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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted onsite 08/02/2022-08/04/2022 and continued with offsite review on 08/10/2022. 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 166 certified bed facility was 156 at the time of the survey.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and complaint survey was conducted onsite 08/02/2022- 08/04/2022. 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. The survey sample consisted of 24 residents. Four complaints were investigated during the survey. VA00055749 - Unsubstantiated VA00055502 - Unsubstantiated VA00054133 - Unsubstantiated VA00054601 - Substantiated with deficiency The census in this 166 certified bed facility was 156 at the time of the survey. The survey sample consisted of 24 resident reviews and 6 employee reviews.	F 000		
F 804	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		9/13/22

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

Electronically Signed 08/15/2022

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F 804 SS=E	Continued From page 1 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility record review and in the course of a complaint investigation, the facility staff failed to provide food that was palatable on one of four Resident care units. The findings included: On 8/2/22 at approximately 11:45 AM, the food arrived to the Shenandoah unit from the kitchen. The food was placed on the steam table and temperatures were taken by Employee E/dietary aide. The temperatures were as follows: chicken Alfredo: 160 degrees, noodles: 158 degrees, soup: 170 degrees, vegetables: 153 degrees. There was no record of the bread temperature recorded. Residents were observed being served in the dining room. Surveyor C conducted Resident interviews in the dining room. Resident #24 reported the food was not good and one of her tablemates proceeded to hit the breadstick on the table indicating it was hard. Continued observations of the meal service was	F 804	1. Warming pellets were ordered for all plates on 8/18/22. 2. Any resident who resides in the center is at risk if food is not palatable to them. 3. Dietary staff will be educated on the use of warming pellets for all plates leaving the steam table. 4. A test tray audit will be conducted on each unit/serving area to ensure food is served at a safe and appetizing temperature weekly for 4 weeks. After 4 weeks, an audit will be conducted monthly for 2 months on each unit. Results will be reviewed and revised through QAPI Process. 5. Date of Compliance: September 13, 2022	

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F 804	Continued From page 2	F 804		

conducted. These observations revealed that no warming pellets were used under the plates to assist in keeping the food warm. The food was placed on the plate and the plate covered by Employee E, then CNA C would then obtain utensils, condiments, dessert and beverages and then place the tray onto a rack. Once four trays were prepared and placed on the rack, other facility staff would transport the rack of trays to the hallway for delivery to the Residents.

On 8/2/22 at approximately 12:48 PM, when the last plate was prepared, Surveyor C requested that a replacement plate be prepared. Employee F, the director of dining services was present.

When the last plate was delivered to the Resident, Employee F was asked to take the temperature of the sample plate/tray. The temperatures were as follows: chicken Alfredo over noodles: 150 degrees, green beans: 146.7 degrees, the bread stick was 104 degrees and the soup was 143.5 degrees. Employee F and Surveyor C sampled each of the food items. The findings were as follows: Even though the temperature of the chicken Alfredo had read 150 degrees, when tasted, it was just above room temperature and was very bland with little to no flavor. The bread stick was room temperature, with no warmth and therefore was not appetizing. The green beans and soup were warm. All of the food items were very bland and had little to no flavor. Employee F agreed with the above findings.

On 8/2/22 at approximately 2:30 PM, an interview was conducted with Resident #2. She stated the food "is not appetizing, they could give you less in quantity and better quality, we get a lot of

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F 804	Continued From page 3 noodles". On 8/2/22 at approximately 2:45 PM, an interview was conducted with Resident #24. Resident #24 reported that usually by the time her roommate gets her food it is cold. Resident #24 also reported, we get pasta almost daily. On 8/2/22, during an end of day meeting the facility Administrator was made aware of the above findings. The Administrator confirmed that they do not use the plate warming pellets to assist with maintaining temperature and indicated that they are very expensive. On 8/4/22, the Resident council minutes from February 2022-July 2022, were reviewed. There was notation that the facility updated their menus. There was no mention of specific concerns regarding the food, but the February minutes stated, "...Food is better..." A review of the facility policy titled, "Tray Line Service" was conducted. This policy didn't address the food temperature at the time of delivery to the Resident. On 8/4/22, during the end of day meeting the facility Administrator was again made aware of the above findings and no further information was provided.	F 804		
F 880 SS=E	Complaint related deficiency. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		9/13/22

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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F 880	Continued From page 5 (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 observation, staff interviews, facility documentation review, and clinical record review, the facility staff failed to implement infection control practices and utilize proper PPE (personal protective equipment) as per the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare & Medicaid Services) guidance to prevent the spread of COVID-19 within the facility, on 3 of 4 nursing units and with Resident #16. The findings included: 1. The facility staff failed to wear appropriate	F 880	1. Facility staff failed to wear appropriate personal protective equipment including eye protection, N-95 masks while providing care to a resident who had a tracheostomy. The facility staff failed to wear eye protection while providing direct resident care, while the facility was in an area of high COVID-19 transmission as per the guidance from CDC. Staff were immediately educated on appropriate PPE usage while in patient care areas. 2. All residents that reside at the center are at risk of infection if appropriate PPE guidance is not followed.	

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F 880	Continued From page 6 personal protective equipment (PPE), specifically an N-95 mask while providing care to a Resident (Resident #16) who had a trach and was not immunized for COVID-19. On 8/2/22 at 3:30 PM, an interview was conducted with the facility Infection Preventionist (IP) and Administrator. The IP confirmed that the facility is in a high level of community transmissibility for COVID-19. She stated that this means, "We have to be on heightened awareness". The IP and Administrator both confirmed they follow CDC guidance. The IP was asked about PPE requirements within the facility. She stated staff should be wearing a procedure mask and eye protection with all Resident care encounters. The IP also said that N-95's are required for staff working on the warm unit. She made no indication that Residents who are unvaccinated or who have a trach, which produces aerosolization of respiratory droplets required N-95's. On 8/3/22 at 9:51 AM, Resident #16 was observed from the hallway, the privacy curtain was not pulled and it was noted that Resident #16 had a trach. CNA D was observed in the room wearing only a procedure mask and eye protection for PPE. From the hallway Surveyor C observed CNA D to touch Resident #16, adjust a towel that was placed on his chest and adjust the oxygen that was being administered via trach collar. Upon CNA D exit from the room, CNA D confirmed that Resident #16 has a trach and when asked what she was doing, she said, "Cleaning him up". On 8/3/22, a clinical record review was conducted of Resident #16's chart. This review revealed	F 880	3. Center staff will be educated on CDC guidance on appropriate PPE use while in patient care areas. 4. DON/ICP will observe 10 staff members while in patient care areas to ensure compliance with appropriate PPE usage as per CDC recommendations based on transmissibility rate of COVID. This will be done 5 times weekly for 4 weeks, then monthly for 2 months. 5. Date of Compliance: September 13, 2022	

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Resident #16 did have a trach and is also unvaccinated for COVID-19. Resident #16's vaccination status was also confirmed as being unvaccinated as noted on the facility submitted Resident vaccination status listing.

The facility policy titled, "Novel Coronavirus Prevention and Response" was reviewed. This policy read, "...5. Interventions to prevent the spread of respiratory germs within the center: ... f. Educate employees on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection..."

The Centers for Disease Control and Prevention (CDC) gives facilities guidance in their document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Feb. 2, 2022". This document read, "...Implement Universal Use of Personal Protective Equipment for HCP: If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: NIOSH-approved N95 or equivalent or higher-level respirators should be used for: All aerosol-generating procedures, All surgical procedures that might pose higher risk for transmission if the patient has SARS-CoV-2 infection, NIOSH-approved N95 or equivalent or higher-level respirators can also be used by HCP working in other situations where additional risk

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factors for transmission are present such as the patient is not up to date with all recommended COVID-19 vaccine doses, unable to use source control, and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place..." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

During an end of day meeting on 8/3/22, the facility Administrator, DON and Infection Preventionist were made aware of the above findings. They confirmed they have 3 Residents with trachs, they were shown the guidance in the CDC document referenced above and were provided a copy of the CDC guidance.

No further information was provided.

2. The facility staff failed to wear eye protection when providing direct Resident care, while the facility was located in an area of high COVID-19 transmission as per the guidance from CDC [Centers for Disease Control and Prevention].

Prior to the survey team's entry to the facility the CDC COVID Data Tracker was reviewed and it noted the facility was located in an area with a "high" level of community transmission for COVID-19.

On 8/2/22 at approximately 10:30 AM, a tour of the facility was conducted by Surveyors C and D. Nurses, certified nursing assistants, therapy staff, maintenance, and housekeeping employees were

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all observed entering Resident rooms wearing only surgical masks, no eye protection on 3 of the nursing units (200 unit, 300 unit and 400 unit).

On 8/2/22 at 10:41 AM, Surveyors C and D hear a Resident calling out, "Nurse" from the shower room on the 400 unit. CNA C responds to the shower room wearing only a procedure mask and was observed to turn the corner to enter the shower stall with the Resident. CNA D then went into the shower room, wearing only a procedure mask. CNA C exited and identified that the Resident wanted to know if his bed was ready.

On 8/2/22 at approximately 10:55 AM, LPN C was observed to enter a Resident room on the 300 hall, approach the bedside and ask the Resident "Are you going to get up today". LPN C was observed to obtain the call bell from behind the Resident's head and clip it across his chest. LPN C was observed to be wearing only a procedure mask.

On 8/2/22 at 11:14 AM, a staff member was observed to enter the unit from the stairwell caring multiple face shields to the nursing station.

On 8/2/22 at 11:16 AM, a therapy staff member was observed to be pushing a Resident in a wheel chair to their room on the 200 unit and entered the room with the Resident wearing only a procedure mask.

On 8/2/22 at 11:18 AM, LPN B was observed to exit the room of a Resident on the 200 unit. Upon her exit she was observed to have on a procedure mask and no eye protection. LPN B stated she had assisted the Resident with toileting because the Resident was getting ready

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to go out on a medical appointment.

On 8/2/22 at 11:19 AM, a CNA was observed at the bedside of a Resident on the 200 unit. Upon exit CNA F confirmed she was bathing the Resident. CNA F was wearing only a procedure mask.

Throughout the remainder of 8/2/22, various staff were observed providing direct Resident care and interactions wearing only a procedure masks. These employees included but were not limited to: Employee J/Physical Therapy Assistant, LPN B, CNA B, and RN B.

On 8/2/22 at 2:23 PM, an observation was made of the therapy gym. Multiple Residents were noted to be in the gym and several therapy staff were working directly with the Residents wearing only a face mask.

On 8/2/22 at 2:47 PM, Surveyor C entered the room of a Resident to conduct an interview. The Resident was observed to be attempting to transfer from wheelchair to the bed so Surveyor C exited and went to the nursing station to request assistance for the Resident. CNA E responded and assisted the Resident wearing a cloth mask.

On 8/2/22 at 3:30 PM, an interview was conducted with the facility's Infection Preventionist (IP). The IP confirmed that the facility was in a high level of COVID transmission and had been most of the year. When asked what PPE staff were expected to wear the IP said, "With any close contact they are to wear a mask and face shield". The IP confirmed "close contact" could further be defined as within 6 feet of the Resident. The IP stated she makes rounds

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daily to ensure staff are wearing the proper PPE. She also confirmed that the facility follows all CDC guidance. When asked if staff are permitted to wear cloth masks, the Administrator stated "No". She was made aware of the observations involving CNA E.

On 8/3/22 at 9:46 AM, 2 therapy staff (Employees H and Employee J) entered the room wearing procedure masks and approached the bedside of Resident #15. Surveyor C waited approximately 10 minutes and then knocked and opened the door. Employees H and J were observed providing care to Resident #15 and when asked they confirmed they were getting her dressed.

On 8/3/22 at 9:51 AM, CNA D entered the room of Resident #16 wearing only a procedure masks. Upon CNA D's exit from the room she stated she was cleaning him up.

On 8/3/22 at 11:28 AM, an interview was conducted with the facility Administrator and IP in the presence of the entire survey team. Both the Administrator and IP again confirmed that all facility staff are expected to wear a procedure mask and face shield with having direct Resident contact.

On 8/3/22 at 2:19 PM, an observation of the therapy gym revealed a group therapy session being conducted that involved 10 Residents and 3 therapy staff sitting in a circular fashion. Everyone was observed to be wearing procedure masks and no eye protection for the facility staff.

On the afternoon of 8/3/22, an interview was conducted with LPN C. LPN C said staff wear masks "because of COVID-19, we don't want to

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bring anything in- it is to protect the Residents and us". When asked about what PPE is worn, LPN C said, "We do a face shield when we are giving care or feeding a Resident".

On the afternoon of 8/3/22, an interview was conducted with CNA C. When asked about PPE she stated that staff wear masks and eye protection and have been for a while. When asked what the importance and purpose of this is, she stated, "To prevent infection control. It protects me and the Resident".

On 8/3/22, during the afternoon a meeting with the facility Administrator, Director of Nursing (DON) and IP was held. They were made aware of the above findings of staff being observed on 3 of the 4 units wearing only procedure masks during direct Resident care encounters and that eye protection was not observed being utilized. When asked what measures the facility management is or has taken to ensure compliance with PPE use, the IP said she makes rounds daily but doesn't always get to each of the units. The Administrator, DON and IP all confirmed they have educated staff on the required PPE to be worn. The facility management staff acknowledged this was an opportunity/area for improvement for them.

On 8/4/22, the facility Administrator provided evidence of staff education that had been implemented following them being made aware of the survey team's findings. The Administrator stated they started educating all facility staff on the requirement to wear eye protection.

The facility policy titled, "Novel Coronavirus Prevention and Response" was reviewed. This

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F 880	Continued From page 13 policy read, "...5. Interventions to prevent the spread of respiratory germs within the center: ... f. Educate employees on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection..." The CDC guidance document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic", with a revision date of Feb. 2, 2022, was reviewed. This document read, "Implement Universal Use of Personal Protective Equipment for HCP [health care personnel]...Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below: ...Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters..." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html On 8/3/22 and 8/4/22, the facility Administrator, Director of Nursing and IP were made aware of the above findings. No further information was provided.	F 880		
F 883 SS=E	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		9/13/22

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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:

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F 883	Continued From page 15 (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, 1) the facility staff failed to provide influenza vaccines for 1 resident, Resident #8, out of 8 residents reviewed for influenza immunization and 2) facility staff failed to provide a pneumococcal vaccine for 4 residents, Residents #4, #8, #10, and #12, out of 8 residents reviewed for pneumococcal immunization. The findings included: 1. The facility staff failed to provide influenza immunization for Resident #8. On 8/2/22, clinical record review was performed and revealed that Resident #8, who was readmitted to the facility on 11/26/21, had no documentation with regard to influenza immunization, to include the resident's current influenza vaccination status, offer to provide immunization against influenza infection, or documentation of resident refusal or medical contraindication. An interview was conducted with the Infection Preventionist (IP) who accessed the clinical record for Resident #8 and verified the findings. A facility policy was requested and received.	F 883	1. Resident # 8 was offered influenza immunization; education was provided on the risks and benefits. Resident #8 still declined immunization. Center provided pneumococcal immunization for resident #4, #8, and #12. 2. Any resident residing at the center is at risk for flu and pneumonia infections if vaccinations are not offered upon admission and annually. A 100% audit will be conducted to identify those residents in need of immunizations, and center will offer vaccine as applicable. 3. Licensed staff will be educated on center policy on pneumococcal and flu vaccine. 4. DON or designee will audit all new admission chart daily for completion of flu and pneumonia education and administration daily times 5 days for 4 weeks, and then weekly for 4 weeks and monthly for 1 month. Results will be reviewed and revised by the QAPI committee. 5. Date of Compliance: September 13, 2022	

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Review of the facility policy entitled, "Influenza Vaccination", subheading, "Policy" read, "It is the policy of this facility to minimize the risk of acquiring, transmitting, or experiencing complications from influenza by offering our residents...annual immunization against influenza" and item #10 read, "The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal".

The Facility Administrator, Director of Nursing, and Infection Preventionist were all made aware of the findings. No further information was provided.

2. The facility staff failed to provide pneumococcal immunizations for Residents #4, #8, #10, and #12.

On 8/2/22, clinical record review was performed and revealed the following:

Resident #4 had no documentation of the facility's offer to provide a pneumococcal immunization, to include education to enable the resident to make an informed consent.

Resident #8 had no documentation with regard to pneumococcal immunization, to include the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of

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F 883	Continued From page 17 resident refusal or medical contraindication. Resident #10 had no documentation with regard to pneumococcal immunization, to include the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication. Resident #12 had no documentation with regard to pneumococcal immunization, to include the resident's current pneumococcal vaccination status, offer to provide immunization against pneumococcal infection, or documentation of resident refusal or medical contraindication. An interview was conducted with the Infection Preventionist (IP) who accessed the clinical records for the previously listed residents and verified the findings. A facility policy was requested and received. Review of the facility policy entitled, "Pneumococcal Vaccination", subheading, "Policy" read, "To reduce morbidity and mortality from pneumococcal disease by vaccinating all adults...the attending physician will evaluate the resident/patient vaccination status upon admission". The Facility Administrator, Director of Nursing, and Infection Preventionist were all made aware of the findings. No further information was provided.	F 883		
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	F 886		9/13/22

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must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:

§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with
COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that 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

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F 886	Continued From page 19 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, 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 #10, #11, #12, #13, and #17, in a sample of 5 Residents and for 1 staff member, Staff #3, in a sample of 6 staff reviewed for COVID-19 testing. The findings included: 1. For Residents #10, #11, #12, and #13, facility staff failed to conduct CDC recommended COVID-19 testing for newly admitted residents. 1a. For Resident #10, the facility staff failed to	F 886	1. Facility failed to conduct COVID-19 testing in accordance with CDC guidance for residents and staff. Resident # 10 no longer resides at the center. Resident #11 was tested on 8/22/22. Resident #12 no longer resides at the center. Resident #13 was tested on 8/4/22. Resident #17 re-admitted to the center on 8/10/22 and was tested upon admission and again 5-7 days later. 2. Any resident who resides at the center is at risk of infection if COVID-19 testing requirements are not followed as recommended by CDC. 3. Center staff will be educated on testing plan and requirements. 4. A) New admission chart will be	

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F 886	Continued From page 20 conduct a second COVID-19 test following admission to the facility on 7/11/22. On 8/2/22, a clinical record review was conducted and revealed facility staff performed a COVID-19 test for Resident #10 on 7/11/22. There was no evidence of any additional COVID-19 testing for Resident #10 within 5-7 days of admission. 1b. For Resident #11, the facility staff failed to conduct COVID-19 testing upon admission to the facility on 7/9/22. On 8/2/22, a clinical record review was conducted and revealed that Resident #11 was admitted to the facility on 7/9/22. There was no evidence of any COVID-19 testing until 7/19/22. 1c. For Resident #12, the facility staff failed to conduct a second COVID-19 test following admission to the facility on 7/20/22. On 8/2/22, a clinical record review was conducted and revealed facility staff performed a COVID-19 test for Resident #12 on 7/20/22. There was no evidence of any additional COVID-19 testing for Resident #12 within 5-7 days of admission. 1d. For Resident #13, the facility staff failed to conduct a second COVID-19 test following admission to the facility on 7/26/22. On 8/2/22, a clinical record review was conducted and revealed facility staff performed a COVID-19 test for Resident #13 on 7/27/22. There was no evidence of any additional COVID-19 testing for	F 886	audited 5 times weekly for 4 weeks to ensure that COVID-19 testing is conducted upon admission, then again on day 5-7; audits will then continue weekly for 4 weeks, then monthly for 1 month. B) Resident chart reviews to identify any new onset of COVID symptoms and completion COVID testing will be conducted by DON or designee daily 5 times weekly for 4 weeks, then weekly for 4 weeks, then monthly for 1 month. C) Staff testing log will be audited to ensure all staff who are not up to date with recommended COVID vaccination are testing as per the policy. This will be done weekly for 4 weeks, then monthly for 2 months. 5. Date of Compliance: September 13, 2022	

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Resident #13 within 5-7 days of admission.

On 8/2/22 at approximately 2:30 PM, an interview was conducted with the Facility Administrator and the Infection Preventionist (IP) who confirmed the facility conducts COVID-19 testing for all residents in accordance with CDC (Centers for Disease Control and Prevention) recommendations. The IP was asked about the facility's protocol for testing newly admitted residents for COVID-19 and she stated, "we test all new admits within a day or so of their arrival and then 5-7 days later". A copy of the facility's COVID-19 testing policy was requested and received.

Review of the facility policy titled, "Coronavirus Testing Plan", revised 2/7/22, page 1, subheading, "Policy Explanation", item 5 read, "Newly admitted patients and patients who have left the center for >[greater than] 24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection: immediately and, if negative, 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 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-CoV2 infection; immediately and, if negative, again 5-7 days after their admission".

On 8/2/22 at approximately 4:00 PM, the Facility Administrator and IP were made aware of the

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findings. The IP verified the admission dates and COVID-19 testing dates for Resident #10, Resident #11, Resident #12, and Resident #13. No further information was provided.

2. For Resident #17, the facility staff failed to conduct COVID-19 testing following the Resident having symptoms of COVID evidenced by an elevated temperature.

On 8/2/22, the facility Administrator and Infection Preventionist indicated that they conducted COVID testing if someone was symptomatic, following a positive case they do contact tracing and if not in outbreak facility staff who are not up-to-date are tested based on the facilities locality transmission rates.

On 8/3/22, a review was conducted of the facility submitted Resident discharge listing. Resident #17 was noted on this listing as having discharged 7/31/22, to the hospital.

On 8/3/22, a clinical record review was conducted of Resident #17's chart. This review revealed the following:
* A COVID-19/Coronavirus Daily evaluation form signed 7/31/22 at 2:18 AM, read, "1. Most recent temperature: 100.6... 1a. does the resident have any of the following NEW signs/symptoms? a. Temp greater than 99" was noted as unchecked. Question L "no new onset of any of the above" was checked.
* A nursing note dated 7/30/22 at 2 PM, read, "COVID-19/Coronavirus Daily Evaluation: [Resident name redacted] daily Coronavirus evaluation was completed. Temperature: 100.6-

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7/31/22 00:52 [12:52 AM]...See evaluation for details".
* A nursing note dated 7/31/22 at 2:26 AM, read, "At start of my shift, after rounds, received report from outgoing nurse that Resident's temp is 99.0 Assessment done, V/S [vital signs] 100.6 [indicating temperature] Resident's PRN [as needed] Acetaminophen solution was administered via G-tube. An hour later, reassessment was done and resident V/S are: 98.6 [indicating temperature]..." There was no mention that the physician was notified or that a COVID test was conducted.
* A nursing note entry dated 7/31/22 at 9:22 PM, read, "At the beginning of the shift while making rounds resident was in bed eyes open and awake with no distress or discomfort noted. Residents' mother was at bedside.....At around 6 PM, Resident's mother spoke with writer that her son is running temperature. Writer quickly went to resident's room and assessed resident again and his vital signs are BP [blood pressure] 149/86, P [pulse] 63 [respirations] 30 T [temperature] 101.1 and O2 sat was 81% on room air. Immediately administered O2 at 2 liters per minute via nasal cannula. Also given Tylenol solution as ordered. Assessed O2 after administered oxygen and O2 went up to 91%. Resident's mother demanded to writer to send resident to hospital... [Dr. Name redacted] was notified and gave order to send Resident to [name of hospital redacted]..."
* A physician order dated 1/2/22, read, "Provide or obtain COVID-19 testing including the use of Rapid POC [point of care] Testing per CMS/VDH guidelines".

Review of the clinical record revealed no indication that any COVID testing was performed on Resident #17 following staff's identification of a

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fever.

On 8/3/22, the facility Administrator reviewed the clinical record and confirmed the findings that Resident #17 had an elevated temperature, which is a symptom of COVID and no COVID testing had been performed. The Administrator reviewed her records in addition to the Resident's chart and confirmed Resident #17 had not returned to the facility at the time of survey but the admitting diagnosis for the hospital was not known at this time.

The facility Administrator later returned to the conference room and provided the survey team with hospital record for Resident #17 which indicated he was tested for COVID-19 at the hospital and tested negative and was admitted with a diagnosis of fever.

Review of the facility policy titled, "Coronavirus Testing Plan" was reviewed. This policy stated, "... 3. Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible..."

The CDC guidance document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", with a revision date of Feb. 2, 2022, was reviewed. This document under the subheading "Testing" read, ... Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible..." Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031062858

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The facility Administrator was made aware that the facility had failed to conduct testing of a symptomatic Resident and she confirmed this.

No further information was provided.

3. The facility staff failed to conduct routine testing of one staff member (Staff 3), who was not vaccinated for COVID-19.

On 8/2/22, the facility Administrator and Infection Preventionist indicated that they conducted COVID testing if someone was symptomatic, following a positive case they do contact tracing and if not in outbreak facility staff who are not up-to-date are tested based on the facilities locality transmission rates.

On 8/3/22, a sample of 4 employees were selected for review of COVID testing conducted November 15, 2021-January 15, 2022. The facility staff were given the staff members names and asked to identify the testing occurrences for the employees.

The facility identified that from November 30, 2022, through January 15, 2022, they were in a COVID outbreak. They further stated that contact tracing had been conducted and employee (Staff 3) was not exposed and therefore was not part of the outbreak testing. Staff 3 was however, subject to routine testing based on COVID transmission levels, which were high at that time.

Staff 3 had a medical exemption on file for exemption from COVID-19 immunization and therefore was not vaccinated. Staff 3 was to be

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F 886	Continued From page 26	F 886		

tested twice per week in accordance with facility policy and CDC guidance from November 15, 2021-January 15, 2022. Review of Staff 3's testing occurrences revealed he/she was tested: 11/16/21. The facility Administrator and IP stated, "I am unable to show evidence of any other testing during that time". Surveyor C then asked for evidence that Staff 3 was currently being tested twice weekly as required. The facility provided evidence of testing occurring on: 6/30/22, 7/1/22, 7/5/22, 7/15/22, 7/22/22, and 7/28/22.

The facility Administrator and IP were made aware that Staff 3 was not being tested twice per week as required and they agreed.

On 8/4/22, a review of Staff 3's time card revealed Staff 3 worked during the time frame of missed testing occurrences. Staff 3 worked the following dates in addition to working on the above noted testing occurrences: 7/4/22, 7/6/22, 7/8/22, 7/9/22, 7/10/22, 7/11/22, 7/12/22, 7/13/22, 7/16/22, 7/17/22, 7/18/22, 7/19/22, 7/20/22, 7/23/22, 7/24/22, 7/25/22, 7/26/22, 7/27/22, 7/28/22, 7/29/22, 7/30/22, and 7/31/22.

A review of the facility policy titled, "Coronavirus Testing Plan" was conducted. This policy read, "Expanded Screening Testing of Healthcare Personnel (HCP)...b. HCP who are not up to date with all recommended COVID-19 vaccine doses should continue expanded screening testing based on the level of community transmission as follows: Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission Level of COVID-19 Community Transmission Minimum Testing Frequency of Non-Up to Date HCP: Low (blue) Not

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F 886	Continued From page 27 recommended, Moderate (yellow) Once a week, Substantial (orange) Twice a week, High (red) Twice a week...". The CDC guidance document titled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", with a revision date of Feb. 2, 2022, was reviewed. This document under the subheading "Testing" read, ... In nursing homes, HCP who are not up to date with all recommended COVID-19 vaccine doses 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, these HCP should have a viral test twice a week...". Accessed online at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031062858 On 8/3/22 and again on 8/4/22, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was provided.	F 886		
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;	F 887		9/13/22

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F 887	Continued From page 28 (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and	F 887		

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F 887	Continued From page 29 (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop a policy for the provision of COVID-19 immunization to residents and the facility staff failed to provide COVID-19 immunization for 4 residents, Resident #8, #11, #12, and #13, in a survey sample of 8 residents reviewed for COVID-19 immunization. The findings included: 1. The facility staff failed to develop a policy for the provision of COVID-19 immunizations to residents. On 8/2/22, a request was made to the Facility Administrator for a copy of the facility's policy regarding the COVID-19 immunization for residents. A second request was made on 8/3/22 to the Facility Administrator. The Facility Administrator stated, "I have checked and I do not believe we have one [COVID-19 immunization policy/procedures for residents]". No further information was received.	F 887	1. The facility updated its vaccination policy to include COVID-19 immunization for residents. Resident #8, #11 and #13 have been offered a COVID 19 vaccination and EMR updated accordingly. Resident #12 no longer resides in facility. 2. Any resident residing at center is at risk of COVID-19 infection if center does not have a COVID vaccine policy for resident and COVID-19 vaccine are not offered or EMR is not updated with documentation. A 100% audit will be conducted to identify those residents not up to date with recommended COVID immunizations, and center will offer vaccine as applicable. 3. Center staff will be educated on COVID-19 vaccine policy for residents. 4. All new admissions that are not up to date with recommended COVID immunizations will be offered COVID-19 vaccine upon admission. Acceptance and declination will be documented in the EMR. New admissions will be audited	

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F 887	Continued From page 30 2. The facility staff failed to provide evidence that Residents #8, #11, #12, and #13 were offered, educated, and provided/or declined COVID-19 vaccination. On 8/2/22, clinical record review was performed and revealed the following: Resident #8 had no documentation with regard to COVID-19 immunization, to include the resident's current COVID-19 vaccination status, offer to provide immunization against COVID-19 infection, or documentation of resident refusal or medical contraindication. Resident #11 had no documentation with regard to an offer to provide a COVID-19 booster vaccine, education, or documentation of resident refusal or medical contraindication. Resident #12 had no documentation with regard to an offer to provide a COVID-19 booster vaccine, education, or documentation of resident refusal or medical contraindication. Resident #13 had no documentation with regard to COVID-19 immunization, to include the resident's current COVID-19 vaccination status, offer to provide immunization against COVID-19 infection, or documentation of resident refusal or medical contraindication. An interview was conducted with the Infection Preventionist (IP) who verified the findings for Residents #8, #11, #12, and #13. The IP stated the COVID-19 immunizations and/or booster vaccines should have been offered to the	F 887	daily times 5 days for 4 weeks, then monthly for 2 months. Results will be reviewed and revised with QAPI Committee. 5. Date of Compliance: September 13, 2022	

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F 887	Continued From page 31 residents, however "this may have been an oversight". The Facility Administrator and Director of Nursing were updated. No further information was provided.	F 887		