STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. BUILDING _____ B. WING _____	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENRICO HEALTH & REHABILITATION CENTER	561 NORTH AIRPORT DRIVE HIGHLAND SPRINGS, VA 23075

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E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification between 09/07/21 through 09/10/21. The facility was not in substantial compliance with 42 CFR 483.73.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004		10/14/21

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

Electronically Signed | 10/01/2021

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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on review of the facility Emergency Preparedness Manual and interview with the facility Maintenance Director, the facility failed to ensure the annual review of the Emergency Preparedness Plan. This had the potential to delay an effective response in the event of an emergency which could affect the safety of all 82 residents. Findings include: Review of the facility Emergency Preparedness Plan located in the Emergency Preparedness Manual revealed the last update of the manual was 11/5/19. During an interview on 09/10/21 at 11:15 AM, the Maintenance Director stated, "based on the signature sheet in the manual it has not been updated in two years."	E 004	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. E 004 Develop EP Plan, Review and Update Annually 1. Review of Emergency preparedness	

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E 004	Continued From page 2	E 004	manual has been completed. 2. Safety of residents are at risk related to a failure to ensure a review of the emergency plan has been completed. 3. Administrator or designee will ensure manual has been reviewed every year or when any changes have been instituted 4. Manual has been updated with any changes and reviewed for accuracy. Will be reviewed in QAPI quarterly to ensure any potential changes have been incorporated reviewed and signed as appropriate 5. Date of compliance 10/14/21	
F 000	INITIAL COMMENTS A Recertification/Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification between 09/07/21 through 09/10/21. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Three complaints (VA00049691- Unsubstantiated, VA00051610-Unsubstantiated, VA00052205- Unsubstantiated) were investigated. On 09/08/21 at 7:39 PM, the Administrator was notified of an immediate jeopardy at F880-L: Infection Control. The immediate jeopardy began on 09/03/21 when the Unit Manager of the North Wing (NWM) tested positive for COVID-19 and the facility failed to initiate COVID-19 outbreak guidelines from Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS) QSO memo, and facility policy. The facility failed to initiate appropriate Personal Protective Equipment (PPE)	F 000		

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F 000	Continued From page 3	F 000		

to include N95 and eye protection for all staff, failed to initiate quarantine of residents during an outbreak, and failed to ensure all staff, visitors, and vendors were screened for COVID-19 signs and symptoms prior to entrance into the facility.

On 09/08/21 at 7:39 PM, the Administrator was also notified of an immediate jeopardy at F886-COVID-19 Testing-Residents & Staff. The immediate jeopardy began on 09/03/21 when the facility failed to implement facility wide testing of residents and staff regardless of vaccination status per CDC and CMS guidelines after the Unit Manager of the North Wing (NWM) tested positive during routine COVID-19 testing on 09/03/21.

On 09/10/21 the facility presented acceptable removal plans for F880-L and F886-L.

The removal plan for F880-L included staff education regarding the appropriate PPE to wear during outbreak status to include an N95 mask and eye protection in the entire building, the entire North Wing Unit was placed on droplet precautions, and screening of all staff, visitors, and vendors for signs and symptoms of COVID-19 prior to entrance into the facility.

The removal plan for F886-L included testing of all residents and staff, regardless of vaccination status, on 09/09/21, continued testing of all COVID negative staff and residents, regardless of vaccination status every 3-7 days until testing identifies no new cases of COVID-19 infections among residents or staff for a period of at least 14 days since the most recent positive case of 09/03/21, notification of staff of testing dates by a memo at the front entrance and time clock,

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F 000	Continued From page 4 documentation of test results of staff and residents on a line list log, review of the line list by the DON or designee for positive results, and re-initiation of outbreak testing with any COVID positive staff or residents. Education of the Infection Preventionist, the DON, and the Administrator on COVID testing requirements and appropriate documentation of the testing results was conducted by the Nurse Consultant on 09/09/21. The survey team validated the immediate jeopardies were removed on 09/10/21 at 3:50 PM following the facility's implementation of the removal plans. The deficient practices remained at a lower scope and severity of an "F" (potential for more than minimal harm) after the removal of the immediate jeopardies. Survey Dates: 09/07/21 through 09/10/21 Survey Census: 82 Sample Size: 27	F 000		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be	F 568		10/14/21

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F 568	Continued From page 5 available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure that each resident or the financial representative received a quarterly accounting of the personal funds for one of 27 sampled residents (Resident (R) 57). Findings include: Review of R57's undated "Admission Record," located in R57's electronic medical record (EMR) under the "Profile" tab, revealed a facility re-admission date of 08/06/20 with multiple medical diagnoses. Review of R57's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/12/21 revealed the facility assessed R57 to have a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R57 was cognitively intact. On 09/08/21 at 3:11 PM an interview with R57 was conducted. R57 stated, "I have not received any statements about my funds account." On 09/10/21 at 2:40 PM an interview with the Business Office Manager (BOM) was conducted. The BOM stated R57 "has a resident fund account with $16.00 in it. There was a $20.00 deposit made on 06/11/21. Statements were sent out in July, there is no address listed on the statement, I do not know where it was sent." On 09/10/21 at 2:50 PM an interview with the BOM was conducted. The BOM stated, "the	F 568	F 568 Accounting and Records of personal Funds 1. Resident #57 has received a written copy of his statement related to personal funds 2. 100% of residents are at risk for deficient practice related to not receiving a written copy of personal funds quarterly or upon request. All residents will be provided with a written statement. 3. Administrator or designee will educate Business office manager in requirement to hand deliver statement of personal funds as they are received in the center quarterly, or upon request to center residents and responsible party. 4. All current residents have been made aware of current available funds .100% of residents will be audited quarterly times 2 to ensure written statements has been delivered to resident and responsible party, 30% of residents will be interviewed to determine if they would like a written copy of their available quarterly and upon request. Variances will be discussed in QAPI meeting monthly times 2 months. 5. Date of compliance 10/14/21	

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F 568	Continued From page 6 corporate office stated the statements for the accounts are sent out by a third party. I'm not sure where it was sent, if it was sent." Review of the facility policy "Patient Trust Funds Accounts," dated 02/01/19, failed to reveal any process related to the processing of resident statements for the trust funds accounts.	F 568		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		10/14/21

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F 623	Continued From page 7	F 623		

this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,

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F 623	Continued From page 8 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility policy, the facility failed to issue a written transfer notice to a resident and/or legal representative and to the state Ombudsman for one of two residents (Resident (R) 5) reviewed for hospitalizations. Findings include: Review of the facility policy titled, "Notice of Discharge /Transfer," dated 01/06/20, revealed	F 623	F 623 Notification requirements before transfer /discharge 1. Resident #5 remains in center and has been provided their transferred notice. Medical director and responsible party have been made aware of deficient practice related to failure to notify written transfer notice to resident and responsible party legal representative and to State long care ombudsman. Residents have their transferred notice. Office of State	

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F 623	Continued From page 9 "When the Center initiates a notice of transfer/discharge to a patient and/or responsible party, discharge planning will pursue timely and appropriate transfer/discharge notifications as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center ... Provide designated copies of the completed MFA Notice of Transfer/Discharge form to each of those specified on the form, which includes the Ombudsman . . . Scan a copy of the Notice of Transfer/Discharge into the patient's medical record in PCC [Point Click Care-electronic medical record] under the "Misc." [Miscellaneous] tab. Once the document has been scanned into PCC, complete a Discharge Planning Progress note confirming the following: Date Patient and/or RP were given the notice and the method in which they received the notice. Date the notice was sent to the ombudsman and the method by which it was sent (The Ombudsman should be notified as close as possible to the actual time of a facility-initiated transfer or discharge) ... " Review of R5's "Face Sheet," found in the electronic medical record (EMR) under the "Profile" tab, revealed that R5 was admitted to the facility on 02/15/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of R5's EMR "Misc. [Miscellaneous]" tab revealed a "Nursing Note," dated 02/21/21, which indicated that R5 was sent to an acute care hospital and subsequently admitted. Review of R5's EMR lacked evidence to support that a written notice of transfer was given to the resident and/or resident representative and the Ombudsman. During an interview on 09/03/21 at 11:30 AM,	F 623	Long Care Term Ombudsman office has been notified of all discharges /transfers last 30 days. 2. 100% of residents are at risk for deficient practice if discharge or transfer from center is initiated. Audits will be done daily; all family members and their responsible parties have been aware of our discharge policy. All residents will be given the bed hold policy upon discharge/transfer from the facility. Admissions/discharge planning assistant will follow up. 3. Administrator or designee will educate Discharge planner on appropriate notification to resident, responsible party, and State Long term care Ombudsman, upon discharge / transfer of any resident from center. 4. 100% of all resident transfers /discharges from center will be reviewed by Director of nursing or designee and faxed to State Long term Ombudsman biweekly for 2 months by center discharge planner or designee. This will be reviewed monthly by Administrator or designee for compliance Variances will be discussed in QAPI meeting monthly times 2 months. 5. Date of Compliance 10/14/21	

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F 623	Continued From page 10 Discharge Planning Director (DPD) verified that there was no evidence that a written transfer notice was provided to the resident and/or resident representative or Ombudsman. During a telephone interview on 09/10/21 at 8:45 PM, the Director of Nursing (DON) verified that the facility is required to provide a written transfer notice to the resident and/or resident representative and to the Ombudsman. During an interview on 09/03/21 at approximately 1:05 PM, the Administrator verified that the facility is required to provide a written transfer notice to include appeal rights to the resident and or representative and the Ombudsman.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		10/14/21

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F 625	Continued From page 11 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide the resident and/or the resident representative a written notice of the bed hold policy in one of two residents (Resident (R) 5) reviewed for hospitalizations. Findings include: The facility was unable to provide the requested bed hold policy by the end of the survey on 09/10/21. Review of R5's "Face Sheet," found in the electronic medical record (EMR) under the "Profile" tab, revealed that R5 was admitted to the facility on 02/15/21 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of R5's EMR "Misc. [Miscellaneous]" tab revealed a "Nursing Note," dated 02/21/21, which indicated that R5 was sent to an acute care hospital and subsequently admitted. Review of R5's EMR lacked evidence to support that a written notice of bed hold was given to the resident and/or resident representative. During an interview on 09/03/21 at 11:30 AM, Discharge Planning Director (DPD) verified that	F 625	F 625 Notice of bed hold policy before/upon transfer 1. Resident #5 was given a bed hold policy. 2. All residents who transfer to Hospital or on therapeutic leave from the center are at risk of deficient practice related to not receiving written notice specific to the bed-hold policy. 100% audits were done, and each resident was provided a bed hold policy upon discharge. 3. Staff development Coordinator / designee will educate all license staff related to policy and procedures for all residents who transferred or on therapeutic leave to the hospital will be provided with a bed hold policy by discharge planner/ nursing staff daily. 4. 100% of all residents transferred to hospital or on therapeutic leave will be audited by Director of Nursing or designee to determine written notice of bed-hold has been provided to resident/ responsible party 5 times a week for 2 weeks, weekly times 2 weeks, monthly times one month. Variances will be reviewed in QAPI monthly times 2 months.	

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F 625	Continued From page 12 there was no evidence that a written notice of bed hold was provided to the resident and/or resident representative. During a telephone interview on 09/10/21 at 7:45 PM, the Director of Nursing (DON) verified that the facility is required to provide a written bed hold notice to the resident and/or resident representative. During an interview on 09/03/21 at approximately 1:05 PM, the Administrator verified that the facility must provide a written bed hold notice to include cost of care to the resident and or representative.	F 625	5. Date of Compliance 10/14/21	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		10/14/21

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F 812	Continued From page 13 Based on observations, interview, and review of facility policies, the facility failed to store, prepare, and serve food under sanitary conditions. Specifically, air vents, portions of the ceiling, and electrical cords above food preparation tables and the steam table were found to be covered with dirt and dust. These failures had the potential to affect 78 of 82 residents living at the facility, who received food from the kitchen; there were four residents requiring tube feedings. Findings include: On 09/07/21 at 9:30 AM, an initial tour of the kitchen was conducted with the Dietary Manager (DM). Observations of the food preparation area in the kitchen revealed six electrical cords, hanging from the ceiling over the steam table and food preparation area, were noted to be covered with dirt and dust. The air conditioner vent and ceiling located over the reach in refrigerator were noted to be covered in dirt and dust. On 09/07/21 at 09:40 AM observations conducted in the walk-in refrigerator of the facility kitchen revealed the ceiling and all four walls to be covered in dust. On 09/07/21 at 9:30 AM an interview with the DM was conducted. The DM confirmed the ceiling, electrical cords and air conditioning vents were covered in dirt and dust. "They are all dirty and need to be cleaned." On 09/07/21 at 9:40 AM an interview with the DM was conducted. The DM confirmed the ceiling, and walls in the walk-in refrigerator were covered in dirt and dust. "They are dirty and need to be cleaned, staff will clean them today."	F 812	F 812 Food Procurement, Store/Prepare/Serve-sanitary 1a Electrical cords have been secured and are currently free from dust or dirt 1b Air conditioner vent and ceiling over the reach in refrigerator have been cleaned and are free from dust or dirt 1c Walk in refrigerator walls and ceiling of the center kitchen have been cleaned and are free from dust and dirt 2. All residents have the potential to be affected by these sanitary deficiencies 3. Dietary Regional consultant or designee will educate dietary manager on appropriate management, storage, and safe sanitary food procurement. 4. Regional dietary consultant or designee will audit electrical cords, air conditioner vents, walk in refrigerator walls and ceiling for safety / cleanliness and are free from dust or dirt related to provision of safe sanitary food procurement 3 times a week times 2 weeks, weekly times 2 weeks, monthly times one month. Variances will be present in QAPI meeting monthly times 2 months 5.Date of compliance 10/14/21	

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F 812	Continued From page 14 Review of the facility cleaning schedule for the walk-in refrigerator dated for the week of 08/27/21 through 08/31/21 revealed the floors, walls, food racks, labeling, and utility carts had all been cleaned.	F 812		
F 880 SS=L	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	F 880		10/14/21

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F 880	Continued From page 15 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, review of facility policy, and review of Center for Disease Control and Prevention (CDC) guidelines, the	F 880	F Tag 880 Infection Prevention and Control 1. The center is no longer in outbreak	

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F 880	Continued From page 16 facility failed to initiate appropriate Personal Protective Equipment (PPE) to include N95 and eye protection for all staff, failed to initiate quarantine of residents during an outbreak, and failed to ensure all staff, visitors, and vendors were screened for COVID-19 signs and symptoms prior to entrance into the facility. These failures had the likelihood of increasing the risk of transmission of COVID-19 to all residents. Based on interviews, observations, and review of facility policy, the facility failed to ensure staff performed hand hygiene during meal delivery. On 09/08/21 at 7:39 PM, the Administrator was notified that the failure to ensure all staff were wearing appropriate PPE for outbreak status after the facility was notified on 09/03/21 that a staff member tested positive for COVID-19, failure to initiate quarantine of residents during an outbreak, and failure to screen all staff, visitors, and vendors constituted immediate jeopardy at F880-L: Infection Control. The facility provided an acceptable plan for removal of the immediate jeopardy for F880-L on 09/10/21 that included staff education regarding the appropriate PPE to wear during outbreak status to include an N95 mask and eye protection in the entire building, the entire North Wing Unit was placed on droplet precautions, and staff education on screening. The survey team conducted the following to verify implementation of the removal plan for F880-L: 1.The survey team conducted observations of staff on wearing the required PPE for Transmission Based Precautions (TBP) during an outbreak.	F 880	status. Residents /Responsible party /Medical Director were made aware of deficient practice related in failure to initiate Covid 19 outbreak status in Staff member, failure in staff screening process for covid 19 upon entry to center prior to shift, failure to employ adequate hand hygiene during patient care and while passing trays at mealtimes. 2. 100% residents and staff are at risk for deficient practice for the facility failure to initiate covid19 outbreak status and requirements per CDC guidelines. Failure to utilize screening process for staff upon entry to center prior to shift, failure to employ adequate hand hygiene during patient care and while passing trays at mealtimes. 3. Staff development coordinator or designee will educate 100% center staff on appropriate use of PPE per CDC guidelines upon positive covid 19 outbreaks in center 3b. Staff Development coordinator or designee will educate 100% center staff in requirement to screen for covid 19 signs symptoms and temperature check via kiosk or written screening logs upon entry to center 3c. Staff development coordinator or designee will educate 100% center Staff on hand hygiene related to passing of trays and providing patient care. 4. Staff development coordinator or designee will complete interview of 2 staff members each shift to determine understanding of appropriate use of PPE	

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F 880	Continued From page 17 2. The survey team conducted interviews with staff on education concerning the required PPE and TBP during an outbreak. 3.The survey team observed signage indicating the facility was in an outbreak status. 4.The survey team observed signage and PPE indicating residents on the North Wing Unit were under quarantine. 5.The survey team reviewed inservice information on screening and PPE usage. 6. The survey team conducted interviews with staff to validate their understanding on screening requirements. The immediate jeopardy was removed on 09/10/21 at 3:50 PM. The deficient practice remained at an "F" (potential for more than minimal harm) scope and severity following the removal of the immediate jeopardy. Findings include: Review of CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, dated 02/23/21 states, "New Infection in Healthcare Personnel or Resident . . . Because of the high risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a Nursing Home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak . . . HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that	F 880	per CDC guidelines 3 times a week for 2 weeks, weekly times 2 weeks, monthly times one month. Variances will be reviewed in QAPI monthly times 2 months. 4b. Staff development coordinator or designee will audit data from Covid 19 screening kiosk / written screening logs to determine compliance with screening upon entry to center 3 times a week for 2 weeks, weekly times 2 weeks, monthly times one month. Variances will be reviewed in QAPI monthly times 2 months 4c. Staff development coordinator or designee will audit 2 staff members each shift while passing trays and 2 staff members each shift providing patient care to validate appropriate hand hygiene 3 times a week for 2 weeks, weekly times 2 weeks, monthly times one month. Variances will be reviewed in QAPI times 2 months 5 Date of compliance 10/14/21	

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covers the front and sides of the face), gloves, and gown . . . Residents should generally be restricted to their rooms and serial SARS-CoV2 testing performed . . . Establish a Process to identify and Manage Individuals with Suspected of Confirmed SARS-CoV-2 Infection. Ensure everyone is aware of recommended IPC practices in the facility. Post visual alert (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene).

Review of facility policy titled "COVID-19," effective date 06/30/21, revealed, "Surveillance -Employees. Screen Center employees prior to beginning shift to include Positive travel history to locations with sustained community transmission of COVID-19 withing the past 14 days. Signs or symptoms of COVID-19 (temperature greater than 99.5 degrees F or 37.5 degrees C), chills, sore throat, cough, nasal congestion, congestion, runny nose, fatigue, myalgia, body aches, shortness of breath, difficulty breathing, headache, nausea, vomiting, diarrhea, or new loss of tase or smell)."

Review of the facility policy titled, "COVID-19 Plan" undated revealed: "Employee screening: 100% screening of all staff entering the center at the beginning of each shift ....".

During the entrance conference on 09/07/21 at 09:00 AM, the Administrator indicated that the facility currently had one staff member out of work that tested positive for COVID-19 during a weekly COVID-19 test on 09/03/21.

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Upon entry to the facility on 09/07/21 at 09:00 AM, no signs were observed on the facility entrance indicating that the facility was in outbreak status.

During an interview with the Director of Nursing (DON) and Administrator on 09/08/21 at 9:45 AM, both the DON and Administrator were observed wearing surgical masks and not the required N95 mask and eye protection as required per CDC guidelines during an outbreak status. At this time the DON was unable to indicate what precautions should be put into place after a staff member and/or a resident tests positive for COVID-19.Per the CDC guidance during outbreak status facility is to implement N95 masks and eye protection for all staff, staff is to wear all PPE (N95, eye protection, gowns, and gloves) when caring for residents who have been exposed, residents are to remain in their rooms unless wearing a face mask and practicing social distancing in common areas, and to post signs indicating outbreak status with required PPE.

During an interview on 09/08/21 at 10:00 AM, the Infection Preventionist (IP) indicated that she was in the building working on 09/03/21 and was not notified of a staff member that tested positive for COVID-19, and had she been notified she would have begun CDC recommendations for outbreak status to include, posting signs of the outbreak on the front door, initiating appropriate PPE to include N95 and eye protection, initiating droplet precautions for the unit the staff member was on, and interviewing the NWM as to where she came in, what her symptoms were, and who she came into contact with.

Observations from 09/08/21 at 9:45 AM through

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09/09/21 at 10:00 AM revealed staff on the North Wing wearing surgical masks, not N95 face masks, and no eye protection despite the facility being in an outbreak.

It took surveyor intervention on 09/09/21 at approximately 10:00 AM for the facility to implement the CDC guidelines during an outbreak.

During an interview on 09/10/21 at 11:07 AM, Registered Nurse (RN)1 indicated she was in serviced that morning [09/10/21] about what PPE is required during an outbreak this morning.

During an interview on 09/10/21 at 11:39 AM, CNA 3 indicated she was at approximately 10:00 AM as to the appropriate PPE to wear during an outbreak status to include N95 mask, eye protection and using droplet precautions when in residents' rooms.

During a telephone interview on 09/10/21 at 5:00 PM, the North Wing Unit Manger (NWM) stated that at approximately 10:00 AM on 09/03/21 there was an announcement for the weekly COVID-19 testing in the dining room. NWM stated she tested positive during the rapid antigen test and the DON then did a PCR test and immediately sent her home. The NWM further stated that she does not screen herself at the entrance and she thought the screening Kiosk was for visitors. She stated she used it the day of her interview and thought that after she was hired, she was not a visitor anymore. VWM further indicated that no one instructed her to screen before entering the facility. VWM stated she was not instructed on the screening process.

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During an interview on 09/09/21 at 4:41 PM, the Administrator indicated that she was unable to find any evidence that NWM screened for signs of COVID-19 prior to working a shift since July 2021. The Administrator was asked to provide to the survey team all screening logs for the facility for the months of July, August, and September 2021. By the end of survey on 09/10/21 at 10:00 PM the Administrator was unable to provide screening logs.

During an interview on 09/09/21 at approximately 5:45 PM, the DON stated that staff are educated upon hire that they are supposed to screen themselves before entering the building, either by using the electronic Kiosk in the front of the building, or the paper form in the back of the building. The DON stated there was no written staff screening policy and procedure, and that it's done "verbally," with no paper documentation to indicate staff screening was done.

2. The facility failed to ensure staff performed hand hygiene during meal delivery.

On 09/07/21 at 12:20 PM multiple observations of Certified Nursing Assistant (CNA) 3 were conducted. CNA3 was observed delivering lunch to Resident (R) 74, R24, R50, R67, R44, R62, and R23. CNA3 was observed pushing the food cart, opening the doors of the food cart, handling multiple trays for other residents, and touching his clothes. CNA3 failed to perform hand hygiene of any kind (ABHR, hand washing) between the handling of the residents' food trays.

On 09/07/21 at 12:20 PM multiple observations of CNA5 were conducted. CNA5 was observed

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delivering lunch to R16, R59, R2, R22. CNA5 was observed pushing the food cart, opening the doors of the food cart, handling multiple trays for other residents, and touching her clothes. CNA5 failed to perform hand hygiene of any kind (ABHR, hand washing) between the handling of the residents' food trays.

On 09/07/21 at 12:20 PM multiple observations of CNA1 were conducted. CNA1 was observed delivering lunch to R3, R71, R6, R52 and R79. CNA1 was observed pushing the food cart, opening the doors of the food cart, handling multiple trays for other residents, and touching her clothes. CNA1 failed to perform hand hygiene of any kind (ABHR, hand washing) between the handling of the residents' food trays.

On 09/07/21 at 12:35 PM an interview with CNA1 was conducted. CNA1 stated, "I was not taught to sanitize between trays."

On 09/07/21 at 12:37 PM an interview with CNA5 was conducted. CNA5 stated, "I was not taught to sanitize between trays."

On 09/07/21 at 12:45 PM an interview with CNA3 was conducted. CNA3 stated, "I'm supposed to wash hands in between trays, but "I don't touch anything (doors, tables, etc.) I only handle the trays, so I don't need to wash."

Observation on 09/07/21 at 12:05 PM, revealed Certified Nursing Assistant (CNA) 4 removing a food tray from a food cart stationed in the hallway, entering room 42, and delivering a food tray to the resident in bed B. CNA4 failed to perform hand hygiene before entering room 42. CNA4 was

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further observed leaving room 42 and obtaining another food tray from the food tray cart in the hallway. CNA4 delivered the food tray to the resident in bed A room 41. CNA4 failed to perform hand hygiene after delivery the tray to the resident in bed A. CNA4 was observed to exit room 41 and obtain a food tray for the resident in room 41 bed B. CNA4 failed to perform handwashing before and after the delivery of two food trays to the two residents in the room 41.

Continued observation revealed CNA4 leaving room 41, proceeding to the food cart, and retrieving a food tray for room 57. No hand hygiene was performed. CNA4 entered room 57 and donned (put on) gloves. CNA4 failed to perform hand hygiene before entering resident's room 57 and before donning gloves. After donning gloves, CNA4 set up the food tray for the resident in room 57 bed A. When set-up was completed, CNA4 doffed (removed) the gloves and left the room without performing any handwashing. CNA4 retrieved a food tray from the food cart, returned to room 57, and delivered the food tray to the resident in B bed. No hand hygiene was performed. CNA4 was then observed retrieving the food tray from the resident in the B bed in room 57 and returning the tray to the food cart. When asked why, CNA4 stated that the resident in 57B had her own food and had declined the food tray. No handwashing was performed throughout the preceding observations.

CNA4 proceeded to retrieve a food tray for the resident B bed in room 58. CNA4 donned gloves to assist the resident in 58B with the tray. CNA4 discarded gloves, left room 58, entered room 59, and failed to perform hand hygiene in between

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assisting the residents in room 58 and 59. Next, CNA4 entered room 47 (only one resident in the room) with a food tray, donned gloves, and began to feed the resident in the A bed. No hand hygiene was performed before entering the room, donning gloves, and feeding the resident. CNA4 doffed the gloves and left room 47 for the pantry to pick up a can of soda for the resident in bed A in room 47. No hand hygiene was performed. CNA4 reentered room 47A and gave the soda to the resident in room 47. CNA4 donned gloves without performing hand hygiene and continued to feed the resident in bed A room 47. CNA4 doffed gloves and left the room for the nurse's station to get a telephone. Upon returning to the room, CNA4 donned gloves and assisted the resident to make a phone call. With the same gloves still on, CNA4 wet a washcloth and cleaned the resident's face. After cleaning the resident's face, CNA4 discarded the gloves and was observed washing her hands at the sink in room 47.

In an interview with CNA4 on 09/07/21 at 12:45 PM, CNA4 stated that she was a TNA (Nursing Assistant in training) and had been a TNA with the facility for about 6 months, training to get her certification as a CNA. CNA4 was told that during observations for the prior 45 minutes that she had been observed going in and out of residents' rooms without performing hand hygiene and only performed hand hygiene one time at 12:45 PM in room 47. CNA4 stated that she only just came on duty and that she had used sanitizer. When CNA4 was told that she had not been observed using hand sanitizer, she gave no further responses.

A review of the facility's policy titled "Infection

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F 880	Continued From page 25 Prevention & Control Policies & Procedures-Handwashing Requirements, Policy Number 401," Effective Date 02/06/20, revealed that: "All staff are trained in proper technique upon hire, annually, and PRN, and are monitored for proper handwashing practices. Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections . . . Hand hygiene can consist of handwashing with soap and water or use of an alcohol-based hand rub (ABHR). . . " "A. Hand Hygiene l. The following is a list of some situations that require hand hygiene: a. When coming on duty. b. When hands are visibly soiled (handwashing with soap and water); before and after direct patient contact (for which hand hygiene is indicated by acceptable professional practice) e. Before and after eating or handling food (handwashing with soap and water) f. Before and after assisting a patient with meals (handwashing with soap and water) g. Before and after assisting a patient with personal care (e.g., oral care. bathing) r. After removing gloves or aprons s. After completing duty"	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	F 885		10/14/21

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F 885	Continued From page 26 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, 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 record review, interviews, review of facility documents, and review of Centers for Medicare and Medicaid Services (CMS) memo QSO-20-29-NH, the facility failed to notify in a timely manner residents and resident representatives when a staff member tested positive for COVID-19. This failure had the potential to affect all 85 residents in the facility. Findings include: Review of the "CMS Ref: QSO-20-29-NH Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes," dated May 6, 2020, revealed "The facility must inform residents, their representatives, and families of those residing in facilities by 5:00 PM	F 885	F 885 Reporting □ Residents, Representatives and Families 1. 100% of residents /Responsible party and staff members have been made aware of positive covid 19 tests in center. 2. All Residents /Staff members are at risk for deficient practice related in failure of center to provide notification of any positive covid 19 tests in center. 3. Administrator or designee will educate Director of nursing, Unit Manager, and 100% of center staff on requirement to notify resident /responsible party /staff upon any positive covid 19 tests in center, or 3 or more residents or staff members with respiratory symptoms within a 72-hr. period. 4. Director of nursing/ SDC or designee	

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F 885	Continued From page 27 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." During an entrance conference on 09/07/21 at 9:10 AM, the Administrator indicated that during a routine weekly testing, an asymptomatic staff member tested positive for COVID-19, as indicated by a rapid antigen test. A polymerase chain reaction (PCR) test was immediately done and sent out and the staff member was immediately sent home. Positive PCR results were obtained on 09/03/21. The Administrator stated that after the positive result all staff and residents were tested on 09/03/21 with negative results. The Administrator stated that all staff, residents and/or their resident representatives were notified that there was positive COVID-19 in the facility immediately after positive results were obtained. During an interview with Resident (R) 67 on 09/08/21 at 10:45 AM, R67 indicated he had not been notified of a staff member who tested positive for COVID-19 on 09/03/21. Review of R67's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/10/21 revealed a "Brief Interview for Mental Status (BIMS)" of 15 out of 15 indicating intact cognition. During an interview with R5 on 09/08/21 at 10:49 AM, R5 indicated that he had not been notified of a staff member who tested positive for COVID-19 by 09/04/21.	F 885	will be responsible for obtaining a resident census upon receipt of a positive Covid-19 test in the center, and notification will begin, by DON/SDC or designee to all residents and their responsible party by mail or letter, then documented in their clinical records. Staff members will be made aware by notification of any positive outbreak. Employees will check their temperature before clocking in at the time clocks and at the strive 360 in the lobby before assigning to work. DON/SDC will do an audit by 5 pm for two weeks. 4b. Director of nursing or designee will audit 24 hr. clinical nursing summary for signs and symptoms of respiratory issues in 3 or more residents within 72-hour period, 5 times a week times 2 weeks, weekly times 2 weeks, monthly times one month. Director of nursing or designee will interview 2 staff members each shift to validate their awareness of where they will find notification of any positive covid 19 tests in center, and requirement to notify unit manager or immediate supervisor of any respiratory symptoms exhibited 5 times a week for 2 weeks, Weekly times 2 weeks, monthly times one month. All Variances will be reviewed in QAPI times 2 months. 5. Date of compliance 10/14/21	

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Review of R5's MDS with ARD of 06/09/21 revealed a BIMS of 15 out of 15 indicating intact cognition.

During an interview on 09/08/21 at 9:45 AM with the Director of Nursing (DON) and Administrator, the DON indicated when a resident or staff member test positive for COVID-19 the receptionist is responsible to ensure that all the families are notified of a positive case of COVID-19 in the building. Staff are notified by a notice on the time clock and verbally. The DON was unable to provide evidence that this was done.

During a follow up interview on 09/08/21 at 10:14 AM, the Administrator confirmed residents and/or family representative were not notified of a staff member that tested positive for COVID-19 by 5:00 PM on 09/04/21.

During an interview on 09/08/21 at 10:43 AM, the Infection Preventionist (IP) stated that she was present in the building on 09/04/21 and was not aware that a staff member tested positive for COVID-19. The IP stated that if she had been made aware she would have printed out a resident census and given it to the receptionist to notify family members and would have ensured that staff and residents were notified.

During an interview on 09/08/21 at 11:39 AM, Certified Nursing Assistant (CNA) 5 stated that she was notified by one of her co-workers that there was a positive staff member "mid-morning" on 09/04/21 after she had already begun her shift. CNA5 verified that she was not notified by the facility management.

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F 885	Continued From page 29 During an interview on 09/08/21 at 11:42 AM, Licensed Practical Nurse (LPN)1 indicated that she was given a facemask and face shield upon entrance but was not informed that the facility was in outbreak status. During an interview on 09/09/21 at approximately 11:06 AM, the Receptionist (RS) indicated that they used to get a facility census during an outbreak, and they would document on the census when they contacted family members to notify them of the outbreak, but she has not seen the book since the old Administration left. The RS could not remember if a census list was provided on 09/03/21 and indicated that it would have been given back to the Administrator. During an interview on 09/09/21 at 1:21 PM, the Nurse Consultant confirmed that the facility COVID-19 policy did not include, when and how to notify residents and/or resident representatives of a positive case of COVID-19 in the facility.	F 885		
F 886 SS=L	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:	F 886		10/14/21

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F 886	Continued From page 30 (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 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	F 886		

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F 886	Continued From page 31 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 interview, record review, review of policies and procedures, and review of the Centers for Medicare and Medicaid Services (CMS) QSO 20-38-NH Revised memo, the facility failed to implement outbreak testing of staff and residents to prevent the spread of COVID-19 upon identification that a North Wing Unit Manager (NWM) tested positive for COVID-19 on 09/03/21. This failure increased the likelihood of COVID-19 transmission to the 82 residents living at the facility. As of 09/08/21 at 7:01 PM, the facility had not begun outbreak testing per CMS guidance. On 09/08/21 at 7:39 PM, the Administrator was notified that the failure to ensure that all residents and staff were tested for COVID-19, regardless of vaccination status, after the facility was notified on 09/03/21 that the NWM tested positive for COVID-19, constituted immediate jeopardy at F886-L: COVID 19 Testing Residents and Staff. The facility provided an acceptable removal plan for the immediate jeopardy at F886-L on 09/10/21. The removal plan for F886-L included: 1. testing	F 886	F 886 Covid 19 testing Residents and Staff. 1. 100% of residents and staff have been tested twice a week with no positive covid 19 tests. Residents /Responsible party and medical director have been made aware of deficient practice related to failure to begin outbreak testing per CMS guidelines. 2. All residents and staff are at risk for deficient practice related to failure to initiate outbreak testing following positive Covid 19 staff member in center. 3. Staff development coordinator or designee will educate all center staff in CMS guidance to include testing of all residents and staff following initiation of outbreak status. 4. 100% education in the above guidelines has been completed, weekly times 2 weeks and then monthly. 5. Date of compliance 10/14/21	

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of all residents and staff, regardless of vaccination status, completed on 09/09/21; 2. continued testing of all COVID negative staff and residents, regardless of vaccination status every 3-7 days until testing identified no new cases of COVID 10 infections among residents for staff for a period of at least 14 days since the most recent positive case of 09/03/21; 3. staff to be notified of testing dates by a memo at the front entrance and time clock; 4. the Director of Nursing (DON) or designee to document test results of staff and residents on a line list log, the line list will be reviewed by the DON or designee for positive results, and any positive staff or residents will restart the outbreak testing guidelines; and 5.the Infection Preventionist, the DON and the Administrator were educated by the Nurse Consultant on COVID testing requirements and appropriate documentation of the testing results on 09/09/21.

The survey team conducted the following to verify implementation of the removal plan for F886-L:

1.The survey team reviewed the testing logs for all the residents and staff completed on 09/09/21.

2.There were no positive results for the residents and/or staff from the 09/09/21 testing to reset the duration of the outbreak testing at the time of the survey.

3.The survey team observed the posting for staff testing dates.

4.The survey team reviewed the testing/results line list log from 09/09/21.

5. The survey team reviewed the education

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provided by the Nurse Consultant on COVID testing and documentation.

The immediate jeopardy was removed on 09/10/21 at 3:50 PM. The deficient practice remained at an "F" scope and severity (potential for more than minimal harm) following the removal of the immediate jeopardy.

Findings include:

Review of facility policy titled, "COVID-19 Testing," dated 05/04/21, revealed "COVID-19 testing will be performed by trained personnel following CMS recommendations for testing ... Outbreak testing for employees and patients: a. An outbreak is defined as a new COVID-19 infection. Upon identification of a single new case of COVID-19 infection in any employee or patient, testing is indicated. b. Outbreak testing of all employees and patients will occur as soon as possible when a new case is identified, regardless of vaccination status. Retesting of negative individuals will occur every 7 days until testing identifies no new cases of COVID-19 infection among employees or patients for a period of at least 14 days since the most recent positive result."

Review of Centers for Medicare & Medicaid Services (CMS), Ref: QSO-20-38-NH, dated 04/27/21, revealed ". . . For outbreak testing, all staff and residents should be tested, regardless of vaccination status, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or

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residents for a period of at least 14 days since the most recent positive result . . . Documentation of testing: Symptomatic patients and employees-document the date(s) and times(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the Center took based on the results. Identification of a new COVID-19 case in the Center-document the date the case was identified, date that all other patients and employees were tested, and the dates that all negative patients and employees were retested . . .For routine unvaccinated employee testing, document the centers county positive rate, corresponding testing frequency, and the date each positivity rate was collected, as well as date(s) that testing is performed . . . "

During the entrance conference on 09/08/21 at 09:00 AM, the Administrator indicated that the facility currently had one staff member out of work that tested positive for COVID-19 during a weekly COVID-19 test on 09/03/21. The Administrator further indicated the entire staff and residents were tested on 09/03/21 and all results were negative. The facility was unable to provide evidence that the residents and staff were tested for COVID-19 on 09/03/21.

During an interview on 09/08/21 at 10:43 AM, the Infection Preventionist (IP) stated that the facility did not perform any COVID testing on 09/03/21. The IP stated that she is required to report the test results to the Department of Health (DOH). Upon asking the DOH for evidence of facility testing, the IP received an email indicating that the DOH was unable to provide any specific information about submitted results.

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On 09/08/21 at 11:35 AM an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA2 stated "I have not been tested in the last two weeks."

During an interview on 09/08/21 at 11:39 AM, with two residents (Resident (R) 6 and R52) was conducted. Both stated they were tested last week but neither could remember the exact day. Review of a R6's electronic medical record (EMR) significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 06/05/21 revealed a "Brief Interview for Mental Status (BIMS)" of 14 out of 15 indicating intact cognition. Review of R52's EMR quarterly "MDS" with an ARD of 08/10/21 revealed a "BIMS" of 14 out of 15 indicating intact cognition.

Interview with North wing Licensed Practical Nurse (LPN)1 on 09/08/21 at 11:42 AM indicated that she was given a facemask and face shield upon entrance to the facility but was not informed that the facility was in outbreak status.

During an interview with the Director of Nursing (DON) and Administrator on 09/08/21 at 10:14 AM, the DON confirmed that the facility could not provide evidence that the residents and staff members were tested for COVID-19 after a staff member tested positive on 09/03/21. The DON indicated that it was the IP who kept the testing logs of both staff and residents. The facility was unable to provide any line listings of staff and/or resident testing prior to the survey team leaving the facility on 09/09/21 at 10:00 PM.