STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER NURSING HOME	11 NORTH BROAD ST SALEM, VA 24153

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/21/23 through 8/23/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/21/23 through 8/23/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The census in this 45 certified bed facility was 29 at the time of the survey. The final survey sample consisted of 13 current Resident reviews and 1 closed record review.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		10/1/23

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

Electronically Signed | 09/12/2023

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F 657	Continued From page 1 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive person-centered plan of care for 3 of 14 residents in the survey sample, Residents #10, #18, and #22. The findings included: 1. For Resident #10, the facility staff failed to revise the comprehensive person-centered care plan following the development of an unstageable pressure injury. Resident #10's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease, Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus, and Chronic Congestive Heart Failure. The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 5/16/23 assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 indicating the resident was moderately	F 657	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that the facility's resident care plans are reviewed and revised timely. On August 22, 2023, a Facility Incident Report was filed on behalf of Resident #10, #18, #22 and the Nursing Department. Clarification and verification were sought from the Medical Director, Director of Nursing, and the MDS/Care Plan Coordinator assigned to Resident #10, #18, and #22. On August 23, 2023, the Facility Director of Nursing provided the Survey Team with care plan revisions for residents #10, #18 and #22. On August 24, 2023, Residents #10, #18 and #22 were seen by the facility Medical Director and it was determined that no adverse outcomes were identified pertaining to the timing and revision of	

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F 657	Continued From page 2 cognitively impaired. A review of Resident #10's clinical record revealed a report entitled "Weekly Pressure Ulcer Progress Report" indicating a 1 cm x 1 cm unstageable wound was identified to the resident's left heel on 8/08/23. A physician's order was obtained on 8/08/23 to apply Betadine to the left heel wound twice a day until healed. Surveyor reviewed Resident #10's comprehensive person-centered care plan and was unable to locate documentation of a pressure wound to the resident's left heel. The plan of care included a focus area stating the resident had the potential for pressure ulcers due to frequent bowel and bladder incontinence and requiring assistance with bed mobility. On 8/22/23 at 4:00 PM, the survey team met with the administrator and director of nursing (DON) and discussed the concern of staff failing to revise Resident #10's care plan following development of an unstageable pressure injury. On 8/22/23 at 8:27 AM, the DON informed the surveyor they had now revised Resident #10's care plan and provided a copy of the revised care plan which included the unstageable pressure area. Surveyor requested and received the facility policy entitled "Comprehensive Care Plan" with the revision date of 10/01/17 which read in part " ...6. The comprehensive care plan will be reviewed and revised by IDT [interdisciplinary team] composed of individuals who have knowledge of the resident and his/her needs ..."	F 657	their individualized care plans. In addition, Resident #10, #18 and #22 POA's were informed of the Physician's visit pertaining to the revision and timing of their care plans. To prevent the reoccurrence of this type of deficiency, all nurses will receive additional training and education pertaining to documentation and the timely revision of resident care plans. This training will be conducted by the Director of Nursing and/or her designee and our partnership with Relias Learning Services. This training and education will be completed by September 30, 2023. On August 23, 2023, an audit of all current resident care plans was initiated by the Director of Nursing. This audit is scheduled for completeion on September 15, 2023. Any omissions or errors will be identified and necessary corrections completed. To prevent the reoccurrence of this type of deficiency, the Director of Nursing and/or her designee will perform a monthly care plan compliance audit specific to acute resident needs. These audits will be monthly for three months and then quarterly thereafter. Any care plans not in compliance will be identified and corrected. This compliance audit will begin on October 1, 2023. To prevent the reoccurrence of this type of deficiency, the facility's policy and procedure pertaining to the establishment,	

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F 657	Continued From page 3 No further information regarding this concern was presented to the survey team prior to the exit conference on 8/23/23. 2. For Resident #18, the facility staff failed to review and revised the comprehensive person-centered care plan following COVID-19 exposure and placement on transmission-based precautions (TBPs). Resident #18's diagnosis list indicated diagnoses, which included, but not limited to Multiple Sclerosis, Essential Hypertension, Hyperparathyroidism, and Paraplegia. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/12/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. On 8/21/23 at approximately 3:00 PM, surveyor observed signage present outside of Resident #18's room indicating contact and droplet precautions were in place. Resident #18's clinical record revealed a physician's order dated 8/20/23 for contact and droplet precautions related to roommate being positive for COVID-19. Surveyor reviewed Resident #18's comprehensive person-centered care plan and was unable to locate documentation of the resident's COVID-19 exposure and subsequent placement on transmission based-precautions. Surveyor requested and received the facility policy entitled "Comprehensive Care Plan" with the revision date of 10/01/17 which read in part "	F 657	accuracy and timing of resident care plans will be reviewed for revision by the Medical Director, Director of Nursing and the Administrator. This review will be completed by October 1, 2023. To prevent the reoccurrence of the type of deficiency the facility will utilized its partnership with Health Quality Innovators (HQI), LeadingAge Virginia and Chiles Healthcare Consulting. These partnerships will be called on for additional interpretive guidance, training and education with a focus on resident care planning. This will be an ongoing compliance measure. To prevent the reoccurrance of the type of deficiency, the Facility QA/QI and QA/PI teams will review this Plan of Correction at least quarterly for ongoing complianace. This will be an ongoing QA/QI and QA/PI measure.	

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F 657	Continued From page 4	F 657		

...6. The comprehensive care plan will be reviewed and revised by IDT [interdisciplinary team] composed of individuals who have knowledge of the resident and his/her needs ..."

On 8/23/23 at approximately 10:15 AM, the survey team met with the administrator and director of nursing and discussed the concern of staff failing to revise Resident #18's care plan to reflect their exposure to COVID-19 and subsequent transmission-based precautions.

No further information regarding this concern was presented to the survey team prior to the exit conference on 8/23/23.

3. For Resident #22, the facility staff failed to revise the comprehensive person-centered care plan after the resident tested positive for COVID-19 and was placed on transmission-based precautions.

Resident #22's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Essential Hypertension, Dementia, and Type 2 Diabetes Mellitus.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/12/23 assigned the resident a brief interview for mental status (BIMS) summary score of 1 out of 15 indicating the resident was severely cognitively impaired.

On 8/21/23 at approximately 3:00 PM, surveyor observed signage present outside of Resident #22's room indicating contact and droplet precautions were in place. A review of Resident

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F 657	Continued From page 5	F 657		

#22's clinical record revealed a nursing progress note dated 8/19/23 at 9:30 AM stating the resident had tested positive for COVID-19. A physician's order dated 8/19/23 was received to place Resident #22 on contact and droplet precautions.

Surveyor reviewed Resident #22's comprehensive person-centered care plan and was unable to locate documentation of the resident's COVID-19 diagnosis and subsequent placement on transmission based-precautions.

On 8/22/23 at 4:00 PM, the survey team met with the administrator and director of nursing (DON) and discussed the concern of staff failing to revise Resident #22's care plan following testing positive for COVID-19 and placement on transmission-based precautions.

On 8/23/23 at 8:27 AM, the DON informed the surveyor they had now revised Resident #22's care plan and provided a copy of the revised care plan which included the diagnosis of COVID-19 and the intervention of contact and droplet precautions.

Surveyor requested and received the facility policy entitled "Comprehensive Care Plan" with the revision date of 10/01/17 which read in part " ...6. The comprehensive care plan will be reviewed and revised by IDT [interdisciplinary team] composed of individuals who have knowledge of the resident and his/her needs ..."

No further information regarding this concern was presented to the survey team prior to the exit conference on 8/23/23.

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F 684	Continued From page 6	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow the providers orders for 1 of 14 residents, Resident #20. The findings included: For Resident #20, the facility staff failed to administer the medication Metoprolol per the providers orders. Resident #20's diagnoses included, but were not limited to hypertension, atrial fibrillation, and congestive heart failure. Section C (cognitive patterns) of Resident #20's quarterly MDS assessment with an assessment reference date (ARD) of 07/12/23 included a brief interview for mental status (BIMS) score of 14 out of a possible 15 points. Resident #20's clinical record included an order for Metoprolol 50 mg take 1 tablet by mouth every day for hypertension hold if systolic is less than 90 AND diastolic less than 60.	F 684	Snyder Nursing Home maintains, that it does ensure that residents receive quality care and their treatment and care is in accordance with professional standards of practice, identifiable by a written comprehensive person-centered care plan that is inclusive of resident choices. On August 22, 2023, a Facility Incident Report was filed on behalf of Resident #20 and the Nursing Department. Clarification for hypertension medication ordered for resident #20 was sought from the Medical Director. On August 24, 2023, Resident #20 was seen by the facility Medical Director and it was determined that no adverse outcomes were identified pertaining to hypertension medication held on August 20, 2023. In addition, the POA for Resident #20 was informed of the Physician's visit pertaining to the resident's prescribed hypertension medications.	10/1/23

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F 684	Continued From page 7 A review of Resident #20's medication administration records for August 2023 revealed that Licensed Practical Nurse (LPN) #1 held Resident #20's Metoprolol for a blood pressure of 106/68 on 08/20/23 for the administration time of 8:00 a.m. Resident #20's comprehensive care plan included the focus area has hypertension. Interventions included, but were not limited to, give anti-hypertensive medications as ordered. On 08/21/23 3:05 p.m., the Director of Nursing (DON) was made aware of the issue regarding Resident #20's medication Metoprolol. On 08/23/23 10:00 a.m., during a meeting with the Administrator and DON the DON stated they would have the provider review Resident #20's blood pressure medication orders. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684	On September 11, 2023 an audit of physician standing orders and resident specific orders pertaining to anti-hypertensive medications were reviewed by the Director of Nursing to determine a need for parameter revisions. On September 14, 2023, the Medical Director will take these findings/recommendations under advisement. To prevent the reoccurrence of this type of deficiency, all nurses will recieve additional training and education pertaining to the administration of medications. Subject matter will include, but not limited to "The Prevention of Medication Errors and Adverse Events" and "Avoiding Common Medication Errors". This training will be conducted by the Director of Nursing and/or her designee and our partnership with Relias Learning Services and our pharmacy consultant. This training and education is to be completed by Septmeber 30, 2023. On August 23, 2023, an audit of all current resident medication administration records (MAR) was initiated by the Director of Nursing. This audit is scheduled for completion by September 15, 2023. To prevent the reoccurrence of this type of deficiency, the Director of Nursing and/or her designee will perform a monthly medication administration record complaince audit for three months and	

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F 684	Continued From page 8	F 684	then quarterly thereafter. These complaince audits are scheduled to begin on October 1, 2023 and will be an ongoing compliance measure. To prevent the reoccurrence of this type of deficiency, the facility's policy and procedure pertaining to physician standing orders for medication administration will be reviewed for revision by the Medical Director, Director of Nursing, and the Administrator. This review will be completed by September 30, 2023. To prevent the reoccurrence of this type of deficiency, the facility will utilize its partnership with Health Quality Innovators (HQI), LeadingAge Virginia and Chiles Healthcare Consulting. These partnerships will be called upon for additional interpretive guidance, training and education with a focus on Medication Administration. This will be an ongoing complaince measure. To prevent the reoccurrence of this type of deficiency, the facility QA/QI and QA/PI teams will review this Plan of Correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		10/8/23

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F 880	Continued From page 9	F 880		

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
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 10 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, resident interview, staff interview, interviews with local health department staff, clinical record review, and facility document review, the facility staff failed to maintain an infection prevention program for preventing and controlling infection and communicable diseases during an identified outbreak of COVID-19. Facility staff failed to follow facility policy and procedure and CDC (Centers for Disease Control and Prevention) guidance related to cohorting COVID-19 positive and untested, asymptomatic residents together when vacant rooms were available creating the likelihood of the resident being exposed to and contracting COVID-19 for 1 of 29 current residents residing in the facility,	F 880	Snyder Nursing Home maintains, in accordance with accepted professional standards and practices, that the facility does maintain an effective infection prevention and control program that is inclusive of COVID-19 CDC/CMS guidance and recommendations. On August 29, 2023, a Facility Incident Report was filed on behalf of Resident #3, #18 and #22 and the facility Infection Control Preventionist. Clarification and guidance were sought for the improvement of the idenification, reporting, investigating and controlling of COVID-19 with emphasis on CDC/CMS	

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Resident #18.

Facility staff failed to follow CMS (Centers for Medicare and Medicaid Services) and CDC guidance related to performing COVID-19 testing for exposed residents and staff following residents testing positive for COVID-19 on 8/19/23 and 8/21/23.

At the time of the survey, two (2) residents were positive for COVID-19.

The findings included:

1. For Resident #18, the facility staff failed to test the resident for COVID-19 or move the resident to a vacant room following the roommate testing positive for COVID-19 on 8/19/23.

Resident #18's diagnosis list indicated diagnoses which included, but not limited to, Multiple Sclerosis, Essential Hypertension, paraplegia, and Hyperparathyroidism. The resident's current physician's orders included the active diagnosis of congestive heart failure.

The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/12/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact.

On 8/21/23 at approximately 3:00 PM, surveyor observed signage present outside of Resident #18's room indicating contact and droplet transmission-based precautions were in place. Resident #18 shared a semi-private room with Resident #22. Surveyor donned necessary

accepted national standards. Clarification was sought from the Medical Director, Director of Nursing and Local Health Department Epidemiologist.

On August 24, 2023 Resident #3, #18 and #22 were seen by the facility Medical Director as scheduled and it was determined that no adverse outcomes were identified pertaining to COVID-19 isolation precautions. COVID precautions for Resident #3 were lifted on September 1, 2023 with Resident #18 and #22 having their COVID precautions lifted on August 30, 2023. With no other COVID positive cases detected resident or staff it is expected that on September 18, 2023 the Local Health Department's Epidemiologist will declare our facility COVID out-break over. In addition, POA's for Resident #3, #18 and #22 were informed of the Physician's scheduled visit.

On August 30, 2023, members of the facility QA/QI and QA/PI met to review policy and procedure pertaining to "Managing COVID-19 after the end of the public health emergency". Interruptive guidance and recommendations were provided by the Local Health Department Epidemiologist. It was agreed that the facility policy and procedure would be revised to meet CDC/CMS COVID-19 accepted national standards. It was agreed that the policy and procedure revisions would be implemented no later than September 30, 2023. This policy will incorporate the following: CDC infection control guidance as updated May 2023,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER NURSING HOME	11 NORTH BROAD ST SALEM, VA 24153

(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 personal protective equipment (PPE) and entered the residents' room. Upon entrance, surveyor observed the privacy curtain drawn approximately halfway across the room, Resident #18's left side of the bed was against the wall and Resident #22's right side of the bed was against the wall, the residents were greater than six feet apart with the privacy curtain drawn between them. Each resident was in bed and neither resident was wearing a facial covering. Resident #18 was lying in bed and receiving oxygen via nasal cannula at 2 liters per minute. Resident #18 stated they were usually in the dining room but could not because of their roommate. A review of Resident #18's clinical record revealed a physician's order dated 8/20/23 for contact and droplet precautions related to roommate testing positive for COVID-19. Surveyor reviewed Resident #18's clinical record and was unable to locate documentation of the resident being tested for COVID-19 following exposure to the positive roommate. Resident #18 had no documented signs or symptoms of COVID-19. Resident #18 received COVID-19 vaccinations on 2/17/21, 3/10/21, and 11/09/22. According to the roommate's (Resident #22) clinical record, they tested positive for COVID-19 on 8/19/23 at 9:30 AM. On 8/21/23 at 3:45 PM, surveyor observed five (5) vacant resident rooms available for use and one (1) vacant resident room being used for storage. Surveyor requested and received facility room census reports for 8/19/23 and 8/20/23. A review of the room census reports revealed the five (5) identified vacant rooms were also vacant	F 880	CDC considerations for SAR-CoV2 Antigen Testing for Healthcare Providers as updated May 2023 and CMS memo QSO-23-13-ALL-May 2023. Areas of revision will be, but not limited to, include: General Guidance, Resident and Staff Vaccination, Source Control, Use of PPE, Optimize the use of Engineering Controls and Indoor Air Quality, Performing SARS-CoV-2 Viral Testing, responding to SARS-CoV-2 Exposure, Infection Control Practices when Caring for a Resident with Suspected or Confirmed SARS-CoV-2 Infection, Duration of Transmission Based Precautions for Symptomatic Resident being Evaluated for SARS-CoV-2, Duration of Transmission Based precautions for Asymptomatic Residents following Close Contact, Resident Placement, Duration of Transmission-Based Precautions for residents with SARS-CoV-2 Infection, Aerosol Generating Procedures, Visitation, and Environmental Infection Control. To prevent the reoccurrence of this type of deficiency, all staff will receive additional training and education pertaining to "Accepted National Standards for COVID-19". This training will be provided by the facility Administrator, Infection Control Preventionist, and Relias Learning Services, Subject matter will include, but not limited to : "CMS Targeted Training", "COVID Requirements for LTC: and COVID Vaccines What You Need to Know". This training and education will be completed by October 8, 2023.	

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F 880	Continued From page 13 on 8/19/23 and 8/20/23. Upon entrance on 8/21/23, the census in this 45-bed facility was 29. On 8/21/23 at 3:55 PM, the director of nursing (DON) provided the facility policy entitled "Coronavirus Disease-COVID-19 - Resident Cohorting" with an effective date of 9/01/21 which read in part " ... 1. During the pandemic, residents may be cohorted in a room utilizing the following guidelines: a. All resident [sic] who are COVID-19 positive (symptomatic or asymptomatic) may only be cohorted with residents who are also positive ..." The administrator and DON verified this was a current policy. On 8/22/23 at 11:06 AM, surveyor spoke with the DON who stated the facility medical director did not want residents moved due to COVID-19 and the possibility of spreading it to other areas in the facility. Surveyor asked the DON if Resident #18 was offered a room move and the DON stated "no." DON stated staff were monitoring Resident #18's vital signs every shift to monitor for signs or symptoms of COVID-19. On 8/22/23 at 1:36 PM, surveyor spoke with the facility medical director (MD) who stated they instructed the staff not to move either resident due to possibility of exposing additional residents in other areas. MD further stated that the exposure was already there, and it was reasonable to keep the residents where they were. On 8/22/23 at 3:00 PM, surveyor spoke with Resident #18 who stated they were on isolation because their roommate had COVID, and staff had not talked to them about changing rooms.	F 880	To prevent the reoccurrence fo this type of deficiency, the following performance improvement measure will be initiated. The facility will utilize its partnerships with Health Quality Innovators(HQI), LeadingAge Virginia, Chiles HealthCare Consulting and Relias Learning Services. To prevent the reoccurrence of this type of deficiency, the Facilty's QA/QI and QA/PI teams will review the Plan of Correction at least quarterly for ongoing compliance. This will be an ongoing QA/QI and QA/PI measure.	

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Resident #18 also stated they had not been tested for COVID-19.

On 8/22/23 at 4:00 PM, the survey team met with the administrator and DON and discussed the concern of Resident #18 not being tested for COVID-19 and remaining in the room with a COVID-19 positive roommate despite having multiple vacant rooms available. The administrator acknowledged the facility had vacant rooms available. Surveyor shared and discussed current CDC guidance. The following information was provided:

CDC COVID-19 "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated 5/08/23 documents in part, " ...The ICP [infection prevention and control] recommendations described below (e.g., patient placement, recommended PPE [personal protective equipment]) also apply to patients with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic patients who have met the criteria for empiric Transmission-Based Precautions based on close contact with someone with SARS-CoV-2 infection. However, these patients should not be cohorted with patients with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing ...Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room ...If cohorting, only patients with the same respiratory pathogen should be housed in the same room ...If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning

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for COVID-19, residents should remain in their current location ..."

On 8/23/23 at 10:03 AM, surveyor spoke with the local health department epidemiologist who stated they were unaware of the current COVID-19 activity in the facility and had not spoken to any facility staff. Surveyor informed the epidemiologist of the concern of Resident #18 remaining in the room with a COVID-19 positive roommate without being tested for COVID-19. Epidemiologist stated they always recommended the current guidelines. The epidemiologist then referred surveyor to the case investigator working with area facilities.

On 8/23/23 at 10:09 AM, the administrator stated the medical director instructed them to leave the residents where they were and only to test residents if they were symptomatic and the facility did as they were directed. The administrator stated they saw this as a standing order. The administrator stated they were appreciative of the survey team identifying the issue and would be looking at the concerns.

On 8/23/23 at 10:35 AM, surveyor spoke with the case investigator (CI) with the local health department who stated they were also unaware of the COVID-19 activity in the facility. Surveyor informed the CI of the concern regarding Resident #18; CI stated it was negligent for Resident #18 to remain in the room with a COVID-19 positive roommate when empty rooms were available. CI stated their recommendation would be to separate COVID-19 positive and negative roommates and do point prevalence testing.

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F 880	Continued From page 16 On 8/23/23 at 10:55 AM, the survey team met with the administrator and DON and provided contact information for the local health department case investigator for additional guidance. No further information regarding this concern was presented to the survey team prior to the exit conference on 8/23/23. 2. Facility staff failed to follow CMS (Centers for Medicare and Medicaid Services) and CDC (Centers for Disease Control) guidance related to performing COVID-19 testing for exposed residents and staff following residents testing positive for COVID-19 on 8/19/23 and 8/21/23. Upon facility entrance on 8/21/23, the survey team was informed of one (1) active case of COVID-19 stating Resident #22 had tested positive for COVID-19 on 8/19/23. According to Resident #22's clinical record, they tested positive for COVID-19 on 8/19/23 at 9:30 AM. On 8/21/23 at approximately 3:00 pm, surveyor observed signage present outside of Resident #22's room indicating contact and droplet transmission-based precautions were in place. Resident #22 currently shared a semi-private room with Resident #18. Surveyor reviewed Resident #18's clinical record and was unable to locate documentation of the resident being tested for COVID-19 following exposure to the positive roommate. Resident #18's physician's orders included a current order for a rapid COVID test as needed. Resident #18 had no documented signs or symptoms of COVID-19. On 8/22/23 at approximately 8:30 am, the survey	F 880		

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team was informed an additional resident, Resident #3, had tested positive for COVID-19 on the evening of 8/21/23. On the previous day, surveyor observed Resident #3 outside on the patio with a minimum of ten (10) additional residents and attended a resident council meeting with a surveyor outdoors on the patio. Surveyor had also observed Resident #3 having lunch in the facility dining room with other residents and the resident remained in the dining room following lunch.

On 8/22/23 at 9:37 AM, surveyor spoke with the director of nursing (DON) and requested the facility testing policy. At 10:55 AM, the DON provided surveyor with pages 1 and 6 of the CMS QSO-23-13-ALL memo dated 5/01/23 and stated this was the facility testing policy.

The 5/01/23 CMS QSO-23-13-ALL memo read in part, " ...Requirements for COVID-19 Testing · On August 25, 2020, CMS issued an IFC (CMS-3401-IFC) requiring LTC [Long Term Care] facilities to perform routine testing of residents and staff for the COVID-19 infection. As noted in the IFC, this testing regulation will expire with the end of the PHE [public health emergency]. Note: CMS issued the testing requirements early in the COVID-19 PHE to ensure facilities were conducting the volume and frequency of tests needed to identify COVID-19 cases and prevent transmission, such as surveillance testing of nursing home staff. Throughout the PHE, CDC and CMS have updated the testing guidance, including most recently, removing the recommendation for surveillance testing of staff. However, COVID-19 testing is still an important action and is a nationally recognized standard to help identify and prevent the spread of

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COVID-19. Therefore, while this specific regulatory requirement will end with the PHE, CMS still expects facilities to conduct COVID-19 testing in accordance with accepted national standards, such as CDC recommendations ..."

On 8/22/23 at 11:06 AM, the DON stated they monitor all residents for signs and symptoms of COVID-19 but were only doing vital signs every shift for COVID-19 monitoring on the two positive residents, Resident #22 and #3, and the exposed roommate, Resident #18.

On 8/22/23 at 11:17 AM, surveyor spoke with the administrator who stated they were testing residents and staff based on signs and symptoms only. The administrator stated when a resident tested positive for COVID-19, notices were hung, the COVID information hotline was updated, a report was sent to the local health department, supplies were monitored, and the medical director was notified.

On 8/22/23 at 1:36 PM, surveyor spoke with the medical director (MD) regarding the facility only testing for COVID-19 based on signs and symptoms and not following exposure, the MD stated they thought the facility was testing everyone, but they had no strong feelings either way about testing. MD stated it was reasonable to test Resident #22's exposed roommate.

On 8/22/23 at 3:00 PM, surveyor spoke with Resident #18 who stated they had not been tested for COVID-19.

On 8/22/23 at 4:00 pm, the survey team met with the administrator and DON and discussed the concern of the facility only testing symptomatic

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residents and staff and not performing testing following exposure to COVID-19. The administrator and DON stated their facility medical director instructed them to only test symptomatic residents. The administrator stated COVID-19 testing kits were issued to facility staff to take home and test when symptomatic. Surveyor shared and discussed current CMS and CDC guidance. The following information was provided:

CMS QSO-20-38-NH memo dated 8/26/20, expired 5/11/23 documents in part " ...Effective 05/11/2023, this memo is no longer in effect. Testing for COVID-19 should be conducted by following accepted national standards, such as CDC recommendations ..."

CDC COVID-19 "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated 5/08/23 documents in part, " ...Responding to a newly identified SARS-CoV-2 infected HCP [healthcare personnel] or resident - When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. - A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. - The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. - Perform testing for all residents

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and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. · Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 ..."

On 8/23/23 at 8:30 AM, the DON stated they had not tested or offered to test Resident #18.

On 8/23/23 at approximately 8:45 AM, the DON stated they tested the three (3) residents who Resident #3 shared a table in the dining room on 8/21/23. The DON provided copies of COVID-19 test results for Resident #25, #26, and #27 obtained on 8/22/23, all results were negative.

On 8/23/23 at 10:03 AM, surveyor spoke with the local health department epidemiologist who stated they were unaware of the current COVID-19 activity in the facility and had not spoken to any facility staff. Surveyor informed the epidemiologist of the concern of the facility not conducting testing on exposed residents or staff. Epidemiologist stated they always recommended the current guidelines. The epidemiologist then referred surveyor to the case investigator working with area facilities. The epidemiologist confirmed that a single positive COVID-19 case was considered an outbreak.

On 8/23/23 at 10:09 AM, the administrator stated the medical director instructed them to only to test residents if they were symptomatic and the facility did as they were directed. The administrator

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stated they saw this as a standing order. The administrator stated they were appreciative of the survey team identifying the issue and would be looking at the concerns.

On 8/23/23 at 10:31 AM, the administrator and DON confirmed they were only testing symptomatic staff members and to their knowledge, no staff have been tested for COVID-19 this week.

On 8/23/23 at 10:35 AM, surveyor spoke with the case investigator (CI) with the local health department who stated they were also unaware of the COVID-19 activity at the facility. Surveyor informed the CI of the concern regarding the facility not conducting testing on exposed residents or staff, CI stated their recommendation would be to do point prevalence testing.

On 8/23/23 at 10:55 AM, the survey team met with the administrator and DON and provided contact information for the local health department case investigator for additional guidance.

No further information regarding this concern was presented to the survey team prior to the exit conference on 8/23/23.