STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted 12/29/21 through 01/10/22 with exit from the facility 12/29/21. Additional information was obtained through 01/10/22. Therefore the exit date was changed to 01/10/22. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# P64N11..	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted 12/29/21 through 01/10/22 with exit from the facility 12/29/21. Additional information was obtained through 01/10/22. Therefore the exit date was changed to 01/10/22. The facility was found to be out of compliance with 42 CFR 483.80 infection control regulation and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 4 of 4 complaint allegations were substantiated resulting in deficiencies. Event ID #P64N11.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		2/7/22

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

Electronically Signed | 01/31/2022

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F 622	Continued From page 1	F 622		

because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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F 622	Continued From page 2	F 622		

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

1. Resident is no longer at the facility.

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F 622	Continued From page 3	F 622		

physician which stated the reason the facility could not meet the resident's needs for 1 of 1 resident reviewed for transfer and discharge (Resident #11).

Findings included:

Resident #11 was admitted to the facility 11/20/21 with diagnoses including encephalopathy (a disease of the brain that alters brain function or structure) and seizure disorder.

Review of the admission Minimum Data Set (MDS) dated 11/26/21 revealed Resident #11 was severely cognitively impaired and had wandering behaviors 1 to 3 days during the look back period. The MDS noted Resident #11 was not planning to return to the community.

Review of the behavior care plan last revised on 12/07/21 revealed Resident #11 did not cooperate with care at times related to adjustment to the nursing home and personal choice.

Resident #11 was transferred to the hospital for evaluation after a fall on 12/20/21.

Review of Resident #11's medical record revealed no documentation related to discharge planning, a discharge summary which described the services Resident #11 received while at the facility, a transfer and discharge notice, or documentation by the physician describing the specific needs and behaviors of Resident #11 that could not be met or managed at the facility.

An interview with the former Administrator on 01/06/22 at 5:58 PM revealed he did not recall all the details of Resident #11's transfer to the

2. All residents have the potential to be affected by the deficient practice.

3. Residents who are admitted to the hospital will not be denied readmission for any reason. If any staff member attempts to deny a patient re-admission to the facility, the admissions director, who manages the re-admissions, must inform Regional Vice President of Sales and Marketing immediately.

The Regional Vice President of Sales and Marketing or designee will randomly audit three hospital discharges per week for 12 weeks to ensure proper discharge and re-admission procedures are being followed.

The Director of Nursing will audit 5 charts per week x 24 weeks to assure proper documentation and justification by the physician related to transfer, discharge and re-admission.

All staff will be re-inserviced on re-admission policies and procedures by the Director of Nursing by 2/7/22.

All administrative staff were re-inserviced on transfer and discharge regulation on 12/30/21 by the interim administrator.

4. The Regional Vice President of Admissions will report findings of audit to QAPI monthly for 3 months.
The Director of Nursing will report results of audits for proper documentation by physician to QAPI monthly for six months.

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F 622	Continued From page 4 hospital but he thought Resident #11 was sent to the hospital because of inappropriate behavior. He stated he told hospital staff that if Resident #11 need to return to the facility he would have to have one-on-one supervision and that was a service the facility did not provide.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) 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; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		2/7/22

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F 625	Continued From page 5	F 625		

by:
Based on record review and interviews with the Responsible Party (RP) and staff, the facility failed to provide the resident's Responsible Party (RP) with the bed hold policy for 1 of 1 resident reviewed for transfer and discharge (Resident #11).

Findings included:

Resident #11 was admitted to the facility 11/20/21.

Review of a nurse's note dated 12/20/21 at 5:38 PM revealed Resident #11's RP was notified of Resident #11 being sent to the Emergency Department for evaluation.

An interview with the Social Worker (SW) on 12/29/21 at 4:56 PM revealed she did not provide Resident #11's RP with the written notice of the bed hold policy.

An interview with the Director of Nursing (DON) on 12/29/21 at 5:34 PM revealed she called Resident #11's RP to notify him Resident #11 was being transferred to the hospital to be evaluated after falling earlier in the day on 12/21/21. She stated she did not provide the RP with the written notice of the bed hold policy.

An interview with Resident #11's RP on 01/03/21 at 6:45 PM revealed he was notified via phone Resident #11 was being transferred to the hospital after a fall on 12/20/21. He stated he did not receive a notice of the bed hold policy.

During an interview with the Interim Administrator on 01/10/22 at 4:51 PM she confirmed Resident

1. Resident is no longer at the facility.

2. All residents have the potential to be affected by the deficient practice.

3. The bed hold policy will be added to the discharge packet for resident when leaving the facility. The next business day the Business Office Manager or designee will follow up with the resident or responsible party to discuss bed hold options and charges.

The Business Office Manager was re-informed of this on 2/1/22. Discharge and bed hold follow up will be reported daily by the Business Office Manager x 5x per week for 24 weeks in stand up or stand down to ensure proper procedures are being followed.

All licensed staff will be re-inserviced by the Director of Nursing regarding the bed hold policy by 2/7/22.

4. Administrator will report findings of daily meeting regarding bed hold policy compliance to QAPI monthly for six months.

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F 625	Continued From page 6 #11's RP should have been provided with a copy of the bed hold policy.	F 625		
F 626 SS=E	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given	F 626		2/7/22

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F 626	Continued From page 7	F 626		

the option to return to that location upon the first availability of a bed there.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff and family interviews the facility failed to allow a resident to return to the facility after being sent to the hospital for evaluation without state agency intervention for 1 of 1 resident reviewed for discharge (Resident #11).

Findings included:

Resident #11 was admitted to the facility 11/20/21 with diagnoses including encephalopathy (a disease of the brain that alters brain function or structure) and seizure disorder.

Review of the admission Minimum Data Set (MDS) dated 11/26/21 revealed Resident #11 was severely cognitively impaired and had wandering behaviors 1 to 3 days during the look back period. The MDS noted Resident #11 was not planning to return to the community.

Review of the behavior care plan last revised on 12/07/21 revealed Resident #11 did not cooperate with care at times related to adjustment to the nursing home and personal choice.

Resident #11 was transferred to the hospital for evaluation after a fall on 12/20/21.

Review of Resident #11's medical record revealed no documentation of behaviors.

An interview with the Interim Administrator on 12/29/21 at 5:00 PM revealed she was not aware of any concerns with Resident #11's transfer to

1. Resident was offered a bed and readmitted to the facility on 12/31/21.
2. All residents have the potential to be affected by the deficient practice.
3. Residents who are admitted to the hospital will not be denied readmission. The Admission Director is the primary contact for the hospital for resident re-admission. She has been inserviced by the interim administrator on 12/30/21 that no current residents may be denied re-admission to the facility and proper policies and procedures regarding re-admission. If any staff member, specifically the administrator, who is the direct supervisor to the admission director or Director of Nursing who supervises in Administrator's absence, denies a patient re-admission to facility based, the admissions director must inform the Regional Vice President of Sales and Marketing immediately, who has no reporting relationship to the building at all. The Regional Vice President of Sales and Marketing or designee will randomly audit three hospital discharges per week for 12 weeks to ensure proper discharge and re-admission procedures are being followed.
All licensed staff will be re-inserviced by the interim administrator regarding the re-admission policies and procedures by 2/7/22.
4. The Regional Vice President of Admissions will report findings of audit to

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the hospital or readmission to the facility because the transfer occurred before she became the Interim Administrator. She stated she would look into the matter.

An interview with the Director of Nursing (DON) on 12/29/21 at 5:34 PM revealed Resident #11 began having inappropriate behaviors approximately a week after being admitted to the facility which included wandering into female resident rooms, exposing himself during a church service, and urinating on his roommate twice. She explained that Resident #11 had a fall on 12/20/21, was transferred to the hospital for evaluation, and she notified Resident #11's Responsible Party (RP) he was being transferred to the hospital. The DON stated after Resident #11 was transferred to the hospital the former Administrator decided the resident would not be allowed to return to the facility. She confirmed there was no documentation of behaviors in Resident #11's medical record.

A follow up interview with the Interim Administrator on 12/29/21 at 6:20 PM revealed she had contacted the hospital and had offered a bed for Resident #11 and he would be returning to the facility on 12/30/21.

An interview with the Social Worker (SW) on 12/30/21 at 11:12 AM revealed Resident #11 was transferred to the hospital after a fall on 12/20/21. She explained that after Resident #11 was transferred to the hospital the former Administrator made the decision that he would not be allowed to return to the facility. The SW stated she spoke with Resident #11's RP and another family member on 12/21/21 and explained that Resident #11 would not be able to

F 626

QAPI monthly for 3 months.

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F 626	Continued From page 9	F 626		

return to the facility because he urinated on his roommate and they would need to work with case managers at the hospital to find alternate placement for Resident #11.

Resident #11 was allowed to return to the facility on 12/30/21 after state agency intervention.

A joint interview with Resident #11's RP and another family member on 01/03/21 at 6:45 PM revealed the RP was notified Resident #11 was being transferred to the hospital after a fall on 12/20/21. The family member stated around midnight on 12/21/21 she received a telephone call from the hospital advising her Resident #11 was ready to be picked up and she needed to come get him. She explained to hospital staff that Resident #11 was a resident at a skilled nursing facility and they would need to call the facility to pick him up. She stated the hospital told her they were informed the facility was not going to allow Resident #11 to return. The family member stated she spoke with facility staff the morning of 12/21/21 and was informed Resident #11 had urinated on his roommate and was not going to be allowed to return the facility. The RP stated he was not aware of Resident #11 having any behaviors during his stay until 12/21/21. The family member stated Resident #11 ended up staying in the hospital Emergency Department for around 10 days before being allowed to return to the facility.

An interview with the former Administrator on 01/06/22 at 5:58 PM revealed he did not recall all the details of Resident #11's transfer to the hospital but he thought Resident #11 was sent to the hospital because of inappropriate behavior. He stated he told hospital staff that if Resident

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F 626	Continued From page 10 #11 need to return to the facility he would have to have one-on-one supervision and that was a service the facility did not provide. A follow-up interview with the interim Administrator on 01/10/22 at 4:51 PM revealed Resident #11 should have been allowed to return to the facility after his evaluation at the hospital on 12/21/21 but was allowed to return to the facility 12/30/21.	F 626		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		2/7/22

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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	345329	A. BUILDING _____ B. WING _____	C 01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, facility staff (Nurse Aide #1) failed to perform hand hygiene between residents when delivering meal trays and assisting with meal tray set up for 4 of 4 residents (Resident # 3, #4, #5, #6). This failure occurred during a global pandemic.

Findings included:

The facility's "Hand Hygiene" policy dated 9/6/2016 stated hand hygiene included either handwashing, antiseptic handwashing or antiseptic hand rubs. It stated the purpose of hand hygiene was to reduce the spread of germs in the healthcare setting, and hand hygiene should be performed before and after patient care and after contact with inanimate objects in the immediate patient vicinity.

On 12/29/2021 at 1:04 p.m., Nurse Aide (NA) #1 was observed exiting Resident #7's room without performing hand hygiene or using hand sanitizer and gathered a meal tray from the meal cart for Resident #3. NA #1 entered the Resident #3's room, placed the meal tray on the bedside table and positioned the bedside table in front of Resident #3. NA #1 was observed exiting Resident #3's room without performing hand hygiene.

On 12/29/2021 at 1:07 p.m., NA #1 was observed returning to the meal cart with two cups. Using a coffee pitcher on top of the meal cart, NA #1 removed the cup lids and placed on top of the cart, poured coffee in the two cups and delivered the coffee cups to Resident #3's meal tray. NA #1 was observed exiting Resident #3's room without

1. Certified Nurse Aide #1 was re-educated regarding hand hygiene while passing trays during meals on 12/29/21.

2. All residents have the potential to be affected by the deficient practice. Root Cause Analysis was conducted with the help of the infection preventionist and QAPI committee to determine the root cause of failure to conduct proper hand hygiene between meals.

3. Hand sanitizer will be put on all meal carts so that it is readily available during meal pass. All staff will be re-inserviced by 2/7/22 on hand hygiene during meal pass by the Director of Nursing. The Director of Nursing or designee will randomly observe three meals per week for 12 weeks to assure that hand hygiene procedures are being followed.

A Root Cause Analysis will be completed by the Director of Nursing, Infection Preventionist and QAPI committee by 2/5/21.

4. Director of Nursing will report results of observations to QAPI monthly for three months.

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performing hand hygiene.

On 12/29/2021 at 1:08 p.m. after exiting Resident # 's room, NA #1 was observed entering Resident #4's room to assist Resident #4, who was sitting in a wheelchair in the doorway, back into his room beside his bed and moved the bedside table in front of him. NA#1 exited Resident #4's room without performing hand hygiene and gathered Resident #4's meal tray from the meal cart. NA #1 re-entered Resident #4's room and placed the meal tray on the bedside table and assisted Resident #4 in opening the lids on the cups and utensils. NA #1 used his utensils to cut the meat on the tray. NA #1 was observed not performing hand hygiene before leaving Resident #4's room and returning to the meal cart.

On 12/29/2021 at 1:11 p.m., NA #1 was observed gathering Resident #5's meal tray, placing the meal tray on the bedside table and positioning the bedside table in front of Resident #5. NA #1 removed the cup lids and opened the utensils for Resident #5 and was observed exiting the room without performing hand hygiene.

On 12/29/2021 at 1:12 p.m., NA #1 was observed returning to the meal cart and gathering the meal tray for Resident #6. NA #1 placed the meal tray on the beside tray and used the hand crank on the bed to raise the head of the bed before positioning the bedside table in front of Resident #6. NA #1 was observed assisting Resident #6 set up the meal tray by removing lids from the cups and opening the utensils for Resident #6. NA #1 was observed exiting Resident #6 room without performing hand hygiene. Hand sanitizer was observed on the wall outside Resident #6's room.

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A review of NA #1's orientation packet indicated NA #1 received orientation on Infection Control and Hand Hygiene on 8/15/2021 from the facility.

On 12/29/2021 at 1:13 p.m. in an interview with NA #1, she stated she had not performed hand sanitization or hand washing between the residents while delivering and setting up the meal trays. She stated she had not been informed by the facility to perform hand hygiene between residents when delivering trays. She stated she did not have any hand sanitizer in her pocket, and resident rooms did have soap and water to perform hand washing. She stated the facility provided her an orientation and as an agency staff member she started providing resident care from the start and learned things along the way.

On 12/29/21 at 2:48 p.m. in an interview with the Director of Nursing, she stated staff were to perform hand hygiene between delivering resident's meal trays. She stated education on hand hygiene was covered in orientation.

On 1/4/2022 at 7:23 p.m. in an interview with the Human Resources Coordinator, she stated the agency staff were given an orientation packet. She stated the orientation packet addressed how to perform hand hygiene and did not address performing hand hygiene after delivering meal trays to residents. She stated the facility's orientation to their staff included performing hand hygiene after delivering and assisting residents with their meal tray and would start incorporating the practice into the agency orientation packet.

F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		2/7/22

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§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

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

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medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to offer and/or administer the pneumococcal vaccine for 2 of 5 residents reviewed for immunizations (Resident #9 and Resident #8).

Findings included:

Review of the facility's policy titled Pneumococcal Vaccine last revised October 2019 read in part:

All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.

1. Upon admission residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or the resident has already been vaccinated.

1. Both residents will be offered pneumococcal and flu vaccine by 2/7/22.
2. All residents have the potential to be affected by the deficient practice.
3. The MDS nurse/Staff Development Coordinator will complete all admission assessments and paperwork related to admission including whether a resident was vaccinated previously and if not, does the resident or responsible party consent currently. The MDS nurse/Staff Development Coordinator will document all vaccine statuses on new residents. The MDS/Staff Development Coordinator was informed upon hire on 1/10/22 that part of her job duties would be to include performing all documentation and assessments related to admissions including inquiring about and/or offering flu and pneumococcal vaccine.
Assistant Director of Nursing will audit resident charts to be sure that all current

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2. Assessments of pneumococcal vaccination status will be conducted within 5 working days of the resident's admission if not conducted prior to admission.

3. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effected of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record.

4. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol.

5. Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccine.

A. Resident #9 was admitted to the facility 08/17/18 with diagnoses including diabetes and hypertension.

The quarterly Minimum Data Set (MDS) dated 11/12/21 revealed Resident #9 was cognitively intact.

Review of Resident #9's immunization record did not reflect he was offered the pneumococcal vaccine and declined or received the pneumococcal vaccine.

An interview with the Director of Nursing (DON) on 12/29/21 at 2:40 PM confirmed Resident #9

residents have been offered a pneumococcal and flu vaccine and that it is properly documented by 2/7/22.
All licensed staff will be re-inserviced on the policies and procedures regarding vaccination of residents by the Director of Nursing by 2/7/22. The Director of Nursing will randomly audit three new admissions per week to ensure that the pneumococcal and flu vaccine was offered and documented for 12 weeks.
4. Director of Nursing will report results of audit to QAPI monthly for three months.

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did not receive the pneumococcal vaccine. She also confirmed Resident #9's medical record did not reflect he was offered the pneumococcal vaccine and declined.

An interview with the Administrator on 01/10/22 at 4:51 PM revealed she expected staff to follow the facility's pneumococcal vaccination policy by offering the pneumococcal vaccine if appropriate and documenting administration or declination in the resident's medical record.

B. Resident #8 was admitted to the facility 10/09/18 with diagnoses including diabetes and hypertension.

The quarterly Minimum Data Set (MDS) dated 10/14/21 revealed Resident #8 was cognitively intact.

Review of Resident #8's immunization record did not reflect he was offered the pneumococcal vaccine and declined or received the pneumococcal vaccine.

An interview with the Director of Nursing (DON) on 12/29/21 at 2:40 PM confirmed Resident #8 did not receive the pneumococcal vaccine. She also confirmed Resident #8's medical record did not reflect he was offered the pneumococcal vaccine and declined.

An interview with the Administrator on 01/10/22 at 4:51 PM revealed she expected staff to follow the facility's pneumococcal vaccination policy by offering the pneumococcal vaccine if appropriate and documenting administration or declination in the resident's medical record.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345329	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 1/10/2022

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental

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

The above isolated deficiencies pose no actual harm to the residents

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disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with the Responsible Party (RP) and staff, the facility failed to provide the resident's Responsible Party (RP) a written notification explaining the reason why the resident was transferred to the hospital for 1 of 1 resident reviewed for transfer and discharge (Resident #11).

Findings included:

Resident #11 was admitted to the facility 11/20/21.

Review of a nurse's note dated 12/20/21 at 5:38 PM revealed Resident #11's RP was notified of Resident #6 being sent to the Emergency Department for evaluation.

An interview with the Social Worker (SW) on 12/29/21 at 4:56 PM revealed she did not provide Resident #11's RP a written notification explaining why Resident #11 was transferred to the hospital.

An interview with the Director of Nursing (DON) on 12/29/21 at 5:34 PM revealed she called Resident #11's RP to notify him Resident #11 was being transferred to the hospital to be evaluated after falling earlier in the day on 12/21/21. She stated she did not notify the RP in writing that Resident #11 was transferred to the hospital.

An interview with Resident #11's RP on 01/03/21 at 6:45 PM revealed he was notified via phone Resident #11 was being transferred to the hospital after a fall on 12/20/21. He stated he did not receive a written notification explaining why Resident #11 was transferred to the hospital.

An interview with the Interim Administrator on 01/10/22 at 4:51 PM confirmed there was no written documentation explaining why Resident #11 was transferred to the hospital provided to the RP and written documentation should have been provided when Resident #11 went to the hospital.