction unit and the laundry door connecting with Unit 1) also disclosed no signage. CDC had recommended that long term care facilities developed a written COVID-19 plan which included; Facilities should encourage visitors to be aware of signs and symptoms of acute respiratory illness consistent with COVID-19 and not enter the facility if they have such signs and symptoms. Visual alerts, such as signs and posters, should be placed at facility entrances and other strategic areas instructing visitors not to enter as a visitor if they have fever or respiratory symptoms. Signage should include signs and symptoms of COVID-19 and who to notify if visitors/staff/vendors have symptoms. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/hcf-visitors.html). 3. The facility staff further failed to adhere to the CDC recommended screening process to identify anyone entering the facility who was positive for SARS-CoV-2 or with symptoms of COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at approximately 7:05 p.m., after ringing the doorbell the survey team was allowed to enter the first set of doors where visitors and staff were screened. The staff member stated screening was a self-performed task but assisted us to obtain our temperatures. After multiple days of reviewing the screening logs the team was unable to account for many on duty staff therefore a review of the screening logs for [DATE] - [DATE] were reviewed with the staffing coordinator on [DATE]. The review of [DATE] confirmed eleven direct care staff were not signed in as screened. The review of [DATE] confirmed there were seven direct care staff who did not sign in as screened. On [DATE] - [DATE] many support staff wasn't verified. Another screening review was conducted of the facility's personnel on duty [DATE]. The review disclosed seven direct care staff and eleven support staff had not signed in as screened. Many of the facility Healthcare Personnel (HCP) were foregoing the screening process by entering and exiting the facility through various doors. The outcome of foregoing the screening resulted in a breach in the infection prevention and control (IPC) protocol as evidenced by continuous newly diagnosed residents with SARS-CoV-2 infections, some resulting in hospitalization s and/or death. After this was brought to the facility staff attention on [DATE], staff was assigned to carryout screening. According to the [DATE], Centers for Medicare and Medicaid Services (CMS) Memo QSO,d+[DATE]-NH, Guidance for Infection Control and Prevention of COVID-19, nursing homes should follow the Core Principles of COVID-19 Infection Prevention. One of the Core Principles read; Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status). HCP should not work while acutely ill, even if SARS-CoV-2 testing is negative, in order to minimize the risk of transmission of other infectious pathogens, including respiratory pathogens such as influenza. All visitors should sign in and out on a visitor's log. 4. The facility staff failed to manage residents with suspected or confirmed SARS-CoV-2 infection including new admissions and re-admissions during an outbreak, and to manage staffing of HCP who worked a COVID positive unit and immediately afterward worked a Well unit. A. On [DATE] at approximately 4:00 p.m., a review of resident readmissions/admission was conducted with the DON. The DON stated Resident #21 was readmitted to the facility from the hospital [DATE] with a diagnosis of sepsis related to a urinary tract infection and the resident tested negative for SARS-CoV-2 prior to leaving the hospital. The DON stated they elected not to quarantine Resident #21 an unvaccinated resident, after an eight day hospital stay because of the negative SARS-CoV-2 test and for resident safety related to impaired cognition, gait problems and behaviors. Resident #21 was readmitted to the Memory Unit. The DON further stated they didn't have a quarantine unit for residents who resided on the Memory Unit. B. On [DATE] at approximately 8:30 a.m., Resident #73 was observed sitting in a wheelchair in his doorway. Resident #73 was originally admitted to the facility [DATE] and had never been discharged from the facility. The current diagnoses included; diabetes and high blood pressure. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #73's cognitive abilities for daily decision making were intact. The resident stated he was moving off the COVID-19 positive unit that day. Resident #73 stated he was vaccinated and had never tested positive for SARS-CoV-2. The resident further stated he was admitted to the room in August and he was told [DATE] that he no longer needed to quarantine and he would be moved. Review of the resident's clinical record revealed he was admitted to the facility [DATE]. Resident #73 a fully vaccinated had resided on a COVID-19 positive unit from [DATE] - [DATE]. On [DATE] at approximately 4:00 p.m., a review of Resident #73's admission was conducted with the Director of Nursing (DON). The DON stated Resident #73 was admitted to the room on the Admitting Unit prior to the outbreak of SARS-CoV-2 cases and he remained there to complete his period of quarantine. On day one of the survey, the survey team made observations to determine how the facility was managing admissions/re-admission of residents. Designated rooms for quarantine were not identified for residents returning to the facility after hospitalization or for pending and newly confirmed positive resident within the facility. On [DATE] at approximately 1:55 p.m., the survey team addressed this concern with the facility's team including five corporate consultants. Corporate Consultant #4 stated there was a designated quarantine unit and ask what happened to it. The Administrator stated the positive cases resulted in them outgrowing the COVID-19 positive unit therefore; they didn't have quarantine rooms and new admissions would not be accepted because of the vast number of SARS-CoV-2 positive cases. An email dated [DATE] in reference to the first positive resident case of SARS-CoV-2 read; do you have a COVID unit set up? What will you do if the PCR is positive? Please let us know the results when you know them. The facility COVID-19 Action Plan dated [DATE], read there would be three units set-up for the resident population in accordance with CDC Guidelines. The Units were described as a Well/Cool Unit, a Quarantine/Warm Unit for new admission and readmissions and an Isolation/Hot Unit for COVID-19 positive residents. The facility only had one general well unit, one well memory unit, one COVID-19 positive memory unit and one full COVID-19 positive unit. Facilities should create a plan for managing new admissions and readmissions. In general, all new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission. Exceptions include residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents. (https://www.vdh.virginia.gov/content/uploads/sites/[DATE]/VDH-COVID-19-Guidance-for-Nursing-Homes.pdf) C. Resident #90 was originally admitted to the facility [DATE] and readmitted [DATE] after an acute care hospital stay, returning to the facility [DATE]. The current diagnoses included; SARS-CoV-2 infection and Multiple Sclerosis. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview was coded for intact long and short term memory as well as modified independence with daily decision making. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A physician's progress note dated [DATE] at 10:15 a.m., read; Evaluation following positive COVID-19 test. Resident #90 is seen today for follow-up after a positive COVID-19 test. The resident is currently symptomatic with low grade fevers, positive for Shortness of Breath/Cough, Oxygen saturation at 85% on Room Air. Chest X-Ray shows a Left Lower Lobe pneumonia. Facility unable to obtain the monoclonal antibody infusion from Maryland. Advised nursing to send to Emergency Department for infusion. Resident was subsequently admitted for COVID-19 pneumonia. The resident was readmitted to the facility [DATE]. Upon entering Resident # 90's room on [DATE] at approximately 9:45 a.m., a sheet was observed on the floor and on top of the sheet were elimination saturated towels, a gown and used gloves. Resident #90; a SARS-CoV-2 infected resident; was in bed uncovered and without clothing. The resident stated he no longer felt sick and presented without shortness of breath, cough, diaphoresis or fatigue. Shortly afterwards the wound care Nurse Practitioner and LPN #3 entered the resident's room to assess the resident's impaired skin. After the wound care Nurse Practitioner completed her assessment she stepped on the sheet and soiled linen, proceeded out the room and off the unit with the same dirty shoe protectors on. D. Observation of multiple resident room on the COVID-19 positive unit revealed no trash bags in the trash cans in most rooms, the hallway was with dried brownish spill areas, paper, used gloves and other debris. There were no clean gowns on the unit to be utilized by the staff, the clean linen cart cover was up exposing all the linen and stacks of what appeared to be clean linen was observed in chairs and sitting on top of furniture in rooms in approximately five rooms. An interview was conducted with the DON on the COVID-19 positive unit on [DATE] at approximately 10:05 a.m. The DON stated she didn't agree with the manner the staff allowed Resident #90 to handle his soiled linen but it was the practice. The DON also stated she would have Environmental Services to come immediately to clean the unit and add liners to the trash cans. As the DON walked the hallway she instructed staff to cover the clean linen and remove linen from resident rooms. E. Review of staff scheduling revealed on [DATE], LPN #7 worked a COVID-19 positive Unit from 11:00 - 7:30 a.m., afterwards working from 7:30 a.m. - 3:30 p.m., on a Well Unit. An interview was conducted with LPN #7 on [DATE] at approximately 10:25 a.m. LPN #7 stated she knew it appeared she hadn't been home but she works sixteen hours most days on the same unit and is off for eight hours. LPN #7 didn't say anything about working a positive unit before working a negative unit. The facility COVID-19 Action Plan update [DATE] read; Staff have been assigned to work only on COVID or quarantined or non-affected units/wings/rooms. Staff assignments are documented and time reconciled daily. An interview was conducted with the DON on [DATE] at approximately 4:45 p.m. The DON stated staff are scheduled to remain on the COVID positive unit if they worked the COVID positive unit their first shift and they are working a double shift. She further stated if a staff worked the Well unit the first shift they may work the COVID positive unit the second shift. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with the Medical Director on [DATE] at 11:20 a.m. The Medical Director stated the facility staff informed him of the Immediate Jeopardy status on [DATE] and they conducted a Quality Assurance meeting [DATE] to discuss the SARS-CoV-2 status and means to improve infection control practices in the facility. The Medical Director stated he was aware of the outbreak but he wasn't aware of the cumulative data since the outbreak occurred. He assured us he was notified of cases as they occur but not as cumulative data. The Medical Director stated SARS-CoV-2 infections can be deadly and following CDC guidelines were the expectation of all staff in the facility. The Medical Director further stated education of the staff would be the most effective method to achieve compliance and he would assure regardless of the consequences including disciplinary action that all non-compliance be eradicated. 5. The facility staff failed the implement source control, in accordance with CDC guidance and FDA guidance. A. On [DATE], after the screening process, the team was allowed to enter the second set of doors into the reception area of the facility. The team was met by the Director of Nursing who stated the personal protective equipment (PPE) facility wide included an N-95 mask. The Director of Nursing of Nursing was observed wearing an N-95 below her nose at that time and during most interactions with her. Various types of mask were observed donned by the facility staff but regardless of the types of mask, worn most were not appropriately positioned to cover the nose and mouth. B. On [DATE] at approximately 8:05 p.m., LPN # 6 was observed exiting from the zipped wall of the COVID-19 positive unit wearing an N-95 mask not completely covering the nose and she was observed adjusting it. C. On [DATE] at approximately 10:35 a.m., CNA #5 was observed in the hallway wearing an N-95 mask which wasn't well-fitting and clearly without a tight seal. D. On [DATE] at approximately 10:25 a.m., LPN #7 was observed seated at the nursing station on a COVID positive unit with the facemask around her neck leaving her nose and mouth completely uncovered. E. On [DATE] at approximately 10:27 a.m., CNA #9 was observed in the Dayroom on a COVID positive unit talking to another CNA; five residents were present and CNA #9's facemask was off exposing her nose and mouth. CNA #9 stated I can't breathe when wearing this mask. An emailed dated [DATE] was sent to the facility's Administrator from a Consultant. It read; during a Huddle call (name of the staff member) reminded that all staff must be masked. Meaning over the nose. (Name of the staff member) witnessed staff during rounds and nurses sitting at the desk without mask. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	F. On [DATE] at approximately 8:45 a.m., on a COVID-19 positive Unit CNA #3 was observed putting her gown on the handrail in the hallway. CNA #3 proceeded in the hallway with a water pitcher in hand which was brought off of a SARS-CoV-2 infected resident's room (Resident #47). After filling the water pitcher with ice CNA #3 proceeded back into the resident's room without a gown on (it was still hanging on the handrail). CNA #3 stood in front of the SARS-CoV-2 infected resident and assisted him to drink water afterwards; the resident began to cough weakly. CNA #3 left the resident's bedside washed her hands, picked up a bag of soiled linen from the floor and proceeded into the next room with the soiled linen. An interview was conducted with CNA #3, on [DATE] at approximately 8:55 a.m., she stated she was fully vaccinated and had never tested positive for SARS-CoV-2. CNA #3 stated she had the gown on but forgot to put it back on when she went in to get Resident #47's water pitcher. CNA #3 removed the gown from the handrail and said here it is. An interview was conducted with Resident #47 on [DATE] at approximately 9:00 a.m. Resident #47 was originally admitted to the facility [DATE] and readmitted [DATE] after an acute care hospital stay. The resident was discharged again from the facility [DATE] to an acute care hospital for respiratory distress and wet lungs. The current diagnoses included; SARS-CoV-2 infection, hemiparesis and urinary retention. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of [DATE] coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #47's cognitive abilities for daily decision making were intact. Resident #47 was very short of breath, diaphoretic and constantly requesting water. Observation of the indwelling catheter system revealed a very soiled and coiled catheter leg strap and a catheter drainage bag with approximately 200 milliliters of dark yellow urine. An interview was conducted with LPN #7 on [DATE] at approximately 9:13 a.m., regarding the resident's weak state. LPN #7 stated since the resident was diagnosed with a SARS-CoV-2 infection, the resident's physically abilities had declined to the point he was unable to hold his water pitcher. On [DATE] at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, and Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. The Regional Director of Clinical Services stated corrective action had started and compliance of the facility Infection Control COVID-19 policies in accordance with the CDC and the Virginia Department of Health would include ongoing monitoring by the Administrator. 09546 6. The facility staff failed to move Resident #53 a COVID-19 positive resident from a non-COVID unit to a COVID positive unit timely (2 days later). Resident #53 was admitted to the facility on [DATE] with diagnoses which (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	included hemiplegia, insomnia, type 2 diabetes, major depression, convulsions, hypothyroidism, cerebral infarction, cognitive impairment and contracture of left hand. In the area of Cognitive Patterns Brief Interview for Mental Status (BIMS) this resident was coded as a 15. A Care Plan dated [DATE] indicated: Focus- COVID- 19 active diagnosis. Resident #53 was identified as able to move around using a wheelchair. Resident #53, who resided on a non-COVID-19 unit, was observed on [DATE] at 7:53 P.M. and [DATE] at 9:43 A.M. seated in a wheelchair in her room (#25) door way. Resident #53 was also observed using the bathroom in her room that was shared with her roommate at 11:15 A.M. on [DATE] who was COVID-19 negative at time. Resident #53 was observed without a mask. On [DATE] Resident #53 was identified as COVID-19 positive. Resident #53 was observed moving in and out of her room with the door open. There was no signage observed on the outside door of this room indicating infection control measures and practices were in place. Resident #53 remained in her room (#25) for two days before moved on [DATE] across the hall to room [ROOM NUMBER] as the only resident in a semi-private room (#26), but still on the non-COVID unit. Resident #53's bed linen, personal items, unfinished orange juice and food container were observed in room [ROOM NUMBER] until [DATE]. Resident #53's previous roommate (Resident #65) was identified as COVID-19 positive on [DATE]. 7. The facility staff failed to move Resident #16, who was COVID-19 Positive and living on a non-COVID unit to a COVID unit in a timely manner (3 days later). Resident #16 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, cervical spinal cord sequela, spinal stenosis, chronic pain, hypertension, dysphasia and mood disorder. Resident #16 was identified as COVID-19 positive on [DATE]. Resident #16 was living on Unit II, a non-COVID Unit in room [ROOM NUMBER]. Resident #16 was not transferred out of bedroom [ROOM NUMBER] until [DATE]. Resident #16's bed linen, personal items and food container remained in his room until [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #16's floor, bed and other areas of the room remained un-sanitized and not cleaned. There was no signage observed on the outside door of this room indicating infection control measures and practices were in place. 8. The facility staff failed to move Resident #65, a COVID-19 positive resident, from a non-COVID unit to a COVID unit in a timely manner (2-days). Resident #65 was admitted to the facility on [DATE]. Diagnoses for this resident included dementia, COPD, cerebral infarction, depression, dysphasia, and hypertension. A Quarterly Minimum Data Set (MDS) coded this resident in the area of Cognitive Patterns - with a BIMS score of 13. Resident #65 was assessed in the area of ADLs as being able to walk and transfer with one person physical assist. This resident was assessed as steady at all times when walking. A Care Plan dated [DATE] indicated: Focus- The resident is an elopement risk/wander due to impaired awareness; Goal- The resident's safety will be maintained through the review date. Interventions- Distract resident from wandering by offering pleasant diversions, activities, food, conversation, television, book. Resident #65 was identified as COVID-19 positive on [DATE]. Resident #65's Roommate, Resident #53, was identified as COVID-19 positive on [DATE]. Resident #53 remained in the room with Resident #65 for two days after testing positive for COVID-19. Resident #65 was observed moving in and out of her room with the door open at 9:43 A.M. on [DATE] and at 2:43 P.M. and [DATE]. Staff were observed on [DATE] at 9:15 A.M. assisting Resident #65 with removal of her breakfast tray. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Staff were not wearing PPE. Resident #65 was observed walking around in the room on several occasions. There was no signage observed on the outside door of this room indicating infection control measures and practices were in place. 40711 9. The facility staff failed to ensure infections control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19), and other infectious diseases by not wearing the required N95 masks or improperly wearing the required facial coverings. A. On [DATE] at approximately 7:05 p.m., upon facility entrance Dietary Staff member #3 was observed sitting in a chair in the dining room with no facial covering on. Sitting less than four feet near him was dietary staff member #4 with no facial covering. They appeared to be playing a video game. The surveyor was screened at the entrance then entered into the dining area where the two facility staff were seen. She asked Dietary staff member #4 where was his mask. He stated, that he didn't think he needed to wear his mask because he wasn't around residents. B. On [DATE] at approximately 10:10 AM. FSD/OSM (Food Service Director/Other Staff Member) #5 was seen wearing his N95 mask with his nose exposed on several occasions during the kitchen inspection. C. On [DATE] at approximately 12:00 PM, District Dietary Manager (OSM) #6 was interviewed concerning wearing his surgical mask in the kitchen. He stated, N95 Masks are required only inside COVID-19 restricted areas. The dietary staff don't enter those areas. D. On [DATE] at approximately, 10:30 AM Dietary staff (OSM) #18 was interviewed concerning her surgical mask. She stated, I ha [TRUNCATED]

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on information gleamed during the Antibiotic Stewardship task, staff interview, and clinical record review, the facility's staff failed to have a system to ensure that an antibiotic was prescribed based on laboratory results and/or clinical signs and symptoms of true infections when prescribing an antibiotic for 1 of 42 residents (Resident #75), in the survey sample. The findings included: Resident #75 was originally admitted to the facility 1/3/19 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/27/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. In section G (Physical functioning) the resident was coded as requiring total care of two people with transfers, personal hygiene, dressing and bathing, total care of one person with on unit locomotion, extensive assistance of two with bed mobility. An interview was conducted with the Infection Preventionist (IP) during the Antibiotic Stewardship review on 09/28/21 12:34 p.m. A 7/19/21 Practitioner's progress note read Her 7/14 UA/CS reported 25,000 CFU/ML Proteus Mirabilis - orders to Repeat UA C&S (A sensitivity analysis is a method to determine if bacteria are resistant to certain drugs). The IP stated Resident #75 had a urinalysis/culture and sensitivity (C&S) ordered 7/20/21 and the results were received 7/23/21. The lab results were not available on the resident's clinical record but the IP was able to obtain the information from her records. The results were 100,000 CFU/ML (E-coli) but; the resident was asymptomatic for a UTI and the clinical record offered no signs/symptoms related to an acute infection. The Practitioner ordered Keflex 500 milligrams, one capsule by mouth four times each day for seven days. The list of antibiotics the bacteria was susceptible (antibiotic is effective against the bacteria.) was reviewed by the IP; the antibiotics Keflex was not listed. The antibiotic was not adjusted to to a drug the bacteria was susceptible to and resident completed the seven day course of Keflex; an antibiotic the bacteria wasn't susceptible. On 9/30/21 at approximately 6:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. An opportunity was offered to the facility's staff to present additional information or comment but no additional information was provided.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide documentation in the resident's clinical record of the immunization and the administration or the refusal of or medical contraindications to vaccines for 3 of 42 residents (Resident #50, 24 and 5), in the survey sample. The findings included: 1. Resident #50 was originally admitted to the facility 8/7/21 and was discharged to an acute care hospital 9/3/21, returning to the facility on [DATE]. The current diagnoses included; SARS-CoV-2 infection, urinary tract infection, diabetes, high blood pressure and strokes. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/15/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were severely impaired. The resident did not answer questions when asked. Review of Resident #50's 9/8/21 hospital discharge summary revealed the resident received one dose of the Moderna vaccine 2/21 and it would be necessary for the resident to receive the second dose. The clinical record revealed no immunization information except on the MDS. The MDS was coded not in the facility during the flu season to receive the vaccination and the Pneumococcal Immunization wasn't offered. An interview was conducted with the Regional Reimbursement Consultant (RRC) on 9/23/21 at 11:45 a.m. The RRC stated the resident was offered and declined the Pneumococcal vaccine and a modification had been completed on the 8/12/21 MDS assessment to reflect the new information. Documents were presented as printed on 9/23/21 from the hospital data system which provided the following information: Pneumococcal vaccine13 (PCV13) vaccine received 1/29/14, Pneumococcal vaccine23 (PCV23) administered 1/29/13, COVID-19 vaccine Moderna 5/15/21 and Influenza vaccine 8/1/21. If Pneumococcal vaccine23 (PPSV23) was administered prior to age [AGE] years, administer 1 dose PPSV23 at least 5 years after previous dose (https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#note-pneumo) On 9/30/21 an additional review of the resident's clinical record was made. The above information still wasn't documented in the record. On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. An opportunity was afforded for presentation of additional information but they did not. 2. Resident #24 was originally admitted to the facility 7/15/20 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; stroke with right hemiparesis, COPD and a seizure disorder. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/14/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident 24's cognitive abilities for daily decision making were intact. On 9/27/21 at approximately 12:40 p.m. an interview was conducted with Resident #24. The resident stated he hadn't received the COVID-19 vaccination but he wants all three of his shots. The records provided by the Infection Preventionist stated the resident's consent wasn't completed therefore; the vaccine wasn't administered. The clinical record revealed the Influenza vaccine was administered 11/6/20 in the facility, the Pneumococcal vaccine information was only available on the MDS assessment. It was coded as not offered. On 9/30/21 at approximately 12:05 p.m., the IP provided a consent form indicating the responsible party for Resident #24 authorized administration of the Pneumococcal vaccine23 and the Influenza vaccine for this flu season. Status of consent for the COVID-19 vaccination is unknown. The IP stated if a resident refuses a vaccine at intervals (quarterly) it should be reoffered but this resident's problem was consents. On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. An opportunity was afforded for presentation of additional information but they did not. 3. Resident #5 was originally admitted to the facility 7/18/20 and the resident has never been discharged from the facility. The current diagnoses included; dementia, . The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/6/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were intact. Review of the resident's clinical record revealed no information the COVID-19 was administered. The resident tested COVID-19 positive 8/31/21. The clinical record revealed neither the Pneumococcal vaccine23 or the Influenza vaccine for the previous flu season had been administered. An Influenza consent form dated 11/14/20 was in the clinical record. An interview was conducted with the RRC on 9/23/21 at 11:45 a.m. The RRC stated the 9/6/21 MDS assessment was coded the resident was not offered the flu vaccine and the Pneumococcal vaccine was offered and decline but the Pneumococcal vaccine coding was incorrect for the resident wasn't offered the vaccine. The RRC stated a modification had been completed on the 9/6/21 MDS assessment to reflect the new information. On 9/23/21 at 10:20 a.m. and interview was conducted with Resident #5. The resident stated he had not received the COVID-19 vaccine or any other vaccine that he could recall. The IP stated if a resident doesn't have a consent; at intervals (quarterly) an attempt should be made to obtain consent. Resident #5 needed consents for Pneumococcal vaccine23, this season Influenza vaccine and the COVID-19 vaccine when be becomes eligible to receive it. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. An opportunity was afforded for presentation of additional information but they did not.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. 34306 Based on resident interview, clinical record review, and review of facility documents, the facility staff failed to provide cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. The findings included: During an interview with the Infection Preventionist (IP) on 9/22/21 at 10:10 a.m., she stated the SARS-CoV-2 outbreak began 8/28/21 when an alert and oriented resident tested positive after a Rapid test. The resident was confirmed positive on 8/31/21 after the Polymerase Chain Reaction (PCR) test results were received. The IP stated on 8/30/21 all residents in the facility except the first resident who tested positive were tested with the rapid antigen test for the SARS-CoV-2 infection and the test results revealed multiple positive cases. The IP stated as a result of the rapid test, PCR test were performed and the results were available to the facility staff 9/1/21. The IP stated the COVID-19 unit was built because of the number of SARS-CoV-2 positive cases. The facility staff was unable to provide documentation that residents, their representatives, and families were informed of subsequent occurrences. The IP stated on 9/7/21 outbreak testing continued for all residents who previously tested negative and the results were available to the facility 9/9/21. The results disclosed more SARS-CoV-2 positive cases. The IP stated on 9/13/21 outbreak testing continued for all residents who previously tested negative and the results were available to the facility 9/15/21. The results disclosed more SARS-CoV-2 positive cases. The IP stated on 9/21/21 outbreak testing continued for all residents who previously tested negative and the results were available to the facility 9/22/21. The results disclosed more SARS-CoV-2 positive cases. The Regional Director of Clinical Services stated facility wide rapid testing of all negative residents was completed 9/25/21 through 9/29/21 and six residents tested positive for SARS-CoV-2. A random sample of residents and families revealed they were notified of the 8/28/21 SARS-CoV-2 positive case. Notification of residents, their representatives, and families of subsequent occurrences of SARS-CoV-2 case weren't documented. On 9/28/21 at approximately 12:59 p.m., the Administer provided a copy of the letter sent to update representatives and families of the facility status. It was dated 8/27/21, the day before the first positive resident SARS-CoV-2 case. (continued on next page)

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	495150	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Park Rehabilitation	340 Lynn Shores Drive Virginia Beach, VA 23452

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/21 at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. The stated they inform residents and some families verbally as well as by email and the 8/27/21 letter was the last update sent.

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34306 Based on observations, resident interviews, staff interviews and review of facility documentation, the facility's staff failed to adhere to the following Centers for Disease Control and Prevention (CDC) guidance to have an established and effective COVID-19 testing program in place during a major SARS-CoV-2 outbreak and to prevent further transmission, severe infections, hospitalization s and deaths which constituted Immediate Jeapardy at a scope and severity level of 4 widespread (L): The facility failed to ascertain the vaccination status of all Healthcare Personnel (HCP) to determine who was unvaccinated and required expanded screening testing and the facility failed to conduct unvaccinated HCP testing for SARS-CoV-2 infection based on the level of community transmission (high/Red). The facility was broad based testing two times a week. The facility failed to have documentation that the required testing of the results of unvaccinated HCP including contractors, agencies and vendors was completed and corresponded to the facility's testing frequency. On [DATE] at 8:37 p.m., the facility Administrator, Director of Nursing and three Corporate Consultants were informed of the above Immediate Jeopardy concerns at F-886; COVID-19 Testing; during an outbreak of SARS-CoV-2 infections within the facility which was cited at a scope and severity level of 4 widespread (L) which constituted Substandard Quality of Care. The survey team validated the plan of removal through observations, interviews and review of facility documents and the Immediate Jeopardy was removed on [DATE] at 4:25 p.m. The deficient practice was decreased to an F (potential for more than minimum consequence). During this non-compliance the facility was subject to a major SARS-CoV-2 outbreak with increased transmission of COVID-19, hospitalization s and death. The following cumulative data was provided by the facility on [DATE]. From [DATE] to [DATE], there were fifty-three SARS-CoV-2 positive residents, nineteen were hospitalized , one remained in the hospital and nine died . The cumulative of SARS-CoV-2 positive staff was six, one staff was hospitalized and died , four staff returned to work and no staff was still in quarantine. The facility stated they felt this was accurate but was unable to attest it was one hundred percent accurate. The findings included: 1. The facility failed to ascertain the vaccination status of all Healthcare Personnel (HCP) to determine who was unvaccinated and required expanded screening testing and the facility failed to conduct unvaccinated HCP testing for SARS-CoV-2 infection based on the level of community transmission. Interviews with many of the HCP revealed based on CDC guidelines they met the requirements to be tested (they were unvaccinated) but were not tested based on the level of community transmission for they lacked knowledge related to the testing requirements. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE], the level of community transmission was reviewed for the facility's city's level data. The level was HIGH and the community had been at that level during our review period of [DATE] - [DATE]. The guidance stated when the level of community transmission is HIGH unvaccinated staff must be tested two times each week. Many of the facility HCP interviewed [DATE] - [DATE] stated they were unvaccinated and had not tested two times per week from [DATE] - [DATE] for various reasons (specifics for each individual). An interview was conducted with Certified Nursing Assistant (CNA) #4 on [DATE] at 2:27 p.m., CNA #4 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she usually tested approximately one time each week. An interview was conducted with Physical Therapist Assistant (PTA) #4 on [DATE] at 2:33 p.m., PTA #2 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she had not recently tested but she only worked at the facility as needed. An interview was conducted with Certified Nursing Assistant (CNA) #6 on [DATE] at 10:00 a.m., CNA #6 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she usually test approximately one time each week. CNA #6 stated she thinks she was lasted tested [DATE] by the IP. An interview was conducted with Dietary staff #15 on [DATE] at approximately 12:20 p.m., Dietary staff #15 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and was last tested approximately one week ago because the facility administration doesn't want them walking through the building to get tested . An interview was conducted with LPN #11 on [DATE] at 10:04 a.m., LPN #11 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she usually tested on e to two time each week and she was lasted [DATE] at a CVS pharmacy and prior to that [DATE] but no one at the facility had ever asked her to provide documentation of testing. An interview was conducted with Certified Nursing Assistant (CNA) #13 on [DATE] at 10:19 a.m., CNA #13 stated she was unvaccinated, had tested positive for SARS-CoV-2 February 2021 and she tested [DATE] and prior to that she hadn't tested for over a week. An interview was conducted with LPN #10 on [DATE] at 10:27 a.m., LPN #10 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she was last tested approximately [DATE] and hadn't tested since then. An interview was conducted with Certified Nursing Assistant (CNA) #8 on [DATE] at 10:30 a.m., CNA #8 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and she was tested [DATE] when she arrived for her shift but prior to that she hadn't been tested since approximately [DATE]. An interview was conducted with Dietary staff #20 on [DATE] at approximately 10:55 a.m. The Dietary staff #20 stated she was unvaccinated, had tested positive for SARS-CoV-2, [DATE] and was last tested approximately six weeks ago for another. Dietary staff #20 stated the facility had never asked about the vaccination or requested testing status. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	An interview was conducted with Dietary staff #19 on [DATE] at approximately 11:05 a.m. The Dietary staff #19 stated she was unvaccinated, had never tested positive for SARS-CoV-2 and was last tested approximately two weeks ago for another entity. Dietary staff #19 stated the facility had never asked about her vaccination or requested testing status. 2. The facility failed to have documentation that the required testing of the results of unvaccinated HCP was completed and corresponded to the facility's testing frequency. On [DATE] at approximately 10:25 a.m., HCP testing was observed and the documentation of the testing was reviewed. A review of those listed as tested revealed the HCP name/signature only, no documentation of their test results. An interview was conducted with the Infection Preventionist (IP) on [DATE] at approximately 3:20 p.m., the Infection Preventionist stated testing for HCP was two times weekly (Tuesday and Thursday) based on the level of community transmission and that an undocumented test result indicated the result was negative. The tested HCP results for [DATE] remained undocumented throughout the survey. During an interview with the IP on [DATE] at approximately 3:20 p.m., the IP stated all staff testing isn't documented because the licensed nurses who performs the testing often test direct care HCP during their shift and solely provide the HCP with the result. The IP had no documentation indicating which HCP should have been tested , if they had been tested based on the level of community transmission from [DATE] - [DATE], or documentation the testing was completed along with the results. The IP stated she never followed-up with the licensed nurses to gleam information of HCP testing and results except if a staff member tested positive. An interview was conducted with Licensed Practical Nurse (LPN) #3 on [DATE] at 12:04 p.m., LPN #3 stated the Rapid test (The BinaxNOW COVID-19 Ag Card) are used for staff testing and if there is a positive result it is followed-up with a polymerase chain reaction (PCR) test. LPN #3 also stated that the current practice for staff testing is to delegate it to licensed nurses on various shifts and only the Director of Nursing and IP knows where the results are documented for the prior system of documentation was discontinued for the computerized line listing method. On [DATE] at approximately 6:30 p.m., the above information was reviewed with the Administrator, Interim Director of Nursing, and Regional Director of Operations, Regional Reimbursement Consultant and the Regional Director of Clinical Services. The Regional Director of Operations stated beginning [DATE] staff testing and results of unvaccinated employees will be tracked on COVID testing logs. The IP will provide a weekly updated vaccination list to the Administrator/designee who will audit testing three times each week for eight weeks to ensure all unvaccinated staff are in compliance with routine testing according to the level of community transmission 34896 3. The facility staff failed to ensure that 3 Independent Contracted Construction Workers and 1 child who were observed on Unit 4 on [DATE] working, who admitted to working in the building on [DATE] and 30 days prior were tested for Covid-19 based on the facility's testing frequency to coincide with the level of community transmission (HIGH/RED) twice a week. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:45 a.m. a walk-through was conducted on Unit 4. Unit 4 was empty due to a facility refurbishment in progress. During the walk-through 3 construction workers and 1 child was observed on Unit 4. In the dining room two of the construction workers and the child were observed painting. The third construction worker was down the short hall installing ceiling tiles. All 4 individuals were observed without facemasks. On [DATE] at 10:55 a.m., Construction Worker #10 who was on the short hall was asked if he had ever been tested for Covid-19 by anyone at the facility. Construction Worker #10 stated, No English. Construction Worker #10 opened his phone, and was able to speak using a Spanish to English translator application. Construction Worker #10 stated, No tested , no vaccine. On [DATE] at 11:05 a.m., Construction Worker #11 and Construction Worker #9 who were painting in the Unit 4 dining room with the child were asked if they had completed the Covid-19 screening log when they entered the facility today. Construction Worker #9 stated, We forgot to sign in yesterday and today. We just came back yesterday, we haven't been in the building for 30 days. Construction Worker #9 was asked if the 3 of them were vaccinated and if anyone in the facility had informed them that the building was experiencing a Covid -19 outbreak and that facemask's were required. Construction Worker #9 stated, No one is vaccinated. We have masks but no one from the facility told us to wear the masks or anything about the covid. Construction Worker #9 was asked if anyone in the facility had ever tested them for Covid-10. Construction Worker #9 stated, No, we have not been tested . On [DATE] at approximately 1:30 p.m., the Infection Preventionist was asked if she has any documentation to show that the 3 construction workers or the 1 child had been tested when they were in the facility 30 days ago or any results that they had been tested on [DATE] or [DATE] prior to working. The Infection Preventionist was unable to provide the information that was requested. On [DATE] at approximately 4:30 p.m., the Administrator, the Regional Director of Clinical Services and the Regional Director of Operations were made aware of the above observations. The Regional Director of Operations stated, All construction was supposed to be stopped at the end of August when the outbreak started. There should not be anyone back there at all. On [DATE] at approximately 3:30 p.m., the Regional Director of Clinical Services stated, We have place signage at the side construction entrance of the facility indicating to vendors that the facility is in a Covid-19 outbreak status and visitation is restricted as of [DATE]. Signage in Spanish was also placed on the construction door prohibiting entrance until further notice. The construction supervisor was notified a second time that all construction must stop and workers are not authorized to be in the building until further notice. Also the Administrator will walk the construction unit twice daily to assure workers do not enter. The Regional Director of Operations stated, Beginning [DATE] all staff including contracted employees and vendors reporting to work will be required to submit to routine testing per community transmission rates, provide proof of recent testing (within 3 days), provide proof of vaccination status, or get tested on their scheduled shift. The facility policy titled Novel Coronavirus Prevention and Response dated ,d+[DATE] was reviewed and is documented in part, as follows: Policy: The facility will respond promptly upon suspicion of illness associated with a novel coronavirus in efforts to identify, treat, and prevent the spread of the virus. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Policy Explanation and Compliance Guidelines: 4. Considerations/priorities for testing. c. Testing for COVID-19 will occur for staff or residents with signs and symptoms of COVID-19, outbreaks within the facility and routinely following the frequency guidance according to the facility's level of community transmission. On [DATE] at 6:42 p.m., a pre-exit debriefing was conducted with the Administrator, the acting Director of Nursing, the Regional Director of Clinical Services and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. An Immediate Jeopardy Abatement Plan for F-tag 886 signed by the Administrator on [DATE] was provided to the survey team. 1. The facility performed staff testing of scheduled employees and agency staff [DATE]-[DATE]. It was discovered that two unvaccinated dietary staff members did not follow policy for testing and screening and worked on [DATE]. Both employees had received education on [DATE] and one employee received an additional test reminder on [DATE] by the regional director of dining services. Both employees were subsequently tested on [DATE] with negative results. Reeducation on policy for testing and screening was provided to dietary staff members on [DATE]. All staff including contracted employees and vendors reporting to work as of [DATE] will be required to submit to routine testing per community transmission rates, provide proof of recent testing (within 3 days), provide proof of vaccination status, or get tested on their scheduled shift. Per CMS guidelines, vaccinated staff members will not be required to submit to routine testing. 2. There was a cumulative total of 53 resident who have tested positive for Covid-19. 9 residents died , 1 died while still at the facility. 19 residents were hospitalized . 1 resident remains hospitalized . 6 staff tested positive for Covid-19. 1 staff member was hospitalized and passed. 4 staff have returned to work, none are on quarantine. Residents on this list who remain in the facility will continue to be monitored and treated under current COVID protocols until their cases have resolved. The center conducted facility wide rapid testing of negative residents [DATE] -[DATE] and six new resident cases were identified. All six residents currently reside on the COVID unit. All residents of the facility have the potential to be affected by the this practice. 3. Staff education was provided on [DATE] to employees in the following departments; nursing, environmental services, dietary, maintenance, and administrative staff. Staff education included CMS guidelines regarding frequency of testing for unvaccinated employees based on level of community transmission. Beginning [DATE] no employees will be allowed to return to work until the training has been completed. Training will be provided by the SDC in person or by phone. Staffing coordinator will ensure proof of vaccination status or a recent negative test (within three days) for all agency employees prior to scheduling them to work. Unvaccinated agency staff who have not had a recent test must be tested on their scheduled shift in order to be able to work. Scheduled staff testing will be held Monday and Thursday, however a nurse will be assigned to conduct testing seven days a week for all staff in order to remain in compliance with the testing guidelines. The frequency of scheduled staff will be adjusted to reflect current community transmission rates. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	4. Beginning [DATE] staff testing and results for unvaccinated employees will be tracked on COVID testing log. Infection preventionist will provide a weekly updated vaccinated staff list to Administrator or designee who will audit testing log 3 x per week for 8 weeks to ensure all unvaccinated facility staff and unvaccinated contracted staff are in compliance with routine testing according to community transmission rates. Any identified concerns will be immediately corrected. Additional education and disciplinary actions will be taken as appropriate. Results of audits will be summarized and submitted by the Nursing Home Administrator to the QAPI committee for oversight and additional recommendations to this plan. The next QAPI meeting is scheduled for [DATE] and will continue monthly x 6 months to assure ongoing compliance. 5. Medical Director was notified on [DATE] of the Immediate Jeopardy status of the facility and actions taken to abate. The facility conducted an AdHoc QAPI meeting on [DATE] reviewing and approving the Allegation of Compliance and corrective actions. Facility alleges compliance as of [DATE], signed by the Administrator. The survey team validated the plan of removal through observations, interviews and review of facility documents and the Immediate Jeopardy was removed on [DATE] at 4:25 p.m. The deficient practice was decreased to an F (Potential for more than minimal consequence).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09546 Based on observations, record reviews and staff interviews, the facility staff failed to ensure resident rooms who were identified as COVID-19 positive (Resident #16, #27 and #53) were cleaned and sanitized. The findings included: During the survey on 09/21/21-through 09/30/21 observations were made on Unit II. Resident #16, #27 and #53 were identified as being COVID-19 positive during this time period. 1. Resident #53 was admitted to the facility on [DATE] with diagnoses which included hemiplegia, insomnia, type 2 diabetes, major depression, convulsions, hypothyroidism, cerebral infarction, cognitive impairment and contracture of left hand. In the area of Cognitive Patterns Basis Interview for Mental Status this resident was coded as a 15. A Care Plan dated 09/25/21 indicated: Focus- COVID-19 active diagnosis. Resident #53 was identified as able to move around using a wheelchair. Resident #53 was observed on 09/20/21 at 7:53 P.M. and 09/21/20 at 9:43 A.M. seated in a wheelchair in room [ROOM NUMBER] door way. This resident was observed without a mask. On 09/21/20 Resident #53 was identified as COVID-19 positive. Resident #53 was observed moving in and out of her room with the door open. Resident #53 remained in room [ROOM NUMBER] bed A until 09/23/21. Resident #53's bed linen, personal items, unfinished orange juice and food container were observed in the room for days after she vacated her room. This resident was observed to be moved across the hall way to room [ROOM NUMBER]. Observations made during the survey indicated Resident #53 bed at 25-A remained uncleaned and unsanitized. Resident #53's roommate Resident #65 was idenitifiied as COVID-19 positive on 09/27/21. 2. Resident #16 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder, cervical spinal cord sequela, spinal stenosis, chronic pain, hypertension, dysphagia and mood disorder. Resident #16 was identified as COVID-19 positive on 09/22/21. Resident #16 was a resident living on Unit II in room [ROOM NUMBER]. Resident #16's was transferred out of bedroom [ROOM NUMBER] on 09/25/21. Resident #16's bed linen, personal items and food container remained in his room until 09/30/21. Resident #16's floor, bed and other areas of the room remained unsanitized and not cleaned after she vacated the room. 3. Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses for this resident included Multiple Sclerosis, Rhabomylysis, muscle weakness, epilepsy, ataxia, dysphagia, dementia, traumatic subduaral hemorrhage without loss of consciousness, major depression, cerebral vascular disease, and altered mental status. Resident #27 was identified as COVID-19 positive on 09/27/21. Resident #27 was transferred out of his bedroom [ROOM NUMBER] on 09/27/21. Resident #27's floor, bed, linen, personal items, and other areas of the room remained unsanitized and not cleaned afte she vacated her room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/21 11:29 A.M. during an interview with the Regional Director of Housekeeping and the Administrator. They were asked how long should a resident's room remain uncleaned and unsanitized after the resident tested Positive for COVID-19. The Regional Director of Housekeeping stated, the room be deep cleaned as soon as the resident moves out. The Administrator and the Regional Director of Housekeeping were shown the condition of Resident rooms, 25, 22, and 15. A facility policy and procedure dated 11/1/20 indicated: Routine Cleaning and Disinfection: Policy: It is the policy of this facility to ensure the ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: Transmission Based Precautions refers to a group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09546 Based on observations, record review, and staff interview, the facility staff failed to maintain an effective pest control program. The findings included: Roaches and fly's were observed through the facility on all days of the survey and on all units. These units included: The closed unit 4, Rehab Unit, locked units 3 and 5, as well as Unit 1 COVID-19. Roaches were observed in the front corridor bathrooms, as well as the wall ways. A brownish waste like matter was observed oozing from the roaches leaving a trail like substance on the floor. A house keeper was observed walking around with a spray container daily, spraying various areas of the facility. During an interview on 09/22/21 at 10:00 A.M. with the house keeper he stated, his job was to spray the building daily to help control the roaches. A customer service report of a pest control firm dated 4/13/21 indicated: Treated rooms, 9, 11, 13, 15, 17, 21, 23, 25, 26, 28, 29, and 30 for roaches. Rats noted during service bait station 1-8. A pest Sighting Log dated 7/28/21 indicated: Roaches- Unit 1 room [ROOM NUMBER]- several roaches in room. Sighting Log dated 6/9/21 indicated Roaches Unit 1 Nurses Station. A Sighting Log dated 7/21/21 and 8/2/21 indicated Kitchen prep area: mouse in back storage area near bread rack. A 7/30/21 Pest Sighting Log indicated: Roaches nest in nursing med cart Unit 2. During an interview on 09/29/21 with the Administrator he stated, I have a staff member going around daily spraying all areas of the facility to help control the roaches. A Pest Control policy and procedure revised 10/28/20 indicated: It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. An effective pest control program is defined as measures to eradicate and contain common household pests (e. g. bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats).