STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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 A COVID-19 Focused Emergency Preparedness Survey was conducted on 7/20/22 through 7/21/22. The facility was in substantial compliance with 42 CFR Part 483.73(b)(6) emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 65 certified bed facility was 58 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted on 7/20/22 through 7/21/22. Corrections are required for 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. No complaints were investigated during the survey. The census in this 65 certified bed facility was 58 at the time of the survey. The survey sample consisted of 10 resident reviews and 5 employee reviews.	F 000		
F 880 SS=E	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	F 880		8/15/22

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

Electronically Signed | 08/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 1 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 (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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 2 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 observation, staff interviews, facility documentation review, and clinical record review, the facility staff failed to implement infection control practices as per the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) guidance/requirements to prevent the spread of COVID-19 within the facility, which had the potential to affect Residents throughout the entire facility on all Resident units. The findings included: 1. The facility staff failed to post signage at the entrance to inform visitors of the facilities COVID outbreak status. On 7/20/22, upon the survey team's arrival to the	F 880	1. Appropriate signage reflecting outbreak status is posted at the facility main entrance, by the staff timeclock and on the facility's website when warranted. All staff are utilizing N95 facemasks when entering the room of Resident #1 if droplet precautions are in effect. Resident's #1, #2, #4, #5 and #8 are being placed on quarantine when the facility is in outbreak status as they are not up to date with their Covid-19 vaccinations. Resident's #3 and #7 are now up to date with their Covid-19 vaccinations and no longer require quarantine during an outbreak.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 3 facility there was no signage to indicate the facility was in a COVID outbreak noted. Upon screening of the survey team, there was no mention that the facility was in a COVID-19 outbreak. On 7/20/22, during the survey entrance conference held with the facility Administrator, Director of Nursing, Infection Preventionist and Corporate staff it was determined that the facility remained in a COVID outbreak. On 7/20/22, during the facility tour the rear entrance, which is used by facility staff/employees and visitors after 5 PM, there was no signage noted to indicate the facility was in a COVID outbreak. On 7/20/22, signage posted at the facility time clock revealed a document that read, "COVID-19 Update 7/14/22...We currently have no residents or staff who have COVID..." On 7/20/22, a review of the facility's website revealed no information to indicate the facility was in a COVID outbreak. The facility submitted COVID policies were reviewed and did not address the posting of notices. The Centers for Disease Control and Prevention (CDC) gives facilities guidance in their document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, Updated Feb. 2, 2022". This document read, "...Visitation, Have a Plan for Visitation: Send letters or emails to families and post signs	F 880	2. All residents in the facility have the potential to be affected. 3. The Regional Vice President educated the Administrator, Director of Nursing and the Infection Preventionist on 7/28/22 on appropriate signage required during an outbreak and on quarantining residents not up to date with the Covid-19 vaccination(s) during an outbreak. The Risk Manager has educated all employees on donning a N95 facemask prior to entering the room of a resident on droplet precautions. This was completed by 8/15/22. Any employee not receiving this information by this date will receive prior to next scheduled shift. This Information will be presented in new hire orientation. The Risk Manager or designee will monitor signage, staff masking and resident quarantine for accuracy 3 times per week for 4 weeks then weekly for 2 months. Any concerns identified will be addressed at time of discovery. 4. The Risk Manager or Designee will report Results of monitoring monthly x 3 months to the Quality Assurance and Performance Improvement Committee for ongoing compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 4	F 880		

at entrances reminding them of the 1) importance of remaining up to date with all recommended COVID-19 vaccine doses, 2) recommendations for source control and physical distancing and 3) any other facility instructions related to visitation..."

On 7/20/22, during the end of day meeting, the facility Administrator, Director of Nursing, IP and corporate staff all confirmed that they do follow the CDC guidance and recommendations. They were made aware of the above findings and a discussion was held. The facility staff acknowledged they could see the benefit in posting signage of their COVID status so that visitors could make an informed choice about if they chose to proceed with visiting within the facility or not.

No further information was provided.

2. The facility staff failed to wear appropriate personal protective equipment (PPE) while providing care to a Resident (Resident #1) who was on quarantine/isolation.

On 7/20/22, during a survey entrance conference held with the facility Administrator, Director of Nursing (DON) and Infection Preventionist (IP), the IP identified that Resident #1 was under quarantine and on transmission based precautions (TBP).

On 7/21/22 at 12:04 PM, CNA B was observed to don (put on) personal protective equipment (PPE) that included an isolation gown, gloves and eye protection, outside of Resident #1's room. CNA B had on a procedure mask. There was signage on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 5	F 880		

the door that indicated Resident #1 was on droplet precautions. CNA B entered the room of Resident #1.

Upon CNA B's exit from the room she was asked if she should have had on an N-95 mask and she indicated, "I didn't provide care, I just took him his meal tray. Should I have put one on?"

On the afternoon of 7/21/22, the DON was asked what PPE she expects staff to wear when entering a room on droplet precautions. The DON said, "Isolation gown, gloves, eye protection, and N-95 masks". When asked when these items should be utilized, the DON said, "Before entering the room".

The facility policy titled, "Isolation - Initiating Transmission-Based Precautions" was received and reviewed. This policy read, "...3. When transmission-based precautions are implemented, the infection preventionist (or designee):
a. clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used;
b. explains to the resident (or representative) the reason(s) for the precautions;
c. provides and/or oversees the education of the resident, representative and/or visitors regarding the precautions and use of PPE;
d. determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions:
(1) The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 6	F 880		

(2) Signs and notifications comply with the resident's right to confidentiality or privacy.
e. ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment;
f. ensures that protective equipment and supplies needed to maintain precautions during care are in the resident's room; and
g. ensures that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room..."

The Centers for Disease Control and Prevention (CDC) gives facilities guidance in their document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities,
Updated Feb. 2, 2022". This document read, "...New Admissions and Residents who Leave the Facility: Create a Plan for Managing New Admissions and Readmissions...In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as described in the testing section above; COVID-19 vaccination should also be offered... Guidance addressing duration and recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection....Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 7	F 880		

quarantine after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator)..."

During an end of day meeting on 7/21/22, the facility Administrator, DON and corporate staff were made aware of the above findings. They verbalized disappointment because they have trained their staff and conducted audits of PPE use.

3. The facility staff failed to implement transmission based precautions/TBP for Resident's who were not up-to-date with COVID immunizations during an outbreak.

On 7/20/22, during a meeting with the facility Administrator, DON, IP and corporate staff, they identified that they facility was in a COVID-19 outbreak.

On 7/20/22, during the entrance conference the IP confirmed that they had 2 Residents on isolation/transmission based precautions. During a facility tour, Surveyors B and C observed that only 2 rooms (Resident #1 and #2) had signage for isolation/TPB and those two rooms had PPE stations set-up outside of the room.

The facility staff provided the survey team with a Resident COVID-19 vaccination listing. Review of this listing revealed that 7 Residents (Resident #1, 2, 3, 4, 5, 7, and 8) were not up-to-date with COVID vaccinations or were unvaccinated.

On 7/21/22, upon the survey team's entry to the facility they were notified that they facility was in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 8	F 880		

COVID outbreak status.

On 7/21/22 at approximately 11:15 AM, a tour of the entire facility was conducted. Only 2 Residents were identified to have PPE stations outside of the room and to have signage that indicated they were on TBP. Residents #3, 4, 5, 7, and 8 had no indication that they were on TBP.

On 7/21/22 at 11:29 AM, an interview was conducted with LPN B, who was working the west wing. LPN B confirmed that she had no residents on isolation/TBP. LPN B stated, "If a resident were in isolation she would wear gloves, gown and an N95 mask and goggles before entering the room". When asked what the purpose of wearing PPE is, LPN B said, "To prevent me from catching microorganisms or spreading some if I were infected myself". When asked how she knows if someone is on isolation or quarantine, LPN B said, "They have a set-up with PPE that they put on the door and post a sign on the door".

On 7/21/22, an interview was conducted with CNA E. CNA E confirmed that prior to entering a room on TBP, she puts on "goggles, a hair covering, isolation gown, gloves and N95 mask". CNA E stated that before she leaves the room that she has to discord of her PPE in the room, CNA E added, "The trash and linen and everything stays in that room and doesn't come out into the hall". When asked how she knows if a resident is on isolation CNA E said, "There's a bin on the door and signage because we also want visitors to know and that's a visual cue so that they can stop. We let them know that they need to wear PPE as well".

On 7/21/22 at approximately 11:40 AM, Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 9	F 880		

C observed that Resident #5 was not in her room. The facility staff identify resident #5, who is sitting in the hallway at the nurses' station, without a mask on. At 12:13 PM, CNA D enters the room of Resident #5 to take a meal tray, CNA D was wearing a surgical mask and eye protection. CNA D then calls out to Resident #5 to come to her room and then steps over and pushes Resident #5 in her wheelchair to her room, still wearing only a procedure mask and eye protection. No additional PPE was put on. CNA D then proceeds to another room to deliver another Resident their meal tray.

On 7/21/22 at 12:25 PM, CNA C was observed wearing a surgical mask and eye protection. CNA C was observed to enter Resident #3's room, wearing no additional PPE.

On 7/21/22 at approximately 12:45 PM, CNA B was observed entering Resident #8's room to answer a call bell. CNA B was wearing only a surgical mask and eye protection. CNA B then proceeded to the room of Resident #7 and retrieved the meal tray, again wearing the same procedure mask and eye protection worn into Resident #8's room.

Review of the facility policy titled, "COVID-19 Prevention and Control: PPE Mask_ When to use" was conducted. This policy read, "...4.
Positivity Rate: HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection. COVID-19 Community Transmission Rate a. Low (<5%) or Moderate/ Yellow (5%-7.99%) = Medical Mask (i.e., at least a surgical/medical mask) use is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 10	F 880		

required. b. Substantial/ Orange (8%-9.99%) or High/Red (>10%) the following should be worn by HCP while in the facility and for protection during resident care encounters. Recommend facilities to use well-fitted face mask (i) optimization of PPE supply.
(1) i.) A well-fitting facemask (e.g., selection of a facemask with a nose wire to help the facemask conform to the face; selection of a facemask with ties rather than ear loops; use of a mask fitter; tying the facemask's ear loops and tucking in the side pleats; fastening the facemask's ear loops behind the wear's head or ii.) A NIOSH approved N 95 or
iii.) A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering face piece respirators or approved KN95 Approved List | NPPTL | NIOSH | CDC
(2) High/Red (>10%) Eye protection (face shield or goggles with side covering) should be worn during patient care encounters to ensure the eyes are also protected from exposure to respiratory secretions... 6. Facility outbreak: Facility outbreak of COVID-19; refer to 4b, # 1 and #2 for guidance. Mask to be discarded at the end of each shift. 7. Quarantine: Quarantine for COVID-19 observation rooms/Unit; refer to 4b, # 1 and #2 for guidance. Follow donning and doffing procedure before leaving designated rooms/Unit. Mask to be discarded at the end of each shift. 8. Covid-19 Rooms: HCP professionals entering COVID Unit/Rooms should wear N95 mask, eye protection and PPE per isolation precautions; follow donning and doffing procedure before leaving designated rooms/Unit. Mask to be discarded at the end of each shift..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 11	F 880		

The facility policy titled, "Isolation - Initiating Transmission-Based Precautions" was received and reviewed. This policy read, "...3. When transmission-based precautions are implemented, the infection preventionist (or designee):
a. clearly identifies the type of precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used;
b. explains to the resident (or representative) the reason(s) for the precautions;
c. provides and/or oversees the education of the resident, representative and/or visitors regarding the precautions and use of PPE;
d. determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions:
(1) The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room.
(2) Signs and notifications comply with the resident's right to confidentiality or privacy.
e. ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment;
f. ensures that protective equipment and supplies needed to maintain precautions during care are in the resident's room; and
g. ensures that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room..."

The Centers for Disease Control and Prevention (CDC) gives facilities guidance in their document titled, "Interim Infection Prevention and Control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 880	Continued From page 12 Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes Nursing Homes & Long-Term Care Facilities, Updated Feb. 2, 2022". This document read, "...New Infection in Healthcare Personnel or Residents: Respond to a Newly Identified SARS-CoV-2-infected HCP [healthcare personnel] or Resident...Residents and HCP who are not up to date with all recommended COVID-19 vaccine doses: These residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities..." On 7/21/22, during an end of day meeting, the facility Administrator, Director of Nursing and Corporate Staff were made aware of the above findings. The facility staff acknowledged they were familiar with the above referenced CDC guidance document and were shown the guidance of having unvaccinated Residents be cared for with full PPE during a facility outbreak. They all verbalized that they were not aware of that recommendation. No further information was provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative	F 883		8/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 883	Continued From page 13	F 883		

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

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 883	Continued From page 14 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide provide a pneumococcal vaccine for 1 resident, Resident #4, out of 5 residents reviewed for pneumococcal immunization. The findings included: The facility staff failed to provide pneumococcal immunization for Resident #5. On 7/21/22, a clinical record review was performed for Resident #5 and revealed a document entitled, "Informed Consent for Pneumococcal Vaccine", dated 10/11/21, signed by Resident #5's Responsible Party, with a check mark placed next to the statement which read, "I hereby GIVE the facility permission to administer a pneumococcal vaccination, unless medically contraindicated. To the best of my knowledge, I have not received a pneumococcal vaccination in the past five years". There was no further documentation that indicated whether or not Resident #5 had received a pneumococcal vaccine. A group meeting was held that included the Facility Administrator, the Director of Nursing, the Risk Manager, and the Clinical Nurse Consultant	F 883	1. Resident #5 has received the pneumococcal vaccine as consented. 2. All residents in the facility consenting to the pneumococcal vaccine have the potential to be affected. The Director of Nursing has audited resident pneumococcal vaccine consents to validate those consenting did receive the vaccine. All concerns identified were addressed at time of discovery. 3. The Administrator educated all Nurse Managers, including the Director Of Nursing and Infection Preventionist on 7/28/22 on administering resident pneumococcal vaccinations upon consent. This information will be presented in new hire orientation. The Administrator or Designee will monitor resident pneumococcal consents to validate administration weekly for 4 weeks then monthly for 2 months. Any concerns identified will be addressed at time of discovery. 4. The Administrator or Designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 883	Continued From page 15 to provide an update of investigative findings. A facility policy on pneumococcal immunization was requested and received. Review of the facility policy entitled, "Pneumococcal Vaccine", revised August 2016, read: "Policy Statement...All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections". No further information was submitted prior to the survey exit conference held on 7/21/22.	F 883	report Results of monitoring monthly x 3 months to the Quality Assurance and Performance Improvement Committee for ongoing compliance and/or revision.	
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	F 886		8/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 886	Continued From page 16 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 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 interview,	F 886	1. Residents #1, #2, #3, #6 and #7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 886	Continued From page 17	F 886		

and facility documentation review, the facility staff failed to conduct COVID-19 testing in accordance with the Centers for Disease Control and Prevention (CDC) guidance for 5 Residents, Residents #1, #2, #3, #6, and #7, in a survey sample of 5 Residents reviewed for COVID-19 testing.

The findings included:

For Residents #1, #2, #3, #6, and #7, the facility staff failed to conduct COVID-19 testing upon admission to the facility.

1a. For Resident #1, the facility staff failed to conduct COVID-19 testing upon admission to the facility on 7/15/22.

On 7/21/22, a clinical record review was conducted and revealed that Resident #1 was admitted to the facility on 7/15/22, however there was no evidence of COVID-19 testing performed by facility staff until 7/18/22.

1b. For Resident #2, the facility staff failed to conduct COVID-19 testing upon admission to the facility on 7/19/22.

On 7/21/22, a clinical record review was conducted and revealed that Resident #2 was admitted to the facility on 7/19/22, however there was no evidence of any COVID-19 testing performed by facility staff.

1c. For Resident #3, the facility staff failed to conduct COVID-19 testing upon admission to the

do not meet criteria for testing at this time. Resident #6's clinical record was updated to reflect
test performed on 7/7/22.

2. All residents in the facility have the potential to be affected.

3. The Regional Vice President educated the Administrator, Director of Nursing and Infection
Preventionist on 7/28/22 on resident testing protocols for newly admitted residents,
including documentation of test results in the
clinical record. The Director of Nursing or Designee will monitor resident testing
3 times per week for 4 weeks then weekly for 2 months. Any concerns identified will
be addressed at time of discovery.

4. The Director of Nursing or Designee will report
Results of monitoring monthly x 3 months to the
Quality Assurance and Performance Improvement
Committee for ongoing compliance and/or revision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 886	Continued From page 18	F 886		

facility on 6/28/22.

On 7/21/22, a clinical record review was conducted and revealed that Resident #3 was admitted to the facility on 6/28/22, however there was no evidence of COVID-19 testing performed by facility staff until 7/7/22.

1d. For Resident #6, the facility staff failed to conduct COVID-19 testing upon admission to the facility on 7/5/22 and failed to document the results of a COVID-19 test performed on 7/7/22.

On 7/21/22, a clinical record review was conducted and revealed that Resident #6 was admitted to the facility on 7/5/22, however there was no evidence of COVID-19 testing performed by facility staff until 7/7/22. There was no documented occurrence or result for the COVID-19 test performed on 7/7/22 in his medical record.

1e. For Resident #7, the facility staff failed to conduct COVID-19 testing upon admission to the facility on 6/29/22.

On 7/21/22, a clinical record review was conducted and revealed that Resident #7 was admitted to the facility on 6/29/22, however there was no evidence of COVID-19 testing performed by facility staff until 7/7/29.

On 7/21/22, a group meeting was held that included the Facility Administrator, the Director of Nursing (DON), the Infection Preventionist (IP), and the Clinical Nurse Consultant to provide an update of investigative findings. The IP and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 886	Continued From page 19	F 886		

Clinical Nurse Consultant confirmed the admission dates for the sampled residents, their facility COVID-19 test dates, and stated COVID-19 test occurrences including results were expected to be documented within the residents medical record.

The Clinical Nurse Consultant stated that the facility conducts COVID-19 testing for all residents in accordance with CDC (Centers for Disease Control and Prevention) recommendations and guidelines. The IP was asked about the facility's protocol for testing newly admitted residents for COVID-19 and she stated, "Residents are required to be tested for COVID-19 before admission to our facility". A facility policy on COVID-19 testing was requested and received.

Review of the facility policy titled, "COVID Testing", version 3/2022, "Policy Statement", read, "This facility is committed to taking steps to ensure residents and staff are tested at the frequency required by state and federal authorities" and page 1, subheading, "Routine Testing of residents regardless of vaccination status", item 1 read, "Newly admitted residents and residents who have left the facility for >[greater than] 24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-COV-2 infection: first test immediately and, if negative, second test again 5-7 days after their admission".

The CDC document entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", updated February 2, 2022, page 4, subheading, "Testing", item 3, read, "Newly-admitted residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495199	A. BUILDING _____ B. WING _____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSVILLE HEALTH AND REHABILITATION CENTER	214 WEAVER AVE EMPORIA, VA 23847

(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
F 886	Continued From page 20	F 886		

and residents who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV2 infection; immediately and, if negative, again 5-7 days after their admission".

Review of the CMS (Centers for Medicare & Medicaid Services) Memo Ref: QSO-20-38-NH, revision date 3/10/2022, page 11, revealed, "....the results of tests must be done in accordance with standards for protected health information. For residents, the facility must document [COVID-19] testing results in the medical record".

On 7/21/22, the Facility Administrator, DON, IP, and Clinical Nurse Consultant were made aware of the findings. No further information was provided.