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| E 000 | Initial Comments<br><br>An unannounced Emergency Preparedness survey was conducted 12/14/21 through 12/16/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 12/14/2021 through 12/16/2021. No complaints were investigated during the survey. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 120 certified bed facility was 59 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 2 (two) closed record reviews. | F 000 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, resident interview, and clinical record review, the facility staff failed to ensure that a resident who was unable to carry out ADL's (activities of daily living) received the necessary care and services to maintain personal hygiene for one of 17 residents, Resident #19. | F 677 | | |

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

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| F 677 | Continued From page 1 | F 677 | | |

The facility staff failed to provide nail care for a dependent resident. Resident #19's fingernails were observed to be long and jagged, with debris observed underneath the nails.

The findings included:

Resident #19's diagnoses included, but were not limited to, diabetes, peripheral vascular disease, cerebral infarction, acute angle-closure glaucoma, and gout.

Section C (cognitive patterns) of Resident #19's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/22/21 included a BIMS (brief interview for mental status) summary score of 10 out of 15, indicating the resident was moderately impaired of cognition. Section G (functional status) was coded 3/2 for personal hygiene indicating Resident #19 required extensive assistance of one person for this task. The MDS was coded to indicate Resident #19 had limitation in range of motion on one side in the upper and lower extremities and as using a wheelchair for mobility.

Resident #19's comprehensive care plan included the intervention I have a physical functioning deficit related to mobility impairment and self-care impairment. Interventions included nail care prn (as needed).

On 12/15/21, at 8:46 a.m., observation of Resident #19's fingernails revealed long, jagged nails on both hands, with debris present under the nails. Resident #19 stated the facility cut their nails and they were too long.

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| F 677 | Continued From page 2<br>On 12/15/21 1:26 p.m., Resident #19 was observed in hallway and stated they were going to crafts. Observation of Resident #19's fingernails on both hands revealed the nails were long, jagged, with debris present beneath the nails.<br><br>12/15/21 2:00 p.m., during a meeting with the survey team the administrator and DON (director of nursing) were made aware of the above observations and concern regarding Resident #19's finger nails. The DON stated the facility staff were responsible for cutting resident nails.<br><br>12/16/21 11:22 a.m., DON stated the staff had cut the residents nails, sometimes this resident liked them long, but they were unsure about this time. Observation of Resident #19's nails at revealed bilateral had nails had been trimmed.<br><br>No further information regarding Resident #19's nails was provided to the survey team prior to the exit conference. | F 677 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: | F 880 | | |

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| F 880 | Continued From page 3<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. | F 880 | | |

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| F 880 | Continued From page 4 | F 880 | | |

§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 staff interviews and facility document review, it was determined the facility staff failed to properly implement processes to prevent and/or contain COVID-19 as evidence by two (2) of three (3) staff members, sampled for COVID-19 screening, not being consistently screened prior to starting their work shift (CNA (Certified Nurse Aide) #21 and CNA #22).

The findings include:

Review of the facility's staff screening documentation revealed CNA #21 and CNA #22 failed to consistently have evidence of being screened prior to starting their work shifts.

The following information was found in a facility policy/procedure titled "Active Screening Process for COVID-19 Visitors and Employees" (with a revision date of 9/21/2020): "Precautions and Screening Process ... Limit visitor entry to front entrance ONLY to ensure all persons entering the building will be screened as directed. Visitors will be assisted to self-attest immediately upon entry for travel history to affected areas, contact with

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persons confirmed to have COVID-19 and symptoms of new onset of fever, sore throat, sneezing, cough, and shortness of breath ... Each person needs only to self-attest once per day. If a visitor or employee leaves the center and returns on the same day, a repeat screening is not necessary."

The following information was found in a facility policy/procedure titled "Facility COVID-19 Testing" (with a revision date of 9/2021): "Screen all staff, residents, and other visitors for common symptoms of COVID-19".

Review of CNA #21's time-clock records indicated CNA #21 worked on 12/2/21, 12/3/21, 12/6/21, 12/7/21, 12/8/21, 12/9/21, 12/11/21, 12/12/21, 12/13/21, 12/15/21, and 12/16/21. The facility staff was unable to provide evidence of CNA #21 being screened for COVID-19 on 12/3/21, 12/9/21, 12/11/21, and 12/12/21.

Review of CNA #22's time-clock records indicated CNA #22 worked on 12/7/21, 12/9/21, 12/10/21, and 12/14/21. The facility staff was unable to provide evidence of CNA #22 being screened for COVID-19 on 12/9/21.

The failure of the facility staff to ensure all staff members were screening for COVID-19 prior to starting their work shift was discussed during a survey team meeting with the facility's Administrator and Director of Nursing (DON); this meeting occurred on 12/16/21 at 11:20 a.m. The aforementioned dates, where there was no evidence of COVID-19 screening for CNA #21 and CNA #22, was shared with the facility's Administrator and DON. No additional information related to this issue was provided to

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| F 880 | Continued From page 6<br>the survey team. | F 880 | | |
| F 886 SS=D | COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§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:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with<br>COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms<br>consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the<br>transmission of COVID-19.<br><br>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing: | F 886 | | |

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| F 886 | Continued From page 7<br>(i) Document that testing was completed and the results of each staff test; and<br>(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.<br><br>§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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and facility document review, it was determined the facility staff failed to consistently implement processes to prevent and/or contain COVID-19 as evidence by two (2) of three (3) staff members (CNA (Certified Nurse Aide) #21 and CNA #22), who were sampled for COVID-19 screening, who had not been tested for COVID-19 as required by the facility's high community transmission level.<br><br>The findings include: | F 886 | | |

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| F 886 | Continued From page 8 | F 886 | | |

The facility staff failed to test CNA #21 and CNA #22, as required, for COVID-19. CNA #21 and CNA #22 were two (2) of the three (3) facility staff members who were not fully vaccinated. The third staff member, who was not fully vaccinated, had tested positive for COVID-19 during the previous 90 days therefore would not have required COVID-19 testing by the facility.

The following information was found in a facility policy/procedure titled "Facility COVID-19 Testing" with a revision date of 9/2021:
- "Fully vaccinated" refers to a person who is (greater than or equal to) 2 weeks following receipt of the second dose in a 2-dose series, or (greater than or equal to) 2 weeks following receipt of one dose of a single-dose vaccine."
- "Unvaccinated" refers to a person who does not fit the definition of "fully vaccinated," including people whose vaccination status is not known".
- "Routine Surveillance Testing ... Routine testing of unvaccinated staff (including those who received exemptions) will be conducted based on the community transmission of the virus."
- A table in this policy/procedure indicated that a "high" level of COVID-19 community transmission would require a "Minimum Testing Frequency of Unvaccinated Staff" of twice a week.

Review of CNA #21's time-clock records indicated CNA #21 worked on 11/27/21, 11/28/21, 11/29/21, 12/2/21, 12/3/21, 12/6/21, 12/7/21, 12/8/21, 12/9/21, 12/11/21, 12/12/21, 12/13/21, 12/15/21, and 12/16/21. The only COVID-19 test result available for CNA #21 was dated 12/15/21 (this test was negative). On 12/16/21 at 10:30 a.m., the Director of Nursing (DON) reported CNA #21 was tested on 12/15/21 after conversations with the survey team about the facility's COVID-19

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testing process.

Review of CNA #22's time-clock records indicated CNA #22 worked on 12/7/21, 12/9/21, 12/10/21, and 12/14/21. On 12/16/21 at 9:30 a.m., the facility's DON reported CNA #22 was doing orientation paperwork on 12/7/21 and did not work with residents. The DON stated CNA #22 worked with residents on 12/9/21, 12/10/21, and 12/14/21. No COVID-19 test results were available for CNA #22.

The following information was found in a CDC (Centers for Disease Control and Prevention) document titled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" (updated September 10, 2021):
- "Testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic, including if they have had close contact or a higher-risk exposure; this is because some people may be non-infectious but have detectable virus from their prior infection during this period..."
- "Expanded screening testing of asymptomatic HCP should be as follows: - Fully vaccinated HCP may be exempt from expanded screening testing. - In nursing homes, unvaccinated HCP should continue expanded screening testing based on the level of community transmission as follows: In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week. If unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift)."

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| F 886 | Continued From page 10<br>The failure of the facility staff to test the facility's staff, who was not fully vaccinated, was discussed during a survey team meeting with the facility's Administrator and DON; this meeting occurred on 12/16/21 at 11:20 a.m. The DON reported the facility staff should have been doing twice-a-week COVID-19 testing. The DON and Administrator confirmed the facility's county positivity and transmission rates were in the 'high' range. | F 886 | | |