COMMONWEALTH of VIRGINIA
Department of Health

M. NORMAN OLIVER, MD, MA
STATE HEALTH COMMISSIONER

TYY 7-1-1 OR
1-800-828-1120

Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Phone (804) 367-2102
Fax (804) 527-4502

November 24, 2020

NOTICE OF SURVEY RESULTS & IMPOSITION OF REMEDIES

Mr. Irvin Land, Administrator
Bon Secours-Maryview Nursing Center
4775 Bridge Road
Suffolk, VA 23435

RE: Bon Secours-Maryview Nursing Center
Provider Number: 495206

Dear Mr Land:

On 11/17/2020, a COVID-19 Focused Infection Control and complaint survey was completed at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (State Survey Agency) to determine if your facility was in compliance with federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, state licensure regulations. Two complaints were investigated during the survey. One complaint was substantiated with deficiency and one complaint was unsubstantiated with no deficiency. All references to federal regulatory requirements contained in this letter are found in Chapter 7 of Title 42 of the Code of Federal Regulations (42 CFR § 301 et seq.).

This notice does not constitute formal notification of imposition of alternative remedies or termination of your provider agreement. Should the U.S. Centers for Medicare and Medicaid Centers (CMS) or the Virginia Department of Medical Assistance Services (DMAS) determine that termination or any other remedy is warranted, it will provide you with a separate notification of that determination.

- If you do not achieve substantial compliance within three (3) months after the Survey Exit Date, 42 CFR § 488.417(b) requires the denial of payment for new Medicare or Medicaid admissions.
- If you do not achieve substantial compliance within six (6) months after the Survey Exit Date, 42 CFR § 488.412(b) provides that, "CMS will and the State must terminate the facility's provider agreement."

Your facility must maintain compliance with both the National Fire Protection Association 99 Health Care Facilities Code and 101 Life Safety Code requirements in order to continue provider certification.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, Form CMS-2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with 42 CFR § 483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and shall be disclosed to all interested parties upon request.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a S/S of F. Your facility has not been previously cited for an Infection Control deficiency on your last standard survey or within the last two years.

Required Remedy: Plan of Correction

A plan of correction (POC) for the deficiencies must be submitted to the State Survey Agency within ten (10) calendar days of receipt of this notice. If you are participating in ePOC, please submit your POC through the ePOC website. Otherwise, please send all documentation to me at:

Office of Licensure and Certification
Division of Long Term Care Services
ATTN: Laura Veuhoff
9960 Mayland Drive, Suite 401
Henrico, VA 23233

The POC must address:

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.
4. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.
5. Include date(s) when the corrective action(s) will be completed. The corrective action completion date(s) must be acceptable and cannot exceed the 45th day after the completion date of the survey.

The POC serves as the facility's allegation of compliance. If an acceptable POC is not submitted, the State Survey Agency may propose to the CMS Regional Office and/or DMAS that remedies be imposed immediately within applicable notice requirements.

Required Remedy: Directed Plan of Correction

Additionally, in accordance with 42 CFR § 488.424, a Directed Plan of Correction (DPOC) is imposed on your facility, as a result of the deficiency cited at Tag F880, Infection Prevention and Control, S/S of Level D. In accordance with 42 CFR § 488.402(f), a DPOC for the deficiencies must be submitted to the State Survey Agency within fifteen (15) calendar days of receipt of this notice. If you are participating in ePOC, please submit your POC through the ePOC website. Otherwise, please email/mail all documentation to me at:

email address: laura.veuhoff@vdh.virginia.gov

Office of Licensure and Certification
Division of Long Term Care Services
ATTN: Laura Veuhoff
9960 Mayland Drive, Suite 401
Henrico, VA 23233

NOTE: Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567.

A revisit will not be conducted prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice. Please see the enclosed information about what your DPOC must contain.

The DPOC, in addition to the POC above, will serve as the facility's allegation of compliance. If an acceptable DPOC is not submitted, the State Survey Agency may propose to the CMS Regional Office and/or DMAS that remedies be imposed immediately within applicable notice requirements.

Recommended Remedies

Based on the deficiencies cited during the survey and pursuant to Subpart F of 42 CFR Part 488, the following remedies may be imposed by the CMS Regional Office and/or DMAS:

- State monitoring
- Directed in-service training
- Denial of payment for new admissions
- Denial of payment for all individuals
- Civil money penalty, either assessed per instance of noncompliance or per day of noncompliance

Alternative remedies or termination of your provider agreement may also be imposed.

Informal Dispute Resolution

You have one (1) opportunity to dispute the deficiencies cited on the Survey Exit Date through an Informal Dispute Resolution (IDR) process in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation to:

Office of Licensure and Certification
Division of Long Term Care Services
ATTN: Kimberly Beazley, Director
9960 Mayland Drive, Suite 401
Henrico, VA 23233

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes. An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. It is an informal internal process to review additional information submitted by the facility. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution. This request must be submitted within 10 days from the date of the enforcement letter. An incomplete IDR process will not delay the effective date of any enforcement action.

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with 42 CFR § 488.331, you have one (1) opportunity to question cited federal certification deficiencies through the State Survey Agency's Informal Dispute Resolution (IDR) process, which may be accessed at http://www.vdh.virginia.gov/licensure-and-certification/the-division-of-long-term-care/.

Survey Response Form

The LTC Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at:
http://www.vdh.virginia.gov/content/uploads/sites/96/2019/02/LTC-facility-survey-response-form.pdf.
We appreciate your participation and feedback.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Laura Syracuse Veuhoff

Laura S. Veuhoff, LTC Supervisor
Division of Long Term Care

Enclosure

CC: Joani Latimer, State Ombudsman (Sent Electronically)
Bertha Ventura, Dmas (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495206	A. BUILDING _____ B. WING _____	C 11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite from 11/9/20 and continued with offsite review through 11/13/20 and from 11/16/20 through 11/17/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted onsite 11/9/20 and continued with offsite review through 11/13/20 and from 11/16/20 through 11/17/20. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Two complaints were investigated during the survey. The survey sample consisted of 8 current resident reviews (Residents #1 through #8). The census in this 120 certified bed facility was 57 at the time of survey. Seventy-two residents had tested positive for COVID-19 and forty-eight recovered. There were two current COVID-19 positive residents in the facility at the time of the survey. Forty-one staff had tested positive for COVID-19 and all forty-one recovered. There were no current staff that tested positive for the virus at the time of the survey.	F 000		
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	F 880		

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

Exec. Admin. 12/1/2020

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

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F 880	Continued From page 1 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880	F880 1) Resident #1 (BIM score 15) will be provided with information on the importance of wearing a face covering when staff are present in his room. A supply of face coverings will be provided to Resident #1 and placed at his bedside. The two staff members (OT, PT) identified will be re-educated on the facility's universal masking policy and be included as members of the Performance Improvement Project (PIP) team. 2) All residents could potentially be affected. 3) A. Information on the importance of wearing a face covering when staff are present in the room will be shared verbally and in writing with cognitively intact residents (based on most recent BIMS score). B. Therapy and nursing staff members will be reeducated on the facility's universal masking policy. C. If a resident declines the use of a face covering when staff are present in the room, the attending physician will be notified and the care plan updated to reflect the residents decision. D. A directed plan of care and root cause analysis will be developed to ensure that this deficient practice does not reoccur.	

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F 880	Continued From page 2 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to implement infection control measures to prevent the transmission of COVID-19 infection. Two rehabilitation therapists failed to offer 1 of 8 residents (Resident #1), in the survey sample who was COVID-19 positive, a face covering during their in room therapy sessions. The findings included: Resident #1 was admitted to the nursing facility on 10/8/20 with diagnoses that included	F 880	4) A. The Infection Preventionist (or designee) will make ongoing random rounding to check for adherence to the facility's universal masking policy. B. Staff specially trained in infection control monitoring ("spotters") will perform at least 5 audits per day and observe for resident use of face coverings. C. Findings of the audits will be reviewed by the Director of Nursing and/or Infection Preventionist to ensure appropriate and timely follow-up, as needed. D. Findings of the audits will be reviewed during the facility's monthly Quality Assurance & Performance Improvement (QAPI) committee meetings for the next 3 months. 5) Completion date: 12/26/2020	

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F 880	Continued From page 3	F 880		

post-operative left tibia fracture as a result of a motorcycle accident. On 11/2/20, the facility had knowledge that the resident tested positive for COVID-19.

The most recent Minimum Data Set (MDS) assessment dated 10/15/20 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills for daily decision making.

On 11/9/20 at approximately 2:35 p.m., the Occupational Therapist (OT) was observed providing in room therapy to Resident #1. The resident was sitting on a bedside commode without face covering. The OT was observed wearing Personal Protective Equipment (PPE) to include a re-usable isolation gown, procedural mask, gloves and goggles.

On 11/9/20 at 2:45 p.m., Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1 both stated when providing direct care they wear full PPE and the residents wore a surgical mask, but could remove the mask when in their rooms alone. They stated although the residents on the COVID-19 unit were restricted to their rooms, they were compliant with wearing a face mask during direct care and if having to come out of their rooms for any reason.

On 11/9/20 at approximately 3:15 p.m., the Physical Therapist (PT) began therapy donning the same type of PPE as the OT. Resident #1 was observed without a face covering during his PT session.

On 11/10/20 at 3:13 p.m., phone interview was

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F 880	Continued From page 4	F 880		

conducted with the OT. She stated, "I accepted (Resident #1's name) as he was and I did not ask him or the nursing staff to suggest he wear a face mask during my therapy session with him. When I look back on this, I was supposed to request he wear a face mask to protect me from the virus and the potential to spread it to other residents I provide therapy for." She stated the resident was very amenable to therapy and if she had suggested; he would have probably worn a face mask.

On 11/12/20 at 12:46 p.m., a phone interview was conducted with the PT. He stated he performed PT to Resident #1 without encouraging he wear a face mask. He stated, "I was told to encourage, but not force residents to wear a face mask." The PT could not explain what encourage meant and stated the clinical educator used the word encourage. This surveyor asked if encourage may have meant to offer or suggest to the resident to wear a face mask during his therapy sessions. The PT responded, "That sounds like what I should do to prevent my infection, but if they do not have one on when I enter the room, I do not think anymore about it."

On 11/12/20 at 1:15 p.m., a debriefing was conducted with the Administrator and the Director of Nursing (DON). They stated face coverings were to be worn by all residents during care by nursing and or by the rehabilitation staff and when out of their rooms, otherwise they can be removed when in alone in their rooms. The DON stated education was provided to all staff to "offer" residents a face mask during direct care and services, but not to force them if they refused. She stated the refusal should be documented in the clinical record.

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F 880	Continued From page 5 Review of the nurse's notes in the clinical record did not reveal the resident's refusal to wear face coverings during direct care or therapy services. The policy and procedures titled COVID-19 Prevention and Control dated as revised on 9/28/20 indicated universal masking by all healthcare workers and residents when in the presence of another individual. Residents may remove masks when in room alone. When staff are in patient rooms, all residents should cover their noses and mouths with tissues or cloth face coverings, if possible. Patients and residents who must regularly leave the facility for care should wear cloth face coverings when outside of their rooms if tolerated.	F 880		
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents,	F 885	F885 1) Residents #1, #2, #3, #4, #6 and #7 and their legal representatives will be contacted, with notation in each resident's medical record, regarding the confirmed case of COVID19 that resulted on 10/24/20, 10/26/20 and 11/2/20. Since the conclusion of the survey, these residents were tested on the following dates: 11/19/20 and 11/24/20. Results of all resident tests were negative and each resident was informed of their negative result in a timely manner. 2) All residents could potentially be affected.	

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F 885	Continued From page 6 their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of facility documentation, it was determined the facility staff failed to inform residents, their representatives, and or families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of a single confirmed infection of COVID-19 from testing results of 10/24/20, 10/26/20 and 11/2/20. Although it was determined that the facility staff did not inform any of the facility's residents, and/or representatives of COVID-19 cases by 5:00 p.m. the next calendar day, a random sample of 6 residents were put in the survey sample for documentation purposes. The findings included: 1. A review of Resident #1's clinical record did not reveal that the resident, who was his own responsible party, was made aware of a COVID-19 case by 5 p.m. on the next calendar day following the facility's knowledge of a confirmed case of COVID-19 that resulted on 10/24/20 and 10/26/20. Resident #1 was admitted to the nursing facility on 10/8/20 with diagnoses that included post-operative left tibia fracture as a result of a motor cycle accident. On 11/2/20, the facility had knowledge that the resident tested positive for	F 885	3) A. Nursing management and licensed nurses will be reeducated on the regulatory requirement to inform residents and legal representatives of a COVID19 case by 5pm on the next calendar day following confirmed receipt of the test results. B. The MDS Coordinator (or designee) will validate notifications and associated documentation in the medical records by performing a progress note verification audit by 4pm on the next calendar day following confirmed receipt of the test results. C. The facility's automated COVID hotline, which is available to residents and legal representatives, will be updated by the Administrator (or designee), in accordance with regulatory guidelines, in cases of a single confirmed COVID19 case or 3 or more residents/staff with new onset of respiratory symptoms occurring within 72 hours of each other.	

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F 885	Continued From page 7 COVID-19 and was aware of his own test results. The most recent Minimum Data Set (MDS) assessment dated 10/15/20 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills for daily decision making. On 11/13/20 at approximately 5:00 p.m., during an interview that was conducted with the Administrator and the Director of Nursing (DON), they stated they did not have a process in place to inform the facility's residents, representatives or families by 5 p.m. the next calendar day after their awareness of confirmed COVID-19 cases to include those that resulted on 11/24/20 and 11/26/20 or 11/2/20. 2. A review of Resident #2's clinical record did not reveal that the resident, who was his own responsible party, was made aware of a COVID-19 case by 5 p.m. on the next calendar day following the facility's knowledge of a confirmed case of COVID-19 that resulted on 10/24/20, 10/26/20 and 11/2/20. Resident #2 was admitted on 7/24/19 with diagnoses that included chronic congestive heart failure. Resident #2's most recent Minimum Data Set (MDS) dated 8/18/20 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills for daily decision making. On 11/13/20 at approximately 5:00 p.m., during	F 885	4) A. Verification audits performed by the MDS Coordinator (or designee) will be reviewed by the Director of Nursing and/or Infection Preventionist. B. Results will be reviewed during the facility's monthly Quality Assurance & Performance Improvement (QAPI) committee meetings for the next 3 months. 5) Completion date: 12/26/2020	

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F 885	Continued From page 8	F 885		

an interview that was conducted with the Administrator and the Director of Nursing (DON), they stated they did not have a process in place to inform the facility's residents, representatives or families by 5 p.m. the next calendar day after their awareness of confirmed COVID-19 cases to include those that resulted on 11/24/20, 11/26/20 and 11/2/20.

3. A review of Resident #3's clinical record did not reveal that the resident or responsible party was made aware of a COVID-19 case by 5 p.m. on the next calendar day following the facility's knowledge of a confirmed case of COVID-19 that resulted on 10/24/20, 10/26/20 and 11/2/20.

Resident #3 was admitted on 9/17/20 with diagnoses that included acute respiratory failure with pulmonary embolism.

Resident #3's most recent Minimum Data Set (MDS) dated 9/24/20 coded the resident with a score of 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the cognitive skills for daily decision making.

On 11/13/20 at approximately 5:00 p.m., during an interview that was conducted with the Administrator and the Director of Nursing (DON), they stated they did not have a process in place to inform the facility's residents, representatives or families by 5 p.m. the next calendar day after their awareness of confirmed COVID-19 cases to include those that resulted on 11/24/20, 11/26/20 and 11/2/20.

4. A review of Resident #4's clinical record did not reveal his responsible party was made aware of a

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BON SECOURS-MARYVIEW NURSING C	4775 BRIDGE ROAD SUFFOLK, VA 23435

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COVID-19 case by 5 p.m. on the next calendar day following the facility's knowledge of a confirmed case of COVID-19 that resulted on 10/24/20, 10/26/20 and 11/2/20.

Resident #4 was admitted on 1/8/16 and readmitted on 11/12/18 with diagnoses that included Alzheimer's disease.

Resident #4's most recent Minimum Data Set (MDS) dated 9/18/20 coded the resident with a score of 5 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the cognitive skills for daily decision making.

On 11/13/20 at approximately 5:00 p.m., during an interview that was conducted with the Administrator and the Director of Nursing (DON), they stated they did not have a process in place to inform the facility's residents, representatives or families by 5 p.m. the next calendar day after their awareness of confirmed COVID-19 cases to include those that resulted on 11/24/20, 11/26/20 and 11/2/20.
5. The facility staff failed to inform Resident #6 or her family by 5 p.m. of the next calendar day following the occurrence of a single confirmed infection of COVID-19.

Resident #6 was admitted to the facility on 05/16/19 with diagnoses which included congestive heart failure, muscle weakness, type two diabetes, cognitive communication deficit, A-fib, kidney disease stage 3, (History of COVID-19 -5/2/20). Resident #6 nor her family/representatives were informed of confirmed infection of COVID-19.

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A review of a 11/10/20 Quarterly Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) assessed this resident as an 11 which indicated moderate cognitive impairment.

A review of the clinical records indicated one resident had a positive confirmed infection of COVID-19 on 10/24/20, 10/26/20 and 11/2/20. A review of the clinical record did not indicate the facility staff had informed the resident, her family or representatives by 5 P.M. the next calendar day.

6. The facility staff failed to inform Resident #7 or her family or representatives by 5 p.m. of the next calendar day following the occurrence of a single confirmed infection of COVID-19.

Resident #7 was admitted to the facility on 04/28/17 with diagnoses which included muscle wasting, congestive heart failure, cognitive communication deficit, (History of COVID-19 -04/17/20). Resident #7 nor her family/representatives were informed of confirmed infection of COVID-19.

A review of a 11/10/20 Quarterly Minimum Data Set (MDS) - Brief Interview for Mental Status (BIMS) assessed this resident as an 00 which indicated severe cognitive impairment.

A review of the clinical records indicated one resident had a positive confirmed infection of COVID-19 on 10/24/20, 10/26/20, and 11/2/20. A review of the clinical record did not indicate the facility staff had informed the resident, her family or representatives by 5 P.M. the next calendar day.

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F 885	Continued From page 11 On 11/13/20 at approximately 5:00 p.m., during an interview that was conducted with the Administrator and the Director of Nursing (DON), they stated they did not have a process in place to inform the facility's residents, representatives or families by 5 p.m. the next calendar day after their awareness of confirmed COVID-19 cases to include those that resulted on 11/24/20, 11/26/20 and 11/2/20.	F 885		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that	F 886		

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F 886	Continued From page 12 help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and review of facility documentation, it was determined the facility staff failed to consistently document in the clinical record the results of each	F 886	F886 1) Prior to the conclusion of the survey, the COVID-19 laboratory test results for residents #2, #3, #4 and #7 were obtained from the laboratory and placed in each respective resident's medical record. Each test result was negative. 2) All residents could potentially be affected. 3) A. The Director of Nursing will meet with the laboratory manager to ensure a process is in place whereby test results are transmitted timely to the nursing facility. B. Within eight hours of receipt of the test results, designated nursing staff will upload the results into each resident's electronic medical record. C. Designated nursing staff responsible for the uploading of test results will be re-educated on the process. D. Residents and legal representatives will be informed of test results.	

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F 886	Continued From page 13 COVID-19 test for 4 of 8 Residents (Residents #2, #3, #4 and #7) in the survey sample. The findings include: 1. Review of Resident #2's clinical record did not reveal documentation of the COVID-19 tests that resulted as negative on 10/26/20, 11/2/20 and 11/9/20. Resident #2 was admitted on 7/24/19 with diagnoses that included chronic congestive heart failure. Resident #2's most recent Minimum Data Set (MDS) dated 8/18/20 coded the resident with a score of 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills for daily decision making. On 11/13/20 at approximately 5:00 p.m., during an interview that was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated, "We definitely need to get more consistent with recording in the resident's record not only the positive results, but the negative ones as well." 2. Review of Resident #3's clinical record did not reveal documentation of the COVID-19 tests that resulted as negative on 10/26/20, 11/2/20 and 11/9/20. Resident #3 was admitted on 9/17/20 with diagnoses that included acute respiratory failure with pulmonary embolism. Resident #3's most recent Minimum Data Set	F 886	4) A. Infection Preventionist (or designee) will perform a weekly audit of 25% of the current resident's electronic medical records to ensure that test results are posted. B. Audit results will be reviewed during the facility's monthly Quality Assurance & Performance Improvement (QAPI) committee meetings for the next 3 months. 5) Completion date: 12/26/2020	

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(MDS) dated 9/24/20 coded the resident with a score of 11 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the cognitive skills for daily decision making.

On 11/13/20 at approximately 5:00 p.m., during an interview that was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated, "We definitely need to get more consistent with recording in the resident's record not only the positive results, but the negative ones as well."

3. Review of Resident #4's clinical record did not reveal documentation of the COVID-19 tests that resulted as negative on 11/9/20.

Resident #4 was admitted on 1/8/16 and readmitted on 11/12/18 with diagnoses that included Alzheimer's disease.

Resident #4's most recent Minimum Data Set (MDS) dated 9/18/20 coded the resident with a score of 5 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the cognitive skills for daily decision making.

On 11/13/20 at approximately 5:00 p.m., during an interview that was conducted with the Administrator and the Director of Nursing (DON). The Administrator stated, "We definitely need to get more consistent with recording in the resident's record not only the positive results, but the negative ones as well."

4. The facility staff failed to document COVID-19 test results in Resident #7's clinical record.

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F 886	Continued From page 15 Resident #7 was admitted to the facility on 04/28/17 with diagnoses which included muscle wasting, congestive heart failure, cognitive communication deficit, (History of COVID-19 -04/17/20). A review of a 11/10/20 Quarterly Minimum Data Set (MDS) - Brief Interview for Mental Status (BIMS) assessed this resident as an 00 which indicated severe cognitive impairment. Resident #7 was tested on 10/24/20 for COVID-19 infection. The results of the test were made available to the facility staff on 10/26/20, however the results of the COVID-19 testing were not documented in the clinical record nor were Resident #7's family or representative made aware of the result.	F 886	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all regulations, the facility has taken the actions set forth. This plan of correction constitutes the facility's allegations of compliance.	