STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495339	A. BUILDING _____ B. WING _____	C 06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Complaint survey was conducted 5/30/2019, 5/31/2019 and 6/3/2019 through 6/4/2019. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 43 resident reviews. On 05/31/2019 at 4:47 PM, immediate jeopardy was called. On 05/31/2019 at 4:52 PM, the facility administration was informed. On 06/4/2019 at 6:05 AM, immediate jeopardy was abated and was lowered to a level 2 pattern.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	F 583		7/15/19

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

Electronically Signed | 06/27/2019

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F 583	Continued From page 1 mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to maintain privacy of clinical records for one resident (Residents # 43) in a survey sample of 43 residents. The facility staff left the Medication Administration Record open and unattended during medication pass and pour. The findings include: On 6/3/2019 at 11:20 a.m., the medication cart on the Grace Unit across from the nurses station was observed unattended. When walking past the medication cart the screen of the MAR (medication administration record) was available for viewing. Resident # 43's name and diagnoses and other identifying information were observed on the screen. On 6/3/2019 at 11:26 a.m., an interview was	F 583	F000 To remain in compliance with all Federal and State regulations, that facility has or will take the following actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the date(s) indicated. F583 1)MAR computer screen for resident #43 was immediately put in privacy mode on 6/3/19 when this was brought to the nurse's attention. 2)No other computers were identified without privacy screen use. 3)Re-education was provided to nurses on use of privacy mode on computers. 4)During quarterly med pass observation use of privacy mode will be audited. Concerns identified will be addressed by	

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F 583	Continued From page 2 conducted with Licensed Practical Nurse (LPN) F who stated she was the nurse assigned to that medication cart. LPN F stated she thought she had hit the privacy screen (on the MAR). LPN F stated the nurses are supposed to make sure to hit the privacy screen prior to leaving the medication cart. During the end of day debriefing, the facility Administrator, Employee A, and Director of Nursing, Employee B, were informed of the findings. No further information was provided.	F 583	SDC/ auditor with the nurse immediately and reported to the QA committee/compliance for review and recommendations. 5)Date: 7/15/19	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide oxygen therapy consistent with standards of practice for one resident (Resident # 9) in a survey sample of 43 Residents. The facility staff failed to ensure cautionary, safety signs indicating the use of oxygen were posted outside the door of Resident #9's room. The findings include:	F 695	F 695 1)The portable O2 tank was removed from the room, as verified in the 2567, as it was not in use for Resident #9 at the time of the observation or thereafter. 2)Signage was appropriate for all other Oxygen use when audited. 3)Re-education provided to nurses on placing signage outside of the rooms for oxygen when in use.	7/4/19

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F 695	Continued From page 3 Resident # 9 was an 88-year-old female admitted to the facility on 8/8/2018 with the diagnoses of, but not limited to, Pneumonia and Dyspnea (difficulty breathing or labored breathing). Resident # 9's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5/17/2019 was coded as a Quarterly Assessment. Resident # 9 was coded as having a BIMS (Brief Interview for Memory Status) Score of 5, indicating severe cognitive impairment. Resident # 9 was also coded as needing limited to extensive assistance of one staff member to perform her ADLs (activities of daily living) except needing total assistance of one staff person for bathing. She also was coded as always being frequently incontinent of bowel and bladder. On 5/30/2019 at 12:34 p.m., during the initial tour of the facility, Resident # 9 was observed sitting in her room. There was a portable oxygen tank on a rolling cart in the room on the left side of the bed. There was no "oxygen in use" sign on the door. There was a Droplet Precaution sign on the door. On 5/31/2019 at 11:34a.m., 6/3/2019 at 11:20 a.m. and 7:45 p.m., observations revealed no "oxygen in use" sign on the door to Resident #9's room. A portable oxygen tank was observed in room during each observation. On 6/3/2019 at approximately 8:00 p.m., observation of Resident #9's room revealed the oxygen tank was no longer present in Resident #9's room. On 6/4/2019 at 5 p.m., an interview was conducted with (LPN) Licensed Practical Nurse F	F 695	4)During quarterly audits signage will be verified for room with O2 in use. Concerns will be reported to QA committee/compliance for review and recommendations. 5)Date: 7/4/19	

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F 695	Continued From page 4	F 695		

who stated she removed the oxygen from Resident # 9's room on 6/3/2019 because she didn't know why the portable tank was in the room. LPN F stated she noticed there was no sign on the door indicating there was oxygen in use in that room. LPN F stated there should have been a sign on the door. LPN F stated that usually the portable tanks were not used except in case of emergency. LPN F stated that the an oxygen concentrator was normally used for as needed oxygen orders and that oxygen concentrators were kept in storage along with the "oxygen in use" signs and tubing attached to the concentrator. LPN F showed the surveyor the room where the oxygen concentrators were located. Observation revealed oxygen concentrators did have tubing and oxygen in use signs ready for use.

On 6/4/2019, during the end of day debriefing, the facility Administrator, Employee A, Director of Nursing, Employee B, and Director of Compliance, Employee C were informed of the findings. Employee B and C both stated the facility's policy was that oxygen in use signs should be displayed on the doors when oxygen was ordered for a resident.

No further information was provided.

Pneumonia is an infection that inflames the air sacs in one or both lungs. The air sacs may fill with fluid or pus (purulent material), causing cough with phlegm or pus, fever, chills, and difficulty breathing. A variety of organisms, including bacteria, viruses and fungi, can cause pneumonia.Pneumonia can range in seriousness

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F 695	Continued From page 5 from mild to life-threatening. It is most serious for infants and young children, people older than age 65, and people with health problems or weakened immune systems. Accessed on 6/6/2019 on mayoclinic.org	F 695		
F 880 SS=K	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, 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;	F 880		7/15/19

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F 880	Continued From page 6 (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. This REQUIREMENT is not met as evidenced by: The facility staff failed to ensure implementation of infection control practices and precautions to prevent the spread of infection and communicable disease during an identified	F 880	F880 1)During the survey it was brought to the facility's attention "That a housekeeper, laundry aide and a day shift nursing staff	

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F 880	Continued From page 7 outbreak of a respiratory illness on one of three facility units, (Lee unit). The facility staff were observed not implementing standard and droplet precautions while providing care and services to residents, on isolation precautions for a viral respiratory illness on the Lee unit. Staff and a visitor were observed entering isolation rooms without wearing a mask, gowns or gloves and not changing gloves worn while performing care, and duties in the isolation rooms. Fourteen residents, (Resident #18, #19, #20, #22, #21, #23, #4, #25, #27, #29, #28, #24 and #26) residing on the 60 bed Lee unit, exhibited respiratory symptoms requiring transfer to the hospital with admission, resulting in a situation of Immediate Jeopardy. The Findings Include: Surveyor A observations: 1. On 05/30/2019 at 11:45 a.m., surveyors entered the facility on a 2-day complaint investigation regarding an outbreak of respiratory illness-affecting residents in the facility. During tour of the facility on the afternoon of 05/30/2019, and 5/31/19, multiple observations of facility staff failing to implement Droplet Precautions for residents placed on such isolation were observed. On 5/30/2019 at 11:45 a.m., upon entrance to the facility at the Lee Unit entrance, a sign was observed on the front door, which opened automatically. The 8 1/2 inch by 11-inch sign documented in part the following: "Due to reported Pneumonia on Lee Unit, We ask that you postpone your visit, We request that you help us protect the residents by not visiting Lee Unit if you, your children or any of your family	F 880	member did not follow proper droplet (Isolation Precautions). The following plan of correction was immediately implemented. -"Nursing, Laundry and Housekeeping staff for Lee Unit currently on duty will immediately be in-serviced on isolation precautions, completed on 5/31/19. -On each of the following shifts hereafter, all staff on duty in the nursing facility will be educated on isolation precautions. Visitors to residents will be provided education on isolation and entrance signs will remain in place. Staff not on duty during the correction period will not be permitted to work until education has been received. -Nursing supervisor/DON or designee will monitor ongoing use of PPE on Lee unit. Identified concerns will be reported to administration and the facility employee handbook regarding disciplinary process will be followed for any violation of facility policy. -The facility will conduct unannounced skills observation on isolation precautions PPE use. Findings will be monitored and reported to the facility administration and QA committee for review and recommendations. -All steps in POC completed by June 4, 2019, and verified to have been completed by the survey team as per 2567 at 6:05AM. 2)All residents on Lee unit were audited, there are no current residents on isolation precautions. The VDH director lifted precautions on June 18, 2019. 3)All staff re-education on isolation	

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F 880	Continued From page 8 members have symptoms, such as chills, fever, cough, sore throat, runny nose. It is extremely important if you been in contact with someone with a cold or these symptoms, or school aged children who may have been in contact with others having these symptoms that you do not visit as you may be carrying a common cold virus or other viruses, which could be passed to a resident without you being aware. We will be happy assist you [sic] in contacting your loved one, by leaving a note, or making a call to them until your symptoms subside. Thank you for your assistance! Remember to observe good handwashing PRIOR to and AFTER all visits." There were three pictures of individuals beneath the writing. One depicted a woman lying with her eyes closed, blowing her nose and holding a cup. The second picture showed a woman leaning over a child touching his forehead with her left hand and a thermometer in her right hand. The third picture showed a child holding her head while a thermometer was in her mouth. There was an identical sign on the Lee Unit receptionist's desk. Observation of the other entrance (Name of facility entrance) revealed there was no signage on the entry door and no signage on the receptionist's desk located at that entrance. On 5/30/2019 at 12:05 p.m., during the initial tour of the facility, no transmission precautions signs were noted on the first unit (Brantley Unit). There was one contact isolation sign on the door of one resident's room the unit (Grace Unit, this was not for respiratory illness) adjacent to the Lee Unit. There was no signage on the doors leading from	F 880	precautions documented and verified as per 2567. Staff will continue to receive annual training on infection control. The facility guide “Visitation of Residents on Isolation” has been added to the admission pack for all new admission and RP signatures are being obtained at that time to verify review and understanding as the facility cannot force visitors to don any isolation PPE, but only educate them and ask them not to visit if they are ill or have been exposed to those who are ill, as this would be a violation of resident rights. 4)Unannounced quarterly observations will be made of various staff skills for implementation of isolation precautions in a staff development simulation to verify skills and understanding of PPE use. Concerns will be addressed during training observations and reported to QA/Compliance for review and recommendations. 5)7/15/19	

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F 880	Continued From page 9	F 880		

the Grace Unit to the Lee Unit.

The Lee Unit had the capacity for 60 residents and consisted of three hallways. On the nurses' station counter, there was a generic sign distributed by the Minnesota Department of Health, Minnesota Antibiotic Resistance Collaborative and APIC (Association for Professionals in Infection Control and Epidemiology that documented, "Stop the spread of germs that make you and others sick! Cover your Cough, Cover your mouth and nose with tissue when you cough or sneeze or cough or sneeze into your upper sleeve, not your hands. Put your used tissue in the waste basket. Clean your Hands after coughing or sneezing. Wash hands with soap and warm water or clean with alcohol-based hand cleaner." There was no sign about the specific respiratory illness on the Lee Unit.

On 5/30/2019 at 12:26 p.m., there were 10 rooms observed on the Lee Unit with signs denoting droplet precautions. Nine of the rooms were semi private rooms with two residents and one room was a private room. Only three isolation carts were observed on the 60-bed unit, with one isolation cart on each of the three hallways. The flowing observations of isolation rooms were conducted:

On 5/30/19 at 12:28 p.m., a Droplet Precautions sign was observed on the door of a semi-private room in which Resident #15 resided in the B bed. The door was open. No resident were observed in the room. There was an isolation cart located outside the room. The isolation cart had masks on top of the cart. There were two drawers with yellow gowns visible inside. There was no hand

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F 880	Continued From page 10	F 880		

sanitizer and no box of gloves on top of the cart. Review of Resident #15's clinical/ record revealed a physician order that documented, "Droplet Precautions" dated 5/18/19.

On 5/30/19 at 12:31 p.m., a Droplet precaution sign was observed on the wall outside the door of a semiprivate room in which Resident #11 resided in the A bed. The door was open. Resident #11 was in bed eating lunch. There was no isolation cart outside the room. Review of Resident #11's clinical record revealed a physician order that documented, Droplet Precautions" dated 5/18/19.

On 5/30/19 12:32 p.m., a Droplet Precaution sign was observed on the door of a semiprivate room, in which Resident #27 resided in the B bed. The door was open and Resident #27 was sitting in a wheelchair coughing audibly while watching television. Review of Resident #27's clinical record revealed the resident was hospitalized on 05/20/2019. Resident #27 was readmitted to the facility, on 5/28/19. A physician's order dated 5/30/19 documented Resident #27 was on "Droplet Precautions."

On 5/30/19 at 12:34 p.m., a Droplet Precautions sign was observed on the door of semi-private room in which Resident #9 resided in the B bed. Review of Resident #9's clinical record revealed a physician order that documented, "Droplet Precautions" dated 5/19/19.

On 5/30/19 at 12:36 p.m., a Droplet Precaution sign was observed on the door of room in which Resident #5 resided in the B bed. The door was open. A resident was sitting by the window, reading a book. The other resident was not in the

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F 880	Continued From page 11	F 880		

room. Review of Resident #5's clinical record revealed a physician order that documented, "Droplet Precautions" dated 5/19/18.

On 5/30/19 at 12:37 p.m., a Droplet Precaution sign was observed on the door of room in which Resident #3 resided in the A bed. The door was open and a resident was observed sitting by the door in a recliner watching television. There was a mask hanging on the arm of a wheelchair in the room. There was an isolation cart at the door. A review of the chart for Resident #3 revealed the resident had orders for droplet precautions in place starting 05/18/2019 and continuing during the time of the observations on 05/30/2019.

On 5/30/19 at 12:38 p.m., a Droplet Precaution sign was observed on the door of the room in which Resident #4 resided in B bed. Review of Resident #4's clinical record revealed a physician order that documented, Droplet Precautions" dated 5/30/19.

Surveyor B Observation:

On 5/30/19 at 12:39 p.m., a member of laundry services was observed with a cart approximately 3 feet tall with a blue cover, the laundry staff member walked to the isolation cart outside of the room in which Resident #3 resided in the A bed. The laundry staff member retrieved gloves and a gown from the isolation cart and closed the top drawer. She then donned the gown and gloves. No hand sanitizer was used. The staff member was then observed entering the room with linen in her hands without donning a protective mask. The laundry staff member proceeded to work in the room, exit the room, and without donning a mask, replacing gloves, or performing hand

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hygiene, proceeded to gather clean linens off the covered clean linens cart and returned to the droplet isolation room. The staff member exited the room a second time, again without replacing any PPE (personal protective equipment), gathered more clean linens off the covered clean linen cart wearing the same gloves, and returned to the isolation room. At approximately 12:41 p.m., the staff member exited the room for a third time, now having doffed PPE, and proceeded to wheel the contaminated laundry cart further down the hall to deliver linens to other resident rooms not identified as being on isolation precautions.

Surveyor A observations:

On 5/30/19 at 12:44 p.m., the following: a stop sign and Droplet Precaution sign was observed on the door of the private room in which Resident #14 resided. The door of the room was open. There was no isolation cart located outside the room. Review of Resident #14's clinical record revealed a physician order that documented, "Droplet Precautions" dated 5/18/19.

At 12:45 p.m., a Droplet Precaution sign was observed on the door of room in which Resident #30 resided in the B bed. Review of Resident #30's clinical record revealed a physician's progress note for 5/23/19, which documented in part: CXR (Chest x-ray): Mild patchy by basilar densities left greater than right compatible with pneumonia."

At 12:50 p.m., a Droplet Precaution sign was observed on the door of room #149. There was no stop sign on the door. The door to the room was open. The bed closer to the door was unmade. There were no residents in the room.

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On 5/30/19, at 12:52 p.m., six residents were observed in the Lee unit activity room with the Activities Assistant. The Activities Assistant was sitting at a table with five residents participating in a coloring activity. There was one resident sitting in a wheelchair near the window. None of the residents nor the staff member were observed wearing masks.

Surveyor B observation and interviews:

During the course of further investigation of the complaint and after meeting with local Health District staff on 5/30/2019 at 1:28 p.m., surveyors became aware that more than 10 residents had been sent to the hospital for respiratory illness since the outbreak, and at least 3 residents had allegedly died, since 05/15/2019. The local Health District Director (assigned identifier "Employee F") stated they were made aware of a respiratory disease outbreak at the facility on 05/15/2019.

Employee F stated that his office made specific recommendations to the facility to contain the spread of the respiratory illness. The recommendations included but were not limited to, cohorting residents and staff, bleaching of frequently contacted surfaces, washing hands with soap and water rather than alcohol based hand sanitizer, restricting access to the Lee unit, which was the locus of the outbreak, and placing signage at all entrances to the Lee unit informing visitors of the outbreak.

During this interview, (and supported by documentation provided by the facility staff), staff from the local Health District were on-site on 05/20/2019 to obtain swab samples of ill

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residents, to be sent to the Centers for Disease Control and Prevention (CDC) for testing.
Following this visit, Health Department staff met with Facility Staff, including Employee A, the Facility Administrator, and presented the facility staff with written recommendations of actions the facility should take to limit the spread of the outbreak. Both Employee A, the administrator and Employee F, local Health District Director, signed the letter of recommendations. According to Employee F during the same interview on 05/30/2019, facility staff would not agree to sign the letter unless certain elements were edited, which is reflected below. The text of the letter follows:

[HEALTH DISTRICT] Recommendations:
Pneumonia Outbreak, [FACILITY], May 2019
Administrative:
[FACILITY] (struck out, replaced with "Lee Wing") is hereby closed to any new residents until the cessation of this outbreak. The facility may re-admit residents who are hospitalized but may not admit any residents who have not had an opportunity for exposure.
Signs shall be placed at all entrances alerting visitors that there is a pneumonia outbreak at the facility. (struck out, replaced with Lee Wing)
Visitors should be encouraged to postpone their visit until the outbreak has ceased.
Ensure that First Responders/EMS (emergency medical services)/Paramedics who enter the facility are aware of the outbreak so they may take proper precautions.
Surveillance and Reporting:
Maintain a line list including the resident's name, DOB (date of birth), unit, and room, as well as clinical signs and symptoms including cough, coyza, congestion, conjunctivitis, whether a chest

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x-ray has been ordered and results, and any treatment or antibiotics for respiratory complaints.
An example line list is provided. Line Lists must be maintained for both [FACILITY AND ADJACENT BUILDING] (struck out and replaced with Lee Wing). This line list must be updated daily and provided to [EMPLOYEE H, the health department epidemiologist] by fax at [FAX NUMBER] by 4:00p.m. daily.
Report immediately by phone any residents who are sent to the hospital with respiratory complaints and/or suspicion of pneumonia.
Maintain a line list of staff who report illness and provide that information daily.
These enhanced surveillance and reporting efforts shall be in place for at least 2 weeks following the cessation of the outbreak, and this time period may be extended to include at least 2 incubation periods if a pathogen is determined as the cause of the outbreak.
Infection Control:
Standard plus droplet precautions. All staff providing direct medical care shall don a mask when working with any resident who has a respiratory illness or begins exhibiting respiratory complaints. This includes any residents who are on antibiotics for respiratory illnesses.
Staff shall utilize soap and water for hand hygiene when providing care between residents as some respiratory pathogens are resistant to alcohol-based hand sanitizers (ABHS). ABHS may be utilized in between procedures on the same resident as long as hands are not visibly soiled.
Environmental Cleaning:
Bleach shall be used for enhanced environmental cleaning including all high contact surfaces.
Social Distancing
Meals shall be served in resident rooms rather

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than the dining hall. ("For Lee Wing Use Only" appended to the end of this line)
Group activities shall be discontinued until this outbreak is deemed over. (this line entirely struck out)
All ill residents shall remain on isolation.

Signatures follow, document then ends. The document was signed by Employee A and Employee F on 05/24/2019.

Surveyor A interviews and observations:

On 5/30/2019 at 4:25 p.m., an interview was conducted with Employee C (the director of compliance) and Employee B (the director of nursing [DON]). Employee C stated we have spoken with [Employee F] and we are following his recommendations. When asked if any staff members had been sick with upper respiratory symptoms since this outbreak, Employee C and Employee B both replied, "no". When asked if any of the employees worked on other units. Both stated the employees who worked on the Lee Unit only worked on that unit. Employee C stated the Droplet Precautions signs were posted on the doors of residents who had orders for precautions.

On 5/30/2019 at 4:54 p.m., another tour of the Lee Unit was conducted. At the nurses, station was a box of masks. There was no sign about the respiratory illness on that unit. There was a generic sign about cough and cold on the nurse's station desk.

There still was no hand sanitizer on the isolation cart near Resident #15's room. There were

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masks, gowns and gloves in the drawers.

On 5/30/2019 at 4:55 p.m., an interview was conducted with LPN (Licensed Practical Nurse) D who stated she had received "no training but was informed that some residents were on droplet precautions." LPN D stated she did not know exactly what was going on but as a nurse, she knew to wear a mask when encountering those residents.

On 5/30/2019 at 5:18 p.m., an interview was conducted with Employee J who stated she was unsure of exactly what was going on at the facility but knew residents were on Droplet Precautions. Employee J stated she did not have a medical background but was very alarmed when she observed residents on the unit who seemed obviously sick. Some had green mucous coming out of their noses, some were coughing, and others were weak and not their usual selves. Employee J stated she reported what she was seeing to the nurses but did not see anything done. Employee J stated nobody was telling her anything about what needed to be done. Employee J stated she knew of residents who had expired recently due to being ill from this respiratory problem. Employee J stated she had missed five days of work due to being sick with an upper respiratory infection.

On 5/30/2019 at 5:30 p.m., an interview was conducted with the Therapy Program Manager (Employee P) who stated he was aware of a respiratory illness on the unit. Employee P stated his staff would limit contact with those residents on Droplet Precautions and provide the services in the resident's rooms since they probably would not be able to tolerate more than 10-15 minutes

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of therapy activities at a time.

On 5/31/2019 at 9:45 a.m., tour of the Lee Unit revealed there were three rooms with Droplet Precautions signs posted on their door. The previous day there had been 10 rooms on Droplet Precautions.

On 5/31/2019 at 10:50 a.m., an interview was conducted with the Employee C, the director of compliance, who again stated there were no staff members who worked on Lee Unit as well as other units. A copy of the "As worked schedule" for the past month was requested again. Employee C stated the facility did not have the ability to generate an "as worked" schedule because the corrections would override the original schedule.

On 5/31/2019 at 11:00 a.m., an interview was conducted with the Receptionist for the Lee unit (Employee N) who stated she would ask visitors who they were visiting and if they were sick. Employee N stated she was familiar with the family members who came daily so she did not ask them every day if they were sick. Employee N stated some visitors would visit their family members regardless because they wanted to make sure everything was okay.

Interviews were conducted with staff members to determine if any staff members assigned to the Lee Unit worked only on that unit as claimed by Employee C, compliance director. Two employees CNA (Certified Nursing Assistant) B and RN (Registered Nurse) C stated they worked on the Lee Unit and the other units regularly. [Note: CNA B was observed working on the Lee Unit on 5/30/19 and 5/31/2019. CNA B was

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observed working on the Grace Unit on 6/3/2019 and 6/4/2019].

On 5/31/2019 at 12:17 p.m., RN C was interviewed while passing medications on the Grace Unit. RN C stated she also worked on the Lee Unit and that she worked between the two units regularly. RN C stated she had been sick with a sore throat and sniffles recently. Review of the Call in Report for May 2019 revealed RN C had unpaid time off and was scheduled for the Lee Unit.

The surveyors requested a list of residents who were discharged from the facility to include any who had expired at the facility since May 1, 2019. Review of the list revealed the names of residents from the entire facility. Residents identified as being transferred to the hospital within the past month and residents residing on the Lee unit who were on droplet isolation precautions were placed in the survey sample.

One of the residents listed on the discharge report as one who expired in the facility was placed in the survey sample as Resident # 38. Resident # 38 was a 95-year-old female admitted to the facility on 2/20/17 and readmitted on 8/11/2018. Review of the clinical record revealed documentation that Resident # 38 died in the facility on 5/15/2019.
Review of the Nurses Notes for Resident # 38 revealed in part the following documentation:
- 5/12/2019 at 3:38 PM "wheezing in bilateral upper lungs and a non- productive cough."
- 5/12/2019 at 8:59 PM-"continues with non productive coughing medicated per orders for coughing with positive results, no signs of respiratory distress..."

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- 5/13/2019 at 9:22 PM-"continues with cough and cold symptoms, non productive coughing noted, pulse ox 93% on room air, Temp 98.7, no signs of respiratory distress noted, tolerating scheduled nebulizer treatments."

Review of the Physician Progress Notes revealed documentation:
5/13/2019 -"is being seen secondary to congested cough.. states she had a good day yesterday which was Mother's Day and was able to be out with her family without problems however on returning back both she and her son noted a congested cough. ..She does have some runny nose but feels that this is quite chronic. She denies any other respiratory symptoms."
5/19/19 Physician Progress Note stated Resident # 38 "resided on the Lee Unit and developed difficulty with a congested cough suggestive of a viral illness. She was placed on nebulizer therapy as a precaution for another otherwise fairly unremarkable lung exam." Under assessment included diagnoses: "13. Viral respiratory illness, 14. Complications of CHF (Congestive Heart Failure*) 15. Sudden cardiac death."

Congestive heart failure (CHF) is a condition in which the heart's function as a pump is inadequate to meet the body's needs.

On 5/31/2019 at approximately 11:25 a.m., a housekeeping staff member (Employee M) was observed in Resident #27's room. There was a Red Stop sign notice and a Droplet Precautions sign on the door. An Isolation cart was located outside the room and there was a Housekeeping/Laundry cart near the doorway to the room. Employee M was observed spraying a substance on the bed and wiping the mattress.

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Employee M did not have on any PPE (Personal Protective Equipment). Employee M did not have on a gown, gloves or mask. Employee M came out of the room with linen in her hand that was removed from the room, and threw it into her cart in the doorway. When interviewed Employee M stated that, she had been employed at the facility for years.

Surveyor C observation and interview:

On 5/31/19, at approximately 11:15 a.m., this surveyor noted that Resident #4's room door had an infection control sign taped to the door and an infection control cart located across from the door. The infection control sign documented, "Droplet Precautions - See Nurse before Entering."

On 5/31/19 at approximately 11:30 a.m., this surveyor observed a guest in the room sitting beside Resident #4. The guest in Resident #4's room was not wearing a facemask, gloves or gown.

A review of Resident #4's clinical record revealed a physician order dated 5/30/19 for droplet precautions.

On 5/31/19 at approximately 12:05 p.m., an interview was conducted with Resident #4's guest. Resident #4's guest was identified as the son of Resident #4. Resident #4's son was asked if he was aware that Resident #4 was on droplet precautions. Resident #4's son stated, "My mother was recently readmitted to the facility from the hospital and I didn't know anything about droplet precautions." Resident #4's son was asked if anyone had spoken with him about

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wearing a facemask, gloves and gown while visiting in the room. Resident #4 stated, "No one has told me anything about wearing a face mask, gloves or gown while in the room visiting."

On 6/4/19 at approximately 12:30 p.m., an interview was conducted with LPN (licensed practical nurse) A. LPN A was asked about the process followed by staff for implementing droplet precautions. LPN A stated, "An infection control sign is to be placed on or beside the resident's door and an isolation cart should be outside the resident's room which contains face mask, gowns, gloves and hand sanitizer. Any equipment being used on that resident is bought into the room and kept in the room until the resident is removed from isolation." LPN A was asked what staff or guest should do before entering the room of a resident on droplet precautions. LPN A stated, "They need to put a face mask, gloves and gown on. They must also wash their hands or use hand sanitizer prior to entering the room." LPN A was asked if Resident #4's son was wearing a facemask, gown and gloves while in the room visiting Resident #4. LPN A stated, "I personally did not see him." LPN A was made aware of the above observation of Resident #4's son not wearing a facemask, gloves or gown while in the room visiting Resident #4. LPN A stated, "If I had seen him not wearing a face mask, gloves or gown, I would've informed him that he needed to put those items on."

The facility policy titled, "Droplet Precautions", did not document any information regarding guest consideration for droplet precautions.

Surveyor B:

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F 880	Continued From page 23 Observations revealed there was no PPE available to visitors on the Lee unit. According the Employee B, Director of nursing and Employee C, the Compliance director the most recent resident identified as succumbing to the respiratory illness on the Lee Unit was the day of entrance on 5/30/19, evidencing continuation of the outbreak. This information was confirmed with the local health department. On 05/31/2019 at 4:32p.m., the team completed the Immediate Jeopardy (IJ) sheet, the LTC (long-term care) Supervisor was contacted by phone, and a conference call was conducted with two other State Agency supervisors. It was determined the facility's failure to implement infection control practices to prevent the spread of infection and communicable disease for residents on droplet isolation created a situation the infection was likely to be transmitted to other residents residing on the Lee Unit, resulting in Immediate Jeopardy (IJ). On 05/31/2019 at approximately 4:52p.m., the Administrator, Employee A and Director of Nursing, Employee B, were made aware of the situation and the concern for IJ. On 05/31/2019 at 7:18p.m., the Administrator, Employee A presented an acceptable plan of correction. On 05/31/2019 at 7:47 p.m. survey staff verified the education of current staff working on the unit through review of credible evidence of education and interviews. The surveyors verified the plan for educating oncoming staff prior to working and determined that the facility had a plan in place to address the immediacy and that staff were being educated on proper isolation and transmission-based precautions. The facility alleged in their plan of	F 880		

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correction that all staff in the facility on all shifts would be educated by 06/03/2019.

Surveyor A interview:

On 5/31/2019 at 7:30 p.m., an interview was conducted with the Director of Housekeeping (Employee L) who stated the expectation was that the staff should adhere to the guidelines for droplet precautions by wearing a gown, mask and gloves when in those rooms. Employee L stated she was in-service tonight." Employee L stated she was unaware of the recommendations by the Local Health Department. Employee L further stated the Housekeeping Protocols were different for other organisms. The amount of time and the type of chemicals differ for the different organisms."

Surveyor B:

On 6/3 (all shifts) and 6/4/19 (11-7 shift) the survey team verified staff education and implementation of proper isolation and transmission-based precautions and the POC through observations and interviews for each shift. Review of current identified cases revealed no new cases were identified as occurring after 5/30/19 and no additional hospitalizations. This was confirmed through review of the facility tracking of the outbreak, observation and with the local health department who were collaborating with the facility and the local hospital. Upon completion of verification, the IJ was abated at 6:05 a.m. on 6/4/19 and the facility was informed of the abatement at 2:00 p.m. on 6/4/19.

Upon review of the facility medical records, 14 residents residing on the Lee unit were identified

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as having been ill with respiratory symptoms sufficient to cause them to be admitted to the hospital and were reviewed in the survey sample. Of these, 11 were eventually, diagnosed with Pneumonia (2) and the majority cultured were positive for . The resident's hospitalized residents were:

Resident #42 was admitted to the facility on 09/12/2012. Her diagnoses included acute upper respiratory infection, dementia, heart failure, hypertension, and mild cognitive impairment. The most recent Minimum Data Set (MDS) Assessment was an Annual Assessment with an Assessment Reference Date (ARD) of 04/23/2019. The Brief Interview for Mental Status (BIMS) scored Resident #42 at a 3, indicating severe impairment. Per a nursing note dated 05/18/2019 at 10:30a.m.: "Resident up this morning with assist to a wheelchair. Resident still with S/S (signs and symptoms) of cold, runny nose, and cough. Resident observed to be coughing in the dining room and was brought back to the unit for the nurse to assess. Upon assessment resident was noted to be gasping for air. She was looking around at staff members but would not acknowledge that she understood and would not follow commands. Residents skin cold, clammy, and diaphoretic (sweating). Resident skin color noted to be pale. Pulse ox obtained and was at 33% on RA (room air). Resident immediately put on O2 via oxymask (oxygen mask). Resident then became unresponsive with eyes closed. Shallow spontaneous breaths were observed and a carotid pulse was palpable, weak, and thready. Resident was moved from the wheelchair to the floor by staff and no breathing or pulse was detected. CPR (cardiopulmonary resuscitation) was started at 0852 (8:52a.m.) and

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911 was called. The AED (automated external defibrillator) was attached per instructions and no shock was advised. CPR and rescue breathing continued. The rescue squad arrived and began their care at 0907(9:07a.m.). Resident left via squad at 0931(9:31a.m.), before departure squad reported a heart rate of 112 and stated that they were able to obtain a blood pressure. Report called to nurse [Emergency room -ER NURSE] at [HOSPITAL] ED [emergency department]. Resident sister [SISTER] made aware of resident condition and verbalizes understanding."

Further review of the facility progress notes revealed that Resident #42 was transferred from the local hospital to a larger hospital for a higher level of care. Per a nursing note dated 05/18/2019 at 2:44p.m.: "Spoke with ICU (intensive care unit) nurse from [LARGER HOSPITAL] and states resident has been admitted there. Nurse states that she is stable but not conscious at this time..."

A CT (computed tomography) scan from the initial hospital ED revealed the following: "...Right upper and lower lung base on the right infiltrates are seen."

Hospital notes from the larger, second hospital revealed that Resident #42 was placed on a ventilator in the ICU, but did not regain consciousness and her neurological prognosis was "very poor". Per the hospital record's "Hospital Course" document, Resident #42's family elected to withdraw life support on 05/23/2019 and she passed away within about 15 minutes of extubation.

Resident #18 was admitted to the facility on

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12/03/2016. Her diagnoses included Hypertension, Hyperlipidemia, Pneumonia, and Heart Failure. Her most recent MDS (minimum data set) Assessment was a 30 Day Assessment with an ARD (assessment reference date) of 05/01/2019. The BIMS (brief interview for mental status) scored Resident #18 at 14, indicating very mild impairment. Per a Physician Note dated 05/09/2019 at 8:26 p.m., Resident #18 was hospitalized on that date following her pulse oximetry dropping to 75% on 3L (liters) per minute of oxygen, after ambulating to the bathroom and back. Per the medical doctor note, "Her oxygen was increased to 4L per minute and oximetry only increased to 84-88%. She was given albuterol (9) treatment and oximetry increased to 91% on 3L but with talking they would drop to 82% again." Per hospital records, Resident #18 was admitted from the ED [emergency department] to the ICU [intensive care unit]. A chest x-ray revealed, "Basilar (at the base) infiltrates and atelectasis are suspected particularly on the right". Resident #18's discharge diagnoses included acute-on-chronic respiratory failure and healthcare associated pneumonia. Per the tracking list provided by the local Health Department, Mycoplasma Pneumonia was documented as causing Resident #18's respiratory infection.

Resident #19 was admitted on 08/23/2017. His diagnoses included Hypertension, Hyperlipidemia, and Asthma. Resident #19's most recent MDS Assessment was a Quarterly Assessment with an ARD of 02/24/2019. The BIMS scored Resident #19 at 7, indicating significant impairment. Per Physician Note dated 05/14/2019 at 10:47a.m., Resident #19 was

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hospitalized on 05/12/2019 following "relatively rapid onset of respiratory difficulty which was not improved with nebulizer treatment given." Per the MD (medical doctor) note, Resident #19 was also noted to have mild hypoxia, along with significant tachycardia and tachypnea. Review of Resident #19's hospital records revealed he was admitted from the ED to the ICU. Additionally, a chest x-ray was performed which revealed "patchy atelectasis or infiltrate in right upper and left lower lung". Resident #19's discharge diagnoses included both Acute Hypoxemic Respiratory Failure and Pneumonia. Per the tracking list provided by the local Health Department, Rhinovirus was documented as causing Resident #19's respiratory infection.

Resident #20 was admitted on 12/01/2015. Her diagnoses included Hypertension and Dementia. Resident #20's most recent MDS was a Quarterly Review with an ARD of 03/20/2019. The BIMS scored Resident #20 at 4, indicating significant impairment. Per Physician Note dated 05/13/2019 at 10:26p.m., Resident #20 was hospitalized on that date following presentation of a nonproductive cough, general malaise, and "not seeming her usual self. The physician's note documents "Because of the Leukocytosis (an increase in the number of white blood cells in the blood) and ongoing symptoms, she needs a chest x-ray and further evaluation as soon as possible". Per hospital records, a chest x-ray revealed "increasing density in medial (middle) right lung base suggesting a new area of atelectasis or pneumonia." Resident #20's discharge diagnosis was "Pneumonia, right lobe". Per the tracking list provided by the local Health Department, Resident #20's culture results were not yet available.

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Resident #22 was admitted on 05/18/2018. Her diagnoses included pneumonia, septicemia, diabetes, and asthma. Resident #22's most recent MDS Assessment was a 14 Day Assessment with an ARD of 05/02/2019. The BIMS scored Resident #22 at 15, indicating no impairment. Per Physician Note dated 05/15/2019 at 7:22p.m. Resident #22 was hospitalized on 05/14/2019 following a change in condition involving decreased level of awareness, tachypnea (rapid breathing), tachycardia (rapid heart rate), wheezing, and coughing, which did not improve with nebulizer therapy. Of note is the fact that a progress note dated 04/10/2019 at 7:16p.m., reveals that Resident #22 was previously hospitalized on that date for pneumonia and sepsis. There was no documentation of what symptoms at that time precipitated this first hospitalization. Hospital records from her 05/14/2019 hospitalization revealed a discharge diagnosis of healthcare-acquired pneumonia. Per the tracking list provided by the local Health Department, Resident #22's cultures were not yet available.

Resident #21was admitted on 03/27/2019. His diagnoses included hypertension, pneumonia, septicemia, asthma, and dementia. His most recent MDS Assessment was an Admission Assessment with an ARD of 04/16/2019. The BIMS scored Resident #21 at 3, indicating profound impairment. Per a physician's note dated 05/15/2019 at 12:21p.m., Resident #21 was hospitalized on 05/14/2019 following rapid onset of a "significant cough with wheeze, associated with high fever, tachypnea, and tachycardia." The physician's note goes on to state that Resident #21 was admitted to the

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hospital for "recurrent pneumonia". The note also references a previous hospitalization in April, readmission date 04/08/2019, for healthcare associated pneumonia. A review of Resident #21's hospital records from the 05/14/2019 hospitalization revealed a CT Scan (computed tomography scan) noting "patchy airspace disease with some hazy nodularity in the right lower lobe. This is concerning for an infectious/inflammatory infiltrate in the right lower lobe." Resident #21's discharge diagnoses included healthcare associated pneumonia and sepsis. Per the tracking list provided by the local Health Department, Rhinovirus was documented as causing Resident #21's respiratory infection.

Resident #24 was admitted on 06/11/2018. Her diagnoses included hypertension, heart failure, pneumonia, and dementia. Her most recent MDS Assessment was a Quarterly Assessment with an ARD of 04/26/2019. The BIMS scored Resident #24 at 7, indicating significant impairment. Per Physician Progress Note dated 05/19/2019 at 2:30p.m. Resident #24 was hospitalized 05/15/2019 following respiratory symptoms including shortness of breath, and persistent cough that did not respond to nebulizer treatment. Upon admission to the Hospital, Resident #24 was also found to be hypoxic (low level of oxygen in the blood). Upon discharge from the hospital, Resident #24's discharge diagnosis was "Bronchitis with Bronchospasm (3) - Probable viral illness." Per the tracking list provided by the local Health Department, Rhinovirus was documented as causing Resident #24's respiratory infection.

Resident #23 was admitted on 02/17/2017. Her diagnoses included hypertension and anxiety

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disorder. Her most recent MDS Assessment was a Quarterly Assessment with an ARD of 04/10/2019. The BIMS scored Resident #23 at 15, indicating no impairment. Per Hospital Records, Resident #23 was admitted to the hospital on 05/15/2019 following the gradual onset of a productive cough and a fever of 101. Chest X-Ray impression was "new atelectasis (4) or developing pneumonia in left lower lobe. Resident #23's discharge diagnosis was "Gram-Negative Pneumonia - likely started in a setting of viral illness initially." Per the tracking list provided by the local Health Department, Rhinovirus was documented as causing Resident #23's respiratory infection.

Resident #4 was admitted on 04/11/2018. Her diagnoses included hypertension and seizure disorder. The most recent MDS Assessment was a Quarterly Assessment with an ARD of 04/02/2019. The BIMS scored Resident #4 at 12, indicating mild impairment. Per Hospital Records Resident #4 was admitted to the hospital on 05/17/2019 following fever and productive cough. Hospital Chest X-Ray documents "Atelectasis or infiltrate (some substance denser than air occupying space in the lung) in both lower lungs. Upon discharge from the hospital, Resident #4's Discharge Diagnosis was "Healthcare-associated pneumonia" and "acute hypoxemic (involving low levels of oxygen in the blood) respiratory failure". Per the tracking list provided by the local Health Department, Human Rhinovirus/Enterovirus was documented as causing Resident #4's respiratory infection.

Resident #25 was admitted on 07/28/2016. His diagnoses included seizure disorder and depression. The most recent MDS Assessment

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was an Annual Assessment with an ARD of 04/24/2019. The BIMS scored Resident #25 at 15, indicating no impairment. Per Physician Progress Note dated 05/20/2019 at 7:10p.m., Resident #4 was hospitalized on 05/18/2019. The progress note documents "On 05/18/2019 he was noted to have temp of > (greater than) 100 with cough. In light of the fever and shaking chills on 05/17/2019 and with the increased incidence of pneumonia at present, nursing was instructed by Dr. [DOCTOR] to send to ER [emergency room] for evaluation, and from there he was admitted." Per hospital records, Resident #25's chest x-ray showed possible infiltrate in the left lower lung base. Resident #25's discharge diagnosis was healthcare-associated pneumonia. Per the tracking list provided by the local Health Department, Rhinovirus was documented as causing Resident #25's respiratory infection.

Resident #26 was admitted on 09/24/2013. Her diagnoses included hypertension, Alzheimer's disease, and asthma. The most recent MDS Assessment was an Annual Assessment with an ARD of 03/11/2019. The BIMS scored Resident #26 at 5, indicating significant impairment. Per Physician Progress Note dated 05/21/2019 at 2:38p.m. Resident #26 was hospitalized on 05/19/2019 following increasing cough with expiratory wheezing and an exacerbation of her underlying Chronic Obstructive Pulmonary Disease (COPD) (5). Hospital ER Physician Note dated 05/19/2019 at 10:27p.m., documents under "Medical Decision Making": "Admitted for COPD exacerbation and hypoxemic respiratory failure with SIRS (Systemic Inflammatory Response Syndrome) (6). There is concern for respiratory virus given the fact that the patient resides in [Name of facility], and they seem to have an

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outbreak of respiratory virus recently." Resident #26's discharge diagnoses were: COPD Exacerbation, Acute Hypoxemic Respiratory Failure, SIRS. Per the tracking list provided by the local Health Department, Rhinovirus was documented as causing Resident #26's respiratory infection.

Resident #27 was admitted on 01/16/2015. Her diagnoses included heart failure, diabetes, and asthma. The most recent MDS Assessment was a Quarterly Assessment with an ARD of 04/06/2019. The BIMS scored Resident #27 at 13, indicating mild impairment. Per Physician Note dated 05/23/2019 at 9:23p.m., Resident #27 was hospitalized on 05/20/2019 following presenting with tremors, a fever of 100.3, and nonproductive cough. According to the note, at the time of transfer Resident #27's vital signs were as follows: Respirations: 18/minute, Blood Pressure: 95/54, Pulse Oximetry: 95% on room air. The note documents: "Because of her symptoms, fragile status, and knowledge of others with similar illness, ER evaluation was approved by me and from the ER she was hospitalized." Resident #27's Hospital Record revealed that Resident #27's discharge diagnoses included Sepsis and Healthcare Associated Pneumonia. Per the tracking list provided by the local Health Department, Human Rhinovirus/Enterovirus was documented as causing Resident #27's respiratory infection.

Resident #29 was admitted on 02/13/2012. Her diagnoses included heart failure, diabetes, and asthma. The most recent MDS was a Quarterly Assessment with an ARD of 04/10/2019. The BIMS scored Resident #29 at 15, indicating no impairment. Per Physician Progress Note dated

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05/22/2019 at 8:58p.m., Resident #29 was seen in the facility on that date for complaint of a cough and a low-grade fever. The note documents that Resident #29's cough had been present for 2 months or more, but had worsened over the prior two days. The cough was described as producing green, thick sputum (mucus). Resident #27's temperature at the time of the note was recorded as 99.1. Per a Physician Progress Note dated 05/23/2019 at 6:51p.m., a chest x-ray revealed "moderate patchy bilateral densities right greater than left compatible with pneumonia". Per a nurse's note dated 05/24/2019 at 10:36a.m. "Lung sounds diminished with expiratory (on exhalation) wheezes noted to all lobes. Spontaneous cough noted during assessment." Nurses noted dated 05/27/2019 at 8:39a.m. states: "Resident states that she feels 'awful'. VS (vital signs) 144/60, 87, 98.4, 16R, 92% on 2L (liters). Lung sounds with wheezing and rhonchi (7) to all lobes. Respirations even and unlabored. Duoneb administered Resident states that she would like to go to the hospital. MD (medical doctor) made aware of resident request and current condition. New orders received. RP (responsible party) made aware and is in agreement with current plan of care. Resident sent to [HOSPITAL] Emergency Dept. for evaluation via squad." Resident #29's hospital records revealed a chest x-ray presenting "worsened right hilar (8) infiltrates and is presented with possible superimposed congestive changes" Resident #29's hospital discharge diagnoses included Pneumonia. Per the tracking list provided by the local Health Department, Human Rhinovirus/Enterovirus was documented as causing Resident #29's respiratory infection.

Resident #28 was admitted to the facility on

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03/20/2018. Her diagnoses included heart failure and diabetes. The most recent MDS Assessment was a Significant Change Assessment with an ARD of 02/25/2019. The BIMS scored Resident #28 at 14, indicating minimal impairment. Per Physician Note dated 05/24/2019 at 5:07p.m. Resident #28 was hospitalized on 05/23/2019 following a progressive course of: chest x-ray suspicious for pneumonia, for which she was placed on doxycycline (an antibiotic). Per the same note, later in the evening of 05/23/2019 Nursing staff informed the MD that Resident #28 was complaining of feeling "bad" and requesting to be transferred to the ER. Resident #28 continued to express a desire to go to the ER despite education on giving the antibiotic time to work. A review of the hospital records revealed the following under "Summary of Hospital Course": "78-year old female who came in with cough and congestion shortness of breath. Chest x-ray showed some signs of volume overload though given the respiratory illness which was circulating at the facility where she was it was felt that the patient likely picked up this viral respiratory infection and there was some concern about possible healthcare associated pneumonia spectrum antibiotics which were eventually weaned down to Augmentin (an antibiotic)." Resident #28's discharge diagnosis was healthcare-associated pneumonia. Per the tracking list provided by the local Health Department, Resident #28's cultures were negative.

According to the CDC- LCTFs (long-term care facilities) are different from other healthcare settings in that elderly patients at increased risk for infection are brought together in one setting and remain in the facility for extended periods of

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time; for most residents, it is their home." ... "Documented LTCF outbreaks have been caused by various viruses (e.g., influenza virus35, 410-412, rhinovirus413, ...). These pathogens can lead to substantial morbidity and mortality, and increased medical costs; prompt detection and implementation of effective control measures are required. This information was obtained from the website: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

The Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) documents the following for "Rhinovirus: Type of Precaution: Droplet most important route of transmission [104 1090]. Outbreaks have occurred in ..and LTCFs [long-term care facilities] [413, 1091, 1092] ....Contact Precautions ... Duration of Precaution: Duration of Illness." This information was obtained from the website: https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

Standard Precautions are intended to be applied to the care of all patients in all health care settings, regardless of the suspected or confirmed presence of an infectious agent. Implementation of Standard Precautions constitutes the primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and health care personnel.
Examples of standard precautions include: Wearing gloves if hand contact with respiratory secretions or potentially contaminated surfaces is anticipated.

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F 880	Continued From page 37 Wearing a gown if soiling of clothes with a resident's respiratory secretions is anticipated. Changing gloves and gowns after each resident encounter and performing hand hygiene Perform hand hygiene before and after touching the resident, after touching the resident's environment, or after touching the resident's respiratory secretions, whether or not gloves are worn. Gloves do not replace the need for performing hand hygiene. Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Examples of Droplet Precautions include: Placing ill residents in a private room. If a private room is not available, place (cohort) residents suspected of having influenza residents with one another; Wear a facemask (e.g., surgical or procedure mask) upon entering the resident's room. Remove the facemask when leaving the resident's room and dispose of the facemask in a waste container. If resident movement or transport is necessary, have the resident wear a facemask (e.g., surgical or procedure mask), if possible. Communicate information about patients with ... appropriate personnel before transferring them to other departments. Handle used textiles and fabrics with minimum agitation to avoid contamination of air, surfaces and persons. Contain soiled laundry at the location of use in bag ... For persons with acute respiratory symptoms,	F 880		

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HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

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facilities should develop visitor restriction policies that consider location of patient being visited.... Screening visitors for symptoms of acute respiratory illness before entering..
Facilities should provide instruction, before visitors enter patients' rooms, on hand hygiene, limiting surfaces touched, and use of personal protective equipment (PPE) according to current facility policy while in the patient's room.
Visitors should be instructed to limit their movement within the facility.

This information was obtained from the website; https://www.cdc.gov/

The facility staff, Employee A, the administrator, Employee B, the director of nursing and Employee C the compliance director, were again informed of the findings at the end of day meeting on 06/04/2019. At this time Employee A stated, "It's serious; we need to put measures in place to not let it happen again." No further documentation was provided.

COMPLAINT DEFICIENCY

1. Droplet precautions are used to prevent contact with mucus and other secretions from the nose and sinuses, throat, airways, and lungs. Persons entering the room should wear a gown, gloves, and surgical mask. - https://medlineplus.gov/ency/patientinstructions/000446.htm

2. Pneumonia is an infection in one or both of the lungs. Many germs, such as bacteria, viruses,

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and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. People most at risk are older than 65 or younger than 2 years of age, or already have health problems. - https://medlineplus.gov/pneumonia.html

3. Bronchospasm is a tightening of the muscles that line the airways (bronchi) in your lungs. When these muscles tighten, your airways narrow. Narrowed airways don't let as much air come in or go out of your lungs. This limits the amount of oxygen that enters your blood and the amount of carbon dioxide that leaves your blood. Bronchospasm often affects people with asthma and allergies. It contributes to asthma symptoms like wheezing and shortness of breath. - https://www.healthline.com/health/bronchospasm

4. Atelectasis is the collapse of part or, much less commonly, all of a lung. Atelectasis is caused by a blockage of the air passages (bronchus or bronchioles) or by pressure on the outside of the lung. - https://medlineplus.gov/ency/article/000065.htm

5. COPD (chronic obstructive pulmonary disease) makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. This is usually cigarette smoke. Air pollution, chemical fumes, or dust can also cause it. At first, COPD may cause no symptoms or only mild symptoms. As the disease gets worse, symptoms usually become more severe. - https://medlineplus.gov/copd.html

6. SIRS is an alternative name for Sepsis. Sepsis

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is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. A bacterial infection anywhere in the body may set off the response that leads to sepsis. In sepsis, blood pressure drops, resulting in shock. Major organs and body systems, including the kidneys, liver, lungs, and central nervous system may stop working properly because of poor blood flow. - https://medlineplus.gov/ency/article/000666.htm

7. Rhonchi are continuous low pitched, rattling lung sounds that often resemble snoring. Obstruction or secretions in larger airways are frequent causes of rhonchi. They can be heard in patients with chronic obstructive pulmonary disease (COPD), bronchiectasis, pneumonia, chronic bronchitis, or cystic fibrosis. Rhonchi usually clear after coughing. - https://www.easyauscultation.com/rhonchi

8. The hilum of the lung is found on the medial aspect of each lung, and it is the only site of entrance or exit of structures associated with the lungs. That is to say, both lungs have a region called the hilum, which serves as the point of attachment between the lung root and the lung. Broadly speaking, this particular region of the lung can be described as a triangular, depressed area where a lot of anatomical structures enter and leave each lung. - https://www.kenhub.com/en/library/anatomy/hilum-of-the-lung

9. Albuterol is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung

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diseases such as asthma and chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways). Albuterol inhalation aerosol and powder for oral inhalation is also used to prevent breathing difficulties during exercise. Albuterol inhalation aerosol (Proair HFA, Proventil HFA, Ventolin HFA) is used in adults and children 4 years of age and older. Albuterol powder for oral inhalation (Proair Respiclick) is used in children 12 years of age and older. Albuterol solution for oral inhalation is used in adults and children 2 years of age and older. Albuterol is in a class of medications called bronchodilators. It works by relaxing and opening air passages to the lungs to make breathing easier. - https://medlineplus.gov/druginfo/meds/a682145.html

10. Rhinoviruses (plural noun) any of a group of picornaviruses including those which cause some forms of the common cold. Rhinoviruses (RVs) are responsible for more than one-half of upper respiratory tract infections (URTI) and they are considered to be among the most frequent infectious agents in humans worldwide [1]. Most cases of RV infections are benign, self-limited cold-like illnesses. However, these viruses have been also identified as the causal agent of severe pneumonia in the elderly and immunocompromised patients, as well as exacerbations of chronic obstructive pulmonary disease and asthma. At present, no efficient antiviral treatment, vaccines, or other preventive measures exist against these particularly frequent pathogens (apart from poliovirus). The information was obtained from the following websites: https://medical-dictionary.thefreedictionary.com/rh

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