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	345286	A. BUILDING ______ B. WING ______	C 05/21/2020

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 4/25/2020 through 5/21/2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# GRF011.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 4/25/2020 through 5/21/2020. Past-noncompliance was identified at: CFR 483.80 at tag F880 at a scope and severity (L) The deficient practice for F880 began on 3/11/2020 and was corrected on 4/10/2020. 24 of the 30 complaint allegations were substantiated resulting in deficiencies. Event ID: GRF011	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.	F 552		6/19/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/10/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.
This REQUIREMENT is not met as evidenced by:
Based on record review, family interview, and staff interview, the facility failed to inform Resident #11 ' s Responsible Party of a change in the resident's planned admission placement to a private room with a 14-day quarantine to a semi-private room with a roommate and no quarantine. This occurred during the COVID-19 pandemic and was for 1 of 8 residents reviewed for the right to be fully informed.

The findings included:

Resident #11 was admitted to the facility on 3/31/20 with diagnoses that included Alzheimer ' s Disease.

Electronic correspondence on 3/19/20 between Resident #11 ' s Responsible Party (RP), the facility ' s Business Office Manager (BOM), and the former Admissions Director (AD) revealed the following:

-At 8:40 AM Resident #11 ' s RP asked the BOM what the facility ' s protocol was for admitting new residents during the COVID-19 pandemic.
-At 8:59 AM the BOM responded, "We are still admitting people, we are just admitting them to a private room for a few days to make sure they aren't exhibiting symptoms (with the understanding that they will have to come out of

This plan of correction is submitted as required under Federal and State Regulation and statutes applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied.

F-tag 552
1. Corrective action accomplished for those residents found to have been affected by the deficient practice.
Resident #11 no longer resident in the facility
2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken.
New Admissions are at risk. Room placement for new admissions are to be discussed at Morning Meeting by the Interdisciplinary Team prior to admission.
There have been no new admissions to

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the private room). But at this time we aren't allowing any visitors ..."

The facility ' s census record indicated Resident #11 was admitted on 3/31/20 to a semi-private room with a roommate (Resident #26). He remained in this same room with the same roommate throughout his stay.

The admission Minimum Data Set (MDS) assessment dated 4/7/20 indicated Resident #11 had moderately impaired cognition and required supervision only for locomotion on the unit and was independent for locomotion off the unit. He utilized either a walker or wheelchair for locomotion.

A phone interview was conducted with Resident #11 ' s RP on 5/6/20 at 8:15 AM. She reported that prior to his admission she was informed by the BOM or AD that Resident #11 would be admitted to a private room and quarantined for 14 days prior to being integrated into the general population. She stated that she was informed this was a precaution related to the COVID-19 pandemic. She indicated that on the date of admission (3/31/20) she was not able to enter the facility with Resident #11 as visitors were restricted as a precaution related to COVID-19. She stated she was not made aware on this date, 3/31/20, that he was going to be admitted to a semi-private room with a roommate and not quarantined for any period of time. The RP reported that on 4/4/20 she went to visit Resident #11 at the facility, but that due to visiting restrictions she had to visit him through the glass windows in the lobby area. She reported that Resident #11 had no mask on during this visit, which had concerned her as she thought he was

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the facility since 4/7/20.

3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur. The Interdisciplinary Team including the Business Office Manager, Social Worker, Director of Nursing, Activity Director, and Director of Therapy to be re-educated by the Nursing Home Administrator on the importance of communicating room placement of new admissions with the Responsible Party and to notify of any changes in room placement on 6/5/20

4. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Nursing Home Administrator will validate room placement of new admissions and perform an audit to verify that notification was given to the resident and/or family member. This audit will be completed 5xper week for 4 weeks than 3xper week for 2 months. The Nursing Home Administrator will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance.

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going to be under quarantine. Resident #11 ' s RP indicated that she was not sure when she found out for certain that Resident #11 was not in a private room, but that she had multiple communications with the Medical Director who allowed her to see Resident #11 via video call which confirmed he was not in a private room. The RP stated that if she had been fully informed of the changes in planned placement from a private room with quarantine to a semi-private room with no quarantine that she would have reconsidered Resident #11 ' s admission to the facility.

A phone interview was conducted with the former Admissions Director (AD) on 5/6/20 at 1:58 PM. She stated that she no longer worked at the facility. She recalled speaking with Resident #11 ' s RP prior to the resident's admission, but she had no recollection of telling them the resident would be in a private room and quarantined for 14 days. She indicated she was unaware of a requirement for quarantining new residents for 14 days when they were admitted related to COVID-19.

A phone interview was conducted with the Administrator on 5/6/20 at 3:21 PM. She was asked if Resident #11 was admitted to a private room and quarantined on 3/31/20 and she stated that he was. The census record for Resident #11 that indicated he was admitted to a semi-private room with a roommate was reviewed with the Administrator. She revealed her previous statement was incorrect. She further revealed that Resident #11 was admitted to a semi-private with a roommate on 3/31/20 and was not quarantined. The Administrator was unable to explain why Resident #11 ' s placement plan

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changed, and she was unable to explain why his RP was not notified of the change. She indicated that prior to admission the RP would have been communicating with the former AD and BOM.

A phone interview was conducted with the BOM on 5/6/20 at 4:21 PM. She recalled speaking with Resident #11 ' s RP prior to admission, but she had no recollection of telling them the resident would be in a private room and quarantined for 14 days. The BOM indicated that she could not recall if it was a requirement to admit new residents to a private room and quarantine them from the current residents at the time of Resident #11 ' s admission (3/31/20). She stated that she communicated with his RP via electronic correspondence and she needed to read through that information to see if anything was discussed related to a private room or quarantine.

On 5/6/20 at 4:56 PM the BOM forwarded a copy of electronic correspondence that occurred on 3/19/20 at 8:59 AM between herself and Resident #11 ' s RP. This electronic correspondence revealed that she informed Resident #11 ' s RP that he would "be admitted into a private room for a few days to make sure he wasn ' t exhibiting symptoms" of COVID-19. The BOM provided no explanation as to why this planned placement changed and why it was not communicated to Resident #11 ' s RP prior to or upon admission.

A phone interview was conducted with former Unit Manager (UM) #1 on 5/12/20 at 10:26 AM. She confirmed that Resident #11 was admitted to a semi-private room with a roommate on 3/31/20. She stated that upon admission, Resident #11 self-propelled his wheelchair throughout the facility and was not quarantined.

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F 552	Continued From page 5 A phone interview was conducted with Nursing Assistant #12 on 5/12/20 at 11:15 AM. She stated that Resident #11 was admitted to a semi-private room with a roommate and was not quarantined on admission (3/31/20). She reported that at the time of his admission he was able to self-propel his wheelchair and did so throughout the common areas of the facility. In a follow up interview on 5/21/20 at 11:20 AM the Administrator indicated that Resident #11 ' s RP had a right be fully informed of the change in planned placement from a private room with quarantine to a semi-private room with a roommate and no quarantine. She was unable to explain why this information was not conveyed to his RP.	F 552		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		6/19/20

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F 580	Continued From page 6 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, responsible party, staff and physician interviews, the facility failed to notify the resident's responsible party of a resident's death (Resident #2) and failed to promptly notify residents and/or their responsible parties of COVID-19 test results (Residents #7, #24, #18, #17, #30, #20, #28 and #5). This was	F 580	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. Responsible Party notification has been completed by the physician for resident #30 on 4/30/20, #17 in 5/6/20 note, #7 on 4/22/20, and #24 on 4/18/20. Residents	

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for 9 of 9 residents reviewed for notification.

The findings included:

1) Resident #2 was initially admitted to the facility on 1/2/19 with multiple diagnoses that included Alzheimer's dementia. Her most recent readmission to the facility was on 3/31/2020 after a hospitalization for gastrointestinal hemorrhage. She returned to the facility under Hospice care.

The resident's Clinical Resident Profile revealed a family member was listed as emergency contact #1 and responsible party (RP).

The nursing progress notes dated 4/14/2020 at 1:16 PM, revealed Nurse #4 found Resident #2 without a heartbeat and respirations. The resident had expired. The progress note stated Hospice and the funeral home were notified and the funeral home retrieved Resident #2 at 1:30 PM.

A phone interview was conducted with Resident #2's RP on 4/27/2020 at 2:00 PM. The RP revealed he was not notified by the facility of the resident's death on 4/14/2020 but rather by the funeral home on 4/15/2020.

A telephone interview occurred with Nurse #4 on 4/28/2020 at 11:35 AM. She was able to recall the resident and events that took place on 4/14/2020. Nurse #4 explained around 12:00 PM on 4/14/2020 she found Resident #2 without respirations and a heartbeat. She retrieved the acting Director of Nursing (DON- who was the Assistant Director of Nursing at the time) for verification and asked her how the facility handled deaths. She went onto say the acting DON instructed her to call Hospice and Hospice would

F 580

#2 #5 #18 #20 #28 no longer reside in the facility

2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken. All residents are at risk. A 100% audit was completed by the Director of Nursing for the past 30 days to ensure Responsible Party notification of Change in Condition. This was completed on 6/8/20. Responsible Party notification was completed appropriately for 100% resident Change in Condition

3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur. The Licensed Nursing staff will be educated by the Staff Development Coordinator beginning on 6/3/20 on the process of Responsible Party notification with a change in condition and/ or refusal of physician recommendations. This education will be provided by the Staff Development Coordinator and completed by 6/18/20 for Licensed staff including contract staff. Licensed staff not educated by 6/18/20 will receive education prior to working on the floor. New hire will receive education upon hire through Orientation. Physician orders will be reviewed during morning clinical meeting 5 times per week to ensure compliance and to validate Responsible Party notification in the event of resident refusal.

4. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Director of Nursing will audit all physician orders to verify that notification was given to the resident and/or family member. This audit will be

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F 580	Continued From page 8 do the rest of the notifications. Nurse #4 stated she called Hospice and got the phone number for the funeral home. She phoned the funeral home, but she never called the resident's family. On 4/28/2020 at 11:46 AM, the acting DON was interviewed via the telephone and verified instructing Nurse #4 to call Hospice and the funeral home and that Hospice would notify the resident's RP. A phone interview was held with the Hospice Vice President of Compliance and Quality on 4/28/2020 at 1:50 PM. She reviewed hospice documentation for Resident #2 and stated hospice was notified by Nurse #4 on 4/14/2020 relaying Resident #2 expired at 12:15 PM. She added typically the facility staff notified the responsible party regarding a resident's death. The Medical Director was interviewed via the phone on 4/29/2020 at 11:54 AM and confirmed he was notified on 4/14/2020 of Resident #2's death and informed Nurse #4 to call Hospice and when she talked with the family to inquire about the funeral home of choice. The Medical Director stated he was unaware the family had not been notified by the facility and stated it would have been his expectation for the facility to notify the family regarding her death as the nurse would be able to answer any questions they might have had. On 5/4/2020 at 4:25 PM, a phone interview occurred with the Funeral Home Director/Manager and stated when he called the RP on 4/15/2020, the RP stated he was unaware Resident #2 had passed away.	F 580	completed 5xper week for 4 weeks than 3xper week for 2 months. The Director of Nursing will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance.	

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On 5/6/2020 at 12:30 PM, a phone interview was conducted with Hospice Nurse #1. She verified Nurse #4 called her on 4/14/2020 to report Resident #2 had expired and had actually called her twice. The first time was to report the time of death for Resident #2. Hospice Nurse #1 went on to say she asked Nurse #4 if there was anything they could do or calls to be made and was told "no". A few minutes later Nurse #4 called back and asked it there was a funeral home on record as the facility did not have one listed. The number was provided to Nurse #4. The Hospice Nurse #1 added there was no communication that the family needed to be called and normally the facilities call the RP's.

In an interview with the Administrator on 5/21/2020 at 11:15 AM, she indicated the facility should have contacted the RP when Resident #2 passed away. She went onto say that at times the Hospice Nurse would call the families and other times the facility called and felt like caused confusion and breakdown in communication with the families. The Administrator added it was ultimately the responsibility of the facility to notify RP's of any changes to a resident's condition to include death.

2) Resident #7 was admitted to the facility on 5/31/19 with diagnoses that included diabetes and hypertension.

The resident's Clinical Resident Profile revealed a family member was listed as emergency contact #1 and responsible party.

The annual Minimum Data Set (MDS) assessment dated 3/26/2020 indicated Resident

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#7 was cognitively intact.

A nursing progress note dated 4/7/2020 indicated Resident #7's responsible party (RP) was informed a resident at the facility had tested positive for COVID-19.

Resident #7's care plan dated 4/8/2020 read she was positive for COVID-19 with interventions that included notifying the RP of any changes in Resident #7's condition.

The resident's nursing progress notes dated 4/10/2020 to 4/20/2020 did not include any documented information that Resident #7's RP was notified of COVID-19 testing or positive results for COVID-19.

On 4/27/2020 at 1:47 PM, a phone interview occurred with Resident #7. She confirmed she had been made aware by the facility that she tested positive to COVID-19 but was unable to state the date of notification.

A phone interview was conducted with Resident #7's RP on 4/27/2020 at 2:17 PM. He explained he had called the facility on 4/15/2020 to do a wellness check since he wasn't able to visit the facility and was told by the answering nurse that Resident #7 had been tested for COVID-19 on 4/10/2020 and results were received back on 4/13/2020, but was provided no further information to whether she tested positive or negative to the virus. The RP went on to say he had not received any calls from the facility or corporate level regarding Resident #7's test results for COVID-19 and that prior to the COVID-19 pandemic he was receiving notifications from the facility for any changes in

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condition for Resident #7.

On 4/29/2020 at 10:02 AM, via electronic correspondence with the Administrator, she indicated Resident #7 was tested for COVID-19 on 4/10/2020 with results received on 4/13/2020 revealing she was positive for the virus. The Administrator further stated Resident #7 was listed on the alert and oriented notification roster which meant the resident was notified of the COVID positive results.

In an interview with the Administrator on 5/21/2020 at 11:15 AM, she stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP's of the testing results. She verified Resident #7's RP was not notified that she tested positive for COVID-19 and acknowledged the facility should have followed the regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.

On 5/21/2020 at 11:40 AM, the Medical Director was interviewed via the telephone. He stated he presumed Resident #7's RP knew since she talked frequently on the phone with them. The Medical Director acknowledged the facility should have followed the regulations regarding notification of both the resident and the RP for the significant change of positive COVID-19 results.

3) Resident #24 was admitted to the facility on 11/5/19 with diagnoses that included dementia, lack of coordination and depression.

The Clinical Resident Profile revealed a family member was listed as the resident's emergency

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F 580	Continued From page 12 contact #1 and responsible party. A quarterly Minimum Data Set (MDS) assessment dated 1/17/2020 indicated Resident #24 had moderately impaired cognition. A nursing progress note dated 3/13/2020 at 11:39 AM, indicated Resident #24's responsible party (RP) was informed visitors were not allowed due to the COVID-19 pandemic. Resident #24's care plan dated 4/8/2020 read he was positive for COVID-19 with interventions that included notifying the RP of any changes in Resident #24's condition. Resident #24's nursing progress notes dated 4/7/2020 to 4/20/2020 did not include any documented information that Resident #24's RP was notified of COVID-19 testing or positive results for COVID-19. A phone interview was conducted with Resident #24's RP on 5/11/2020 at 12:38 PM. He stated he was contacted by the facility in March 2020, when visitors were no longer allowed but was never informed by the facility that Resident #24 had been tested for COVID-19 or that he had tested positive for COVID-19 until the Nurse Practitioner called him on 4/15/2020 to discuss how symptoms would be handled as they arose. On 4/29/2020 at 10:02 AM, via electronic correspondence with the Administrator, she indicated Resident #24 was tested for COVID-19 on 4/10/2020 with results received on 4/13/2020 revealing he was positive for the virus. The Administrator further stated Resident #24 was listed on the alert and oriented notification roster which meant the resident was notified of the	F 580		

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COVID positive results.

In an electronic correspondence with the Administrator on 5/14/20 at 9:01 AM it read; resident RP's were notified by the corporate nurse if the resident was not capable of making their own decisions. This was done to assist the facility in contacting everyone as fast as possible.

The Nurse Practitioner was interviewed via the phone on 5/14/2020 at 10:27 AM and stated when she arrived at the facility on 4/14/2020 she was provided a list of residents who had tested positive for COVID-19. She asked the Administrator if she needed to make any calls and was told no because the corporate office would be notifying all RP's. She added it was her expectation, if the facility said corporate would be contacting RP's, then it should have been done when they were aware the resident had tested positive to COVID-19.

In an interview with the Administrator on 5/21/2020 at 11:15 AM, she stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP's of the testing results. She verified Resident #24's RP was not notified he had tested positive for COVID-19 until the Nurse Practitioner called on 4/15/2020 during a routine call. She acknowledged the facility should have followed the regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.

On 5/21/2020 at 11:40 AM, the Medical Director was interviewed via the telephone. He stated he presumed Resident #24's RP knew since he talked frequently on the phone with them. The Medical Director acknowledged the facility should

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have followed the regulations regarding notification of both the resident and the RP for the significant change of positive COVID-19 results.

On 5/21/2020 at 4:30 PM, a phone interview occurred with the Nurse Practitioner, who confirmed when she contacted Resident #24's RP on 4/15/2020 she was informed the facility had not notified him of the COVID results.

4. Resident #18 was admitted on 8/27/15 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).

The resident's electronic medical record indicated Resident #18 named a family member as his Responsible Party.

Resident #18's annual Minimum Data Set (MDS) dated 3/26/20 indicated he was cognitively intact.

A nursing note dated 4/7/20 at 6:04 PM read Resident #18's Responsible Party (RP) was informed that a resident at the facility had tested positive for COVID-19.

Resident #18's care plan dated 4/8/20 read he was positive for COVID-19. Interventions included notifying the RP of any changes in Resident #18's condition.

In an electronic correspondence with the Administrator on 5/8/20 at 2:39 PM read Resident #18 was tested for COVID-19 on 4/10/20 and positive COVID-19 results on 4/13/20.

The nursing notes from 4/10/20 to 4/20/20 do not include any documented information that Resident #18's RP was notified of COVID-19

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testing or positive results for COVID-19. Resident #18 expired at the facility on 4/21/20 at 3:56 PM.

A telephone interview was conducted on 5/8/20 at 1:18 PM with Resident #18's RP. She stated she was contacted on 4/7/20 and made aware that one resident had tested positive for COVID-19 but that was all she was told. The RP stated she was never notified that Resident #18 was tested for COVID-19 or that he had tested positive for COVID-19 until the Medical Director called her on 4/20/20. The RP stated the Medical Director discussed Resident #18's decline and it was decided that Resident #18 would be on comfort measures only and he expired on 4/21/20.

In an electronic correspondence with the Administrator on 5/14/20 at 9:01 AM read resident RP's were notified by the corporate nurse if the resident was not capable of making their own decisions. This was done to assist the facility in contacting everyone as fast as possible. Management was letting the staff know about the COVID-19 outbreak in a meeting with the Resident Council President present. The Administrator indicated at that time, management were helping to provide care for the residents. The Medical Director also spoke with residents and RP's as appropriate regarding their test results.

In another email correspondence with the Administrator on 5/14/20 at 4:46 PM read Resident #18 was on the notification list as alert and oriented and it was an error. The RP was notified on 4/20/20 of positive COVID-19 results that were received on 4/13/20.

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In an interview on 5/21/2020 at 11:20 AM, the Administrator stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP's of the testing results. She confirmed Resident #18's RP was not notified that he tested positive for COVID-19 until the Medical Director called her on 4/20/20. She acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.

In a telephone interview on 5/21/20 at 11:50 AM, the Medical Director stated he presumed Resident #18's RP knew since they talked frequently on the phone up until he had a significant decline in his condition. He confirmed he contacted Resident #18's RP on 4/20/20 to discuss comfort measures. The Medical Director acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.

5. Resident #17 was admitted 9/12/19 with cumulative diagnoses of Diabetes and urinary retention. He was diagnosed with Corona Virus (COVID-19) on 4/13/20.

The resident's electronic medical record indicated Resident #17 named a family member as his Responsible Party.

Resident #17's quarterly Minimum Data Set (MDS) dated 2/10/20 indicated he was cognitively intact.

A nursing note dated 4/7/20 at 1:16 PM read a

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message was left for Resident #17's Responsible Party (RP) regarding a facility update.

Resident #17's care plan revised on 4/13/20 read he was positive for COVID-19. Interventions included notifying the RP of any changes in Resident #17's condition.

In an electronic correspondence with the Administrator on 5/8/20 at 2:39 PM read Resident #17 was tested for COVID-19 on 4/10/20 and positive COVID-19 results were received on 4/13/20.

There were no nursing notes in Resident #17's medical record from 4/8/20 to 4/14/20.

A nursing note dated 4/15/20 at 1:01 PM read Resident #17 was asymptomatic with COVID-19.

A telephone interview was conducted on 5/8/20 at 1:18 PM with Resident #17's RP. She stated she was contacted on 4/7/20 and made aware that one resident had tested positive for COVID-19 but that was all she was told. The RP stated she was never notified that Resident #17 was tested for COVID-19 or that he had tested positive for COVID-19.

In an electronic correspondence with the Administrator on 5/14/20 at 9:01 AM she stated resident RP's were notified by the corporate nurse if the resident was not capable of making their own decisions. This was done to assist the facility in contacting everyone as fast as possible. Management was letting the staff know about the COVID-19 outbreak in a meeting with the Resident Council President present. The Administrator indicated at that time, management

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were helping to provide care for the residents. The Medical Director also spoke with residents and RP's as appropriate regarding their test results

In a telephone interview on 5/18/20 at 1:43 PM, Resident #17 stated he recalled staff putting a swab in his nose but that the staff never informed him of the reason for the testing nor was he informed that he tested COVID-19 positive.

In an interview on 5/21/2020 at 11:20 AM, the Administrator stated Resident #17 was cognitively intact and he was informed of the testing results but his RP was not notified. She acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.

In a telephone interview on 5/21/20 at 11:50 AM, the Medical Director stated he presumed the Resident #17's RP knew since they talked frequently on the phone and Resident #17 was able to tell the RP of the positive results. He acknowledged the facility should have followed regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.

6. Resident #30 was admitted on 5/21/19 with cumulative diagnoses of Cerebral Vascular Accident, Aphasia and cognitive deficit.

The resident's electronic medical record indicated that a family member was Resident #30's Responsible Party (RP).

Resident #30's most recent quarterly Minimum

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F 580	Continued From page 19 Data Set (MDS) dated 1/6/20 indicated severe cognitive impairment and with no behaviors. He was coded independent with all activities of daily living. Resident #30's nursing note dated 3/13/20 at 11:42 AM read the nurse spoke with RP letting him know that facility was taking precautions for the COVID 19 virus and asked not to visit at this time. Resident #30's nursing note dated 4/7/20 at 1:13 PM read the RP was given a facility update. Resident #30's revised care plan dated 4/8/20 read as suspected diagnosis of Corona Virus (COVID-19). An intervention included notification Resident #30's Responsible Party (RP) of any changes in his condition. Resident #30's nursing note dated 4/15/20 at 10:30 AM, read Resident #30 was COVID-19 positive. Resident #30's nursing note dated 4/23/20 at 6:03 PM read Resident #30 continued with COVID-19 and was asymptomatic. A Social Services Progress note dated 4/29/20 at 1:23 PM read Resident #30 was able to FaceTime video with his RP. Family was informed that they could contact the facility to schedule another video chat. A Physician Progress notes dated 4/30/20 at 1:43 PM read Resident #30's RP contacted him to ask about Resident #30's COVID-19 testing. The note specified the Physician informed the RP that Resident #30 refused the COVID-19 testing.	F 580		

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In an electronic correspondence with the Administrator 5/8/20 at 1:41 PM read Resident #30 was not tested on 4/10/20. He refused and when attempted again he continued to refuse. The Administrator specified the staff may have got confused and documented that Resident #30 tested positive for COVID-19. She indicated the facility continued to monitor Resident #30 for signs and symptoms of COVID-19 because his roommate had tested COVID-19 positive.

In an electronic correspondence with the Administrator on 5/8/20 at 2:45 PM read she found no evidence of anything documented that Resident #30's RP was made aware of the resident's refusal of COVID-19 testing.

A telephone interview was conducted on 5/11/20 at 1:38 PM with Resident #30's RP. He stated nobody from the facility had contacted him letting him know Resident #30 refused COVID-19 testing on 4/10/20. The RP stated it was not until 4/30/20 when he called the Medical Director to inquire whether Resident #30 was tested for COVID-19 that he was informed that Resident #30 had refused prior testing. The RP stated it was his expectation that the facility would let him know that Resident #30 refused testing earlier in April, so he could have called or video chatted with Resident #30 to convince him to be tested. The RP stated the Medical Director told him that Resident #30 was suspected as having COVID-19 on 4/30/20 but was asymptomatic.

A telephone interview was conducted with Social Worker (SW) #2 on 5/18/20 at 10:42 AM. She confirmed she was present with Resident #30 during his video chat with RP on 4/29/20. She

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stated at no time during the call did she informed the RP that Resident #30 had refused COVID-19 testing or that he was suspected COVID-19 positive.

In an interview on 5/21/2020 at 11:20 AM, the Administrator stated Resident #30's RP should have been notified of his refusal to be tested for COVID-19. She acknowledged the facility should have followed regulations regarding notification of Resident #30's suspected COVID-19 positive diagnosis prior to the Medical Director informing the RP on 4/30/20.
7. Resident #20 was admitted to the facility on 8/24/19 with multiple diagnoses including end stage renal disease (ESRD), on renal dialysis and was diagnosed with COVID 19 on 4/13/20. The quarterly Minimum Data Set (MDS) assessment dated 1/14/20 indicated that Resident #20 had moderate cognitive impairment and had behavior of rejection of care that occurred 4-6 days. Resident #20 was discharged to the hospital on 5/2/20 and did not return.

Interview with the Administrator on 5/11/20 at 1:39 PM revealed that Resident #20 was tested for COVID 19 on 4/10/20 and the result came back positive on 4/13/20. During the interview, the Administrator stated that she didn ' t have documentation that Resident #20 or the resident's family was notified that the resident tested positive for COVID 19. She further reported that the regional office consultant was responsible for notifying the families of residents who were COVID 19 positive.

Interview with the regional office consultant on 5/13/20 at 12:04 PM revealed that she was helping the facility to notify the family members of

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F 580	Continued From page 22 cognitively impaired residents who tested positive for COVID 19. She indicated that the Nurse Practitioner (NP) and/or the attending Physician were responsible for notifying the alert and oriented residents who tested positive for COVID. The regional office consultant further stated that if the resident was alert and oriented, their family members were not notified unless the resident requested to notify her/his family. She stated that Resident #20 was alert and oriented and was the responsible party (RP) for herself so her family was not notified. A follow up interview with the Administrator was conducted on 5/13/20 at 2:20 PM regarding notification of residents and family members when a resident was tested positive for COVID 19. She stated the facility ' s system was to notify the alert and oriented residents of the positive result but not the resident's family unless the resident requested to notify them. The Administrator was unable to provide the date or the person who notified Resident #20 of the positive result. The Administrator verified that the family of Resident #20 was not notified since the resident was alert and oriented. Interview with the attending physician of Resident #20 on 5/14/20 at 1:20 PM revealed that he visited the resident on 4/19/20 and he didn't remember if he notified the resident of the COVID positive result. He reported that the resident's test result came back on 4/13/20, so he assumed the resident was already notified by the staff of the COVID positive result before his visit on 4/19/20. The Physician stated that on 4/13/20, he was told that the Corporate Nurse would be calling the families of residents who tested positive for COVID 19.	F 580		

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On 5/21/20 at 11:20 AM, the Administrator was interviewed. The administrator stated, that the facility had received over a hundred COVID test results back at the same time and her expectation was for the staff to notify the resident and/or the resident's family within 3 days of the results being received. She further stated that in other circumstances she expected notification within 24 hours. The Administrator acknowledged that there was a lack of documentation for notification of residents and resident family members regarding resident testing positive for COVID. The administrator stated she expected this notification be documented in the resident's medical records.

8. Resident #28 was admitted to the facility on 8/23/18 with multiple diagnoses which included; Chronic Kidney Disease and Chronic Obstructive Pulmonary Disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated 3/30/20 indicated that Resident #28's cognition was intact.

A laboratory test collected on 4/10/20 and reported on 4/13/20 revealed that Resident #28 tested positive for COVID 19.

Interview with the Administrator on 5/11/20 at 1:39 PM revealed that Resident #28 was tested for COVID 19 on 4/10/20 and the result came back positive on 4/14/20.

Interview with the regional office consultant on 5/13/20 at 12:04 PM revealed that she was helping the facility in notifying the family members of cognitively impaired residents who were tested

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positive for COVID 19. She indicated that the Nurse Practitioner (NP) and the attending Physician were responsible for notifying the alert and oriented residents that they were positive for COVID. The regional office person further stated that if the resident was alert and oriented, their family members were not notified unless the resident requested to notify her/his family. She stated that Resident #28 was alert and oriented and so his family was not notified of the COVID positive result.

An interview with the Nurse Practitioner (NP) was conducted on 5/13/20 at 1:02 PM. She stated that she visited Resident #28 on 4/13/20 and she didn ' t think the COVID result was back yet. Resident #28 was tested for COVID 19 on 4/10/20 and the result came back positive on 4/14/20. On 4/14/20, she was told that the facility had a designated staff member who would notify alert and oriented residents. The NP verified that Resident #28 was alert and oriented and she had not informed the resident nor the family of the COVID 19 positive result.

A follow up interview with the Administrator was conducted on 5/13/20 at 2:20 PM regarding notification of residents and family members when a resident was tested positive for COVID 19. She stated the facility's system was to notify the alert and oriented residents of the positive result, but not the resident's family unless the resident requested to notify them. The Administrator was unable to provide the date or the person who notified Resident #28 of the COVID positive result. The Administrator verified that the family of Resident #28 was not notified since the resident was alert and oriented.

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On 5/21/20 at 11:20 AM, the Administrator was interviewed. The administrator stated that the facility had received over a hundred COVID test results back at the same time and her expectation was for the staff to notify the resident and/or the resident's family within 3 days of the results being received. She further stated that in other circumstances she expected notification within 24 hours. The Administrator acknowledged that there was a lack of documentation for notification of residents and resident family members regarding resident testing positive for COVID. The administrator stated she expected this notification be documented in the resident's medical record.

9. Resident #5 was admitted to the facility on 9/28/18 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD).

The Clinical Resident Profile revealed a family member was listed as emergency contact #1 and Responsible Party (RP).

The most recently completed Minimum Data Set (MDS) for Resident #5 was a quarterly assessment dated 1/3/20. Resident #5 was assessed as cognitively intact.

Resident #5 ' s care plan dated 4/8/20 read she had a suspected diagnosis for COVID-19 with interventions that included notifying the RP of any changes in Resident #5 ' s condition.

The nursing progress notes dated 4/10/20 to 4/20/20 did not include any documented information that Resident #5 ' s RP was notified of COVID-19 testing or COVID-19 results.

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On 4/27/20 at 2:45 PM, a phone interview occurred with Resident #5. She confirmed she had been made aware by the facility that she tested positive to COVID-19 but was unable to state the date of notification.

A phone interview was conducted with Resident #5 ' s RP on 4/28/20 at 4:30 PM. The RP reported that the facility normally contacted her for any changes in condition with Resident #5 such as falls or infections. She indicated that on 4/15/20 she was made aware by local media sources that the facility had a high number of residents who tested positive for COVID-19. She stated that she was alarmed by this information and was concerned as she had not received any information from the facility on whether or not Resident #5 was tested and if so what the results were. The RP reported that she phoned the facility herself twice on 4/15/20 to find out if Resident #5 was tested for COVID-19. She indicated that on the first phone call she was told by an unknown staff member that someone would call her back later with an update. The RP reported that she waited for several hours and had not received a return phone call, so she phoned the facility again. She stated that on this second phone call on 4/15/20 she spoke with the Assistant Business Office Manager (ABOM) who informed her that Resident #5 tested positive for COVID-19.

On 4/29/20 at 9:55 AM, via electronic correspondence with the Administrator, she indicated Resident #5 was tested for COVID-19 on 4/10/20 with results received on 4/13/20 revealing she was positive for the virus. The Administrator further stated Resident #5 was

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listed on the alert and oriented notification roster which meant the resident was notified of the COVID-19 positive results.

A phone interview was conducted on 4/29/20 at 10:35 AM with the ABOM. She stated that on 4/15/20 the facility started to receive numerous phone calls from family members requesting information on COVID-19 test results. She reported that due to the multitude of phone calls, the Administrator asked her to help field some of the calls that came in. She explained that she was given a list of the residents with the results of their COVID-19 test results and the Administrator asked her to inform the RPs of the test results if they called in. The ABOM indicated that she had not initiated any phone calls herself. She reported that she had a vague recollection of speaking to Resident #5 ' s RP by phone regarding the COVID-19 test results, but she was unsure what date she spoke with her.

In an interview with the Administrator on 5/21/20 at 11:15 AM, she stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP of the testing results. She acknowledged that if Resident #5 ' s RP had not reached out to the facility on 4/15/20 the facility would not have notified her of the positive COVID-19 test results. The Administrator further acknowledged the facility should have followed the regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.

On 5/21/20 at 11:40 AM, the Medical Director was interviewed via the phone. He stated he presumed Resident #5 ' s RP knew she had tested positive for COVID-19 as she was capable

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F 580	Continued From page 28 of talking to them by phone. The Medical Director acknowledged the facility should have followed the regulations regarding notification of both the resident and the RP for the significant change of positive COVID-19 results.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		6/19/20

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F 656	Continued From page 29 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan related to the risk of smoking at the facility for Resident #22. This was for 1 of 3 residents reviewed for accidents. The findings included: Resident #22 was initially admitted to the facility on 10/18/18. Her diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and heart failure. The most recent Minimum Data Set (MDS) completed for Resident #22 was a quarterly assessment dated 1/30/20. Her cognition was intact, and she required supervision of 1 for assistance with locomotion on and off unit. She utilized a wheelchair or walker. Resident #22 received oxygen (O2) therapy. A physician ' s order for Resident #22 dated 3/5/20 indicated O2 via nasal cannula at 4 liters (L) per minute (min) continuous. A nursing note dated 3/17/20 completed by the former Director of Nursing (DON) indicated	F 656	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. The care plan for resident #22has been reviewed and updated and a new smoking screen completed by Social Worker. 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken. A review has been completed on 8 of 8 current like residents to ensure care plans have been updated and smoking screens are in place by the Social Workers on 6/5/20. 8 of 8 care plans were in place. All smoking screens were updated by Social Workers on 6/8/20 to validate appropriate care plans. 3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur. The Licensed Nursing staff will be educated on the process of completing a Smoking Assessment on new admissions and as needed with change of condition. The Licensed Staff will also be educated on completing an appropriate care plan. This education will be provided by the Staff Development	

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F 656	Continued From page 30 Resident #22 was observed outside in the designated smoking area smoking a cigarette. Resident #22 had a portable O2 tank on the back of her wheelchair. The O2 tank provided continuous O2. The former DON wrote that the O2 was removed and taken inside the facility. The resident stated, "I just wanted to smoke" and when asked where she got her cigarette and how she lit it she responded, "I just got it". Resident #22 was educated that all residents who wished to smoke needed to be assessed for safe smoking and adhere to the facility ' s smoking policy. Resident #22 was informed that due to her use of O2 while smoking and without her being previously assessed for smoking she would not be permitted to smoke at this time at the facility. Resident #22 was noted to nod her head and verbalize understanding. A nursing note dated 3/17/20 completed by former Unit Manager (UM) #1 indicated Resident #22 was found smoking outside with a portable O2 tank attached to her wheelchair. The O2 was running continuously via nasal cannula. Resident #22 was noted to refuse to extinguish her cigarette when staff approached her, so the portable O2 was removed from the wheelchair and taken inside. Following the incident, the resident refused to state where she obtained her cigarettes and lighter from. Medical record review on 5/8/20 indicated no smoking assessment was completed for Resident #22 prior to or after the 3/17/20 incident of smoking while utilizing continuous O2. The active care plan for Resident #22 was reviewed on 5/8/20 and revealed no care plan was in place to address the risk of Resident #22	F 656	Coordinator and completed by 6/18/20 for Licensed staff including contract staff. Licensed staff not educated by 6/18/20 will receive education prior to working on the floor 4. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Director of Nursing will audit all smoking assessments to ensure appropriate care plan in place. This audit will be completed 5xper week for 4 weeks than 3xper week for 2 months. The Director of Nursing will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance.	

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smoking.

A phone interview was conducted with former UM #1 on 5/8/20 at 9:24 AM. She verified the 3/17/20 note that indicated Resident #22 was found outside in the designated smoking area (an enclosed courtyard) with a lit cigarette and portable O2 tank in place that was providing continuous O2 via nasal cannula. Former UM #1 stated that smoking assessments were only completed for residents who wished to smoke at the facility. She explained that Resident #22 had not expressed an interest in smoking at the facility prior to the incident, and she had no previous incidents of smoking at the facility before the 3/17/20 incident. Former UM #1 was asked if Resident #22 ' s care plan incorporated the risk of smoking at the facility and non-compliance with the facility ' s smoking policy and she stated that she was not sure, but that it should have been revised after the incident to address this risk. She stated that care plan revisions were able to be completed by any staff member in addition to MDS Nurse #1 and MDS Nurse #2. Former UM #1 stated that she no longer worked at the facility and that she was unable to recall if she had developed a care plan to address the 3/17/20 smoking incident for Resident #22.

On 5/8/20 the following information was provided and received via electronic correspondence:
- At 2:15 PM the Administrator was asked if there was any additional information related to the 3/17/20 smoking incident for Resident #22 other than the nursing notes completed by the former DON and former UM #1.
- At 2:43 PM the Administrator indicated that there was no additional information. She further confirmed there was no care plan in place to

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address the incident.

A phone interview was conducted on 5/8/20 at 2:43 PM with Nursing Assistant (NA) #13. She stated that she began working at the facility in April 2020 and she worked with Resident #22 frequently. She revealed that she was unaware that Resident #22 was at risk for smoking. She reported that this was important information because Resident #22 utilized continuous O2 which made smoking dangerous if the O2 was running while she was smoking. NA #13 indicated that if she was aware of this risk that she would monitor Resident #22 more closely in an effort to prevent any further incidents.

A phone interview was attempted with the former DON on 5/11/20 at 3:27 PM and she was unable to be reached.

A phone interview was conducted with MDS Nurse #1 on 5/18/20 at 12:28 PM. The 3/17/20 smoking while utilizing continuous O2 incident for Resident #22 was reviewed with MDS Nurse #1. She stated that she had no recollection of this incident. MDS Nurse #1 reviewed the active care plan and confirmed the care plan made no mention of this incident nor resident ' s risk of smoking and non-adherence to the facility ' s smoking policy. MDS Nurse #1 stated that typically, incidents such as this were reviewed in the morning meetings that occurred Monday through Friday. She revealed that if she had known about the incident she would have developed a care plan for the resident. She explained that Resident #22 was not an identified smoker, she had no smoking assessment, and if she was utilizing O2 while smoking this put her and other residents at risk harm. She further

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F 656	Continued From page 33 explained that a care plan informed the staff of the risk of smoking for Resident #22 as well as providing them with interventions to implement in order to prevent reoccurrence. A phone interview was conducted with MDS Nurse #2 on 5/18/20 at 12:32 PM. The 3/17/20 smoking while utilizing continuous O2 incident for Resident #22 was reviewed with MDS Nurse #2. She stated that she recalled hearing about this incident during a morning meeting. She reported that normally this type of incident would be addressed in the care plan due to the risk of re-occurrence. MDS Nurse #2 was unable to explain why a care plan was not developed to address Resident #22 ' s risk of smoking at the facility. She stated, "I cannot recall what may have happened with that". During an interview with the Administrator on 5/21/20 at 11:20 AM she stated that she expected a care plan to be developed to address Resident #22 ' s risk of smoking at the facility. The Administrator revealed that the facility had multiple new staff, both nurses and NAs, and without a care plan to address the risk for smoking, these staff would have no plan in place with interventions to implement in an effort to prevent further incidents.	F 656		
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	F 684		6/19/20

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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 record review and Nurse Practitioner (NP), Physician and staff interviews, the facility failed to transcribe verbal orders for medications and to administer Nurse Practitioner (NP) ordered medications for 1 of 6 sampled residents reviewed for provision of care according to professional standards, care plan and resident ' s choice (Resident #28).

Findings included:

Resident #28 was admitted to the facility on 8/23/28 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Chronic Kidney Disease (CKD). The quarterly Minimum Data Set (MDS) assessment dated 3/30/20 indicated that Resident #28's cognition was intact.

A nurse's note dated 4/10/20 at 4:22 AM (written by Nurse #5) revealed Resident #28's oxygen saturation was in the 80's on room air. Oxygen was started via nasal cannula (the note didn't say how many liters (L) of oxygen). The resident denied pain but was making a "whimpering" sounds, denied being cold but was holding covers up to his chest. His temperature was 98.2 degrees Fahrenheit (F). He denied cough. Will continue to monitor and to report to doctor in AM.

A nurse's note dated 4/10/20 at 7:56 AM (written by Nurse #5) revealed the NP was made aware of the resident's change in condition. New orders for complete blood count (CBC), comprehensive

F 684

1. Corrective action accomplished for those residents found to have been affected by the deficient practice.
Resident #28 no longer resides in the facility
2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken.
All residents have the potential to be affected. A review of physician orders for all residents has been completed for the past 30 days to ensure all physician orders have been completed by the Director of Nursing on 6/8/20 all orders were completed appropriately.
3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur. Education for all Licensed staff has been completed on the process for following and transcribing physician orders and appropriate documentation by the Staff Development Coordinator beginning on 6/8/20. This education will be provided by the Staff Development Coordinator and completed by 6/18/20 for Licensed staff including contract staff. Licensed staff not educated by 6/18/20 will receive education prior to working on the floor
4. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Director of Nursing will speak with physician/ nurse practitioner for a list pf 5 random physician verbal

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metabolic panel (CMP), erythrocyte sedimentation rate (ESR), chest x-ray and to get COVID 19 test done when available.

The NP note dated 4/10/20 revealed Nurse #5 had called the NP. The NP was informed that Resident #28 became hypoxic with oxygen saturation in low 80's and the resident was placed on oxygen at 2 Liters (L) per minute (min). The oxygen saturation went up to 87% and the oxygen was increased to 4 L/min and the oxygen saturation increased to 91%. The note further stated that per Nurse #5, the Nurse Aide (NA) stated that the resident has "not been himself for a few days". He had been staying in bed more, was coughing and had increased weakness. The resident stated that he had mild body aches. The assessment/Plan was acute respiratory failure requiring 4 L/min oxygen. Differential diagnoses include bacterial pneumonia versus aspiration pneumonia versus COVID 19 (multiple positive cases in facility). Orders were given for chest x-ray, complete blood count (CBC) with differential, comprehensive metabolic panel (CMP) and Erythrocyte sedimentation rate (ESR). The note further indicated that after discussing with the attending physician, will start on Azithromycin (an antibiotic drug) 500 milligrams (mgs) by mouth daily for 5 days, albuterol inhaler (used to treat or prevent bronchospasm) and Mucinex (a cold and cough medicine). The NP had a long discussion with the resident's family members regarding the plan of care. The family members stated that they were okay with the conservative treatments but if the resident continued to decline, they wanted to transition to comfort measures only.

The April 2020 Medication Administration

orders for completion weekly. This audit will be completed 5xper week for 4 weeks than 3xper week for 2 months. The Director of Nursing will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance.

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Records (MARs) revealed the NP ordered Azithromycin, Albuterol inhaler and Mucinex on 4/10/20 were not transcribed and administered to Resident #20 since 4/10/20.

The NP note dated 4/13/20 revealed that Resident #28 continued to have overall functional decline, very poor intake, increased weakness, generalized body aches but remained afebrile. He was seen sitting up in bed, with difficulty keeping his eyes open during the examination. He claimed that he was in pain and was requesting pain medication. He stated that he was short of breath, but his oxygen cannula was lying beside him. He improved after placing him on oxygen at 4 L/min. Due to continued decline in resident's condition, the family stated they wanted to transition to comfort care. The plan of care was communicated with the family. Orders for Roxanol (a narcotic analgesic) and Lorazepam (an antianxiety drug) were written.

A nurse's note dated 4/15/20 at 11:45 AM (written by Nurse # 4) revealed that Resident #28 was yelling for pain medication and Roxanol was administered. He was saying that his chest hurt, and he was uncomfortable. His vital signs were 135/70 (blood pressure), 74 (pulse rate), 24 (respiratory rate), 100.6-degree F (temperature) and 91% (oxygen saturation).

Interview with the Administrator on 5/11/20 at 1:39 PM revealed Resident #28 was tested for COVID 19 on 4/10/20 and the result came back positive on 4/14/20.

On 5/13/20 at 9:38 AM, the NP was interviewed. She reported that Nurse #5 had called on 4/10/20, and she was informed that Resident #28

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was hypoxic (inadequate supply of oxygen), and his oxygen saturation was low, he was coughing and with increased weakness. She gave verbal order to the Nurse for chest x-ray, CBC, CMP and ESR. Then after talking to the attending physician, she gave verbal order to start Azithromycin, Albuterol inhaler and Mucinex. The NP indicated that she didn't know the name of the nurse she had given verbal order for the medications. The NP reported that she was not aware that the medications she ordered on 4/10/20 had not been transcribed and administered to the resident. She indicated that she had discussed this plan of care to the family and it was frustrating that the plan of care had not been implemented. The NP stated that she had seen Resident #28 on 4/13/20 and since there was no improvement in his condition, he was made comfort care. The NP also stated that since she had written it on her notes, she was sure that she had called the facility and gave a verbal order to the nurse and the order should have been transcribed and carried out.

On 5/13/20 at 3:31 PM, Nurse #5 (3rd shift nurse on 4/9/20) was interviewed. The Nurse stated that she remembered calling the NP on 4/10/20 and notified her of Resident #28 change in condition. The NP gave a verbal order for CBC, CMP, ESR and chest x-ray. She didn't remember receiving orders for Azithromycin, albuterol inhaler and Mucinex.

On 5/14/20 at 12:29 PM, a follow up call was conducted with Nurse #5. Nurse #5 reported that she worked 3rd shift on 4/9/20 and she could not remember receiving orders for Azithromycin, Albuterol inhaler and Mucinex. She added that the NP might have called back after she left the

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F 684	Continued From page 38 building and gave the verbal order for the Azithromycin, Albuterol and Mucinex to the 1st shift nurse who was an agency nurse (Nurse # 4). On 5/14/20 at 12:29 PM, Nurse #4 was interviewed. She stated that she was an agency nurse and she remembered being assigned to Resident #28 on 4/10/20. She reported that she didn't remember receiving a verbal order for Azithromycin, Albuterol inhaler and Mucinex from the NP on 4/10/20 but there was a lot going on with Resident #28 that day. On 5/18/20 at 1:04 PM, the current Director of Nursing (DON) was interviewed. She stated that she asked Nurse #5 if she received the orders for the medications from the NP and she denied receiving medication orders. The DON stated the NP indicated that she had called the facility and gave verbal order for the medications. On 5/21/20 at 11:20 AM, interview with the Administrator was conducted. She stated that she expected the plan of care to be implemented for the resident. On 5/21/20 at 11:50 AM, interview with the Physician was conducted. He stated that he expected the facility to implement the plan of care for the resident as recommended by the NP.	F 684		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and	F 698		6/19/20

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F 698	Continued From page 39 the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview the facility failed to have a doctor ' s order for residents to receive dialysis treatments, failed to monitor dialysis access sites and failed to utilize the communication sheets to exchange information about resident ' s treatments and care with the dialysis center for 4 of 4 sampled residents reviewed for dialysis (Residents # 20, #22, #25 & #40). Findings included: 1. Resident #20 was admitted to the facility on 8/24/19 with multiple diagnoses including end stage renal disease (ESRD) and was on renal dialysis. The quarterly Minimum Data Set (MDS) assessment dated 1/14/20 indicated that Resident #20 had moderate cognitive impairment and had behavior of rejection of care that occurred 4-6 days. The assessment further indicated that the resident was receiving dialysis. The care plan for Resident #20 dated 1/14/20 was reviewed. She was care planned for risk of complications related to hemodialysis. The goal was for Resident #20 not to experience any complications related to chronic renal insufficiency or receiving hemodialysis through next review. The approaches included apply lidocaine cream to fistula on dialysis days, monitor dialysis access for bruit and thrill every shift and as needed and monitor for signs/symptoms of fluid overload. Resident #20 ' s February 2020, March 2020, April 2020 and May 2020 Physician ' s orders	F 698	1. Corrective action accomplished for those residents found to have been affected by the deficient practice. Resident #22 and #40 have had their dialysis orders reviewed and communication binders in place as of 5/9/20 . Residents #20 and #25 no longer reside in the facility 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken. All dialysis residents have the potential to be affected. A review of physician orders has been completed and a visual check on the communication binder have been completed by the Director of Nursing on 5/21/20 for 2 of 2 residents 3. Measure/ systemic changes put in place to ensure the deficient practice does not reoccur. Education for all Licensed staff has been started on 6/8/20 by the Staff Development Coordinator on the process for ensuring the communication binder, orders, and appropriate documentation for dialysis residents. This education will be provided by the Staff Development Coordinator and completed by 6/18/20 for Licensed staff including contract staff. Licensed staff not educated by 6/18/20 will receive education prior to working on the floor 4. Monitoring of the corrected action to ensure the deficient practice will not reoccur. The Director of Nursing will audit dialysis residents for orders and binder completion. This audit will be completed	

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revealed there was no physician ' s orders for the resident to receive dialysis treatments.

Resident #20 had a doctor ' s order dated 02/12/20, for Lidocaine cream 2.5% (topical local anesthetics) to be applied to dialysis access area topically on dialysis days Monday, Wednesday and Friday.

On 5/11/20 at 1:39 PM, the Administrator was interviewed. She reported that Resident #20 was tested for COVID 19 on 4/10/20 and the result came back positive on 4/13/20.

On 5/11/20 at 4:22 PM, the Medical Records/Transportation staff member was interviewed. She reported that before Resident #20 tested positive for COVID 19 on 4/13/20 she received dialysis at a center in Salisbury, NC every Monday, Wednesday and Friday at 6:00 AM. After she was tested positive for COVID 19, her dialysis days were changed to Tuesday, Thursday and Saturday at 1:00 PM and they would be performed at a dialysis center in Spencer, NC. When asked how the change in the resident ' s dialysis schedule and location were communicated to the staff, she responded that she posted these changes at the nurse ' s station and in the dialysis communication book.

On 5/19/20 at 10:15 AM, a follow up interview with the Medical Records/Transportation staff member was conducted. She reported that she was informed by the dialysis nurse of the change in the dialysis schedule for Resident #20 on 4/13/20. She indicated that she didn ' t know that she had to personally inform the nurse of the dialysis change in schedule. She indicated that she just posted Resident #20 ' s dialysis days at

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5xper week for 4 weeks than 3xper week for 2 months. The Director of Nursing will present the results of this audit to the Quality Assurance Performance Improvement committee monthly x3. The QAPI committee can make changes to ensure the facility remains in compliance.

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F 698	Continued From page 41 the nurse ' s station and in the dialysis communication book. She reported that she had searched for the dialysis communication sheets from the thinned records and could not find the resident ' s communication sheets after 4/8/20. She indicated that the nurses might have missed to fill out the communication sheet. Resident #20 ' s April 2020 and May 2020 MAR Medication Administration Records (MARs) revealed that staff did not apply the Lidocaine cream topically to the resident ' s dialysis access area on 4/21/20, 4/23/20, 4/25/20, 4/28/20 and 4/30/20, when the dialysis schedule was changed to Tuesday, Thursday and Saturday. On 5/12/20 at 9:35 AM, interview with the dialysis Nurse at the Kannapolis, NC location was conducted. She stated that their clinic was for residents who were under observation for COVID. The nurse revealed that Resident #20 had received dialysis on 4/13/20 at their clinic. The nurse explained Resident #20 did not have a communication book (with communication sheets) with her during the treatment. On 5/19/20 at 10:24 AM, Nurse # 1 was interviewed. She remembered being assigned to Resident #20 on 4/15/20 and stated that she didn ' t know that her dialysis days were changed to Tuesday, Thursday and Saturday. She indicated that based on the MAR, Resident #20 was to receive Lidocaine cream topically on dialysis days every Monday, Wednesday and Friday. Nurse #1 added that she didn ' t know that Resident #20 did not have a doctor ' s order for dialysis. Nurse #1 stated she that she didn ' t know where the dialysis communication book was kept for the resident.	F 698		

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On 5/19/20 at 12:50 PM, Nurse #4 was interviewed. She was assigned to Resident #20 on 4/13/20 and 4/21/20. The nurse revealed that she had sent Resident #20 to dialysis on 4/21/20 but she didn ' t remember filling out the dialysis communication sheet. She stated that she just heard it from somebody that Resident #20 ' s dialysis days were changed from Monday, Wednesday and Friday to Tuesday, Thursday and Saturday. Nurse #4 reported that she didn ' t remember the exact date and the person who told her about the change. She also stated that she didn ' t know who was supposed to change the order for the Lidocaine cream to be applied to the resident ' s dialysis access area on Tuesdays, Thursdays and Saturdays when the resident ' s dialysis days were changed. She also reported that she didn ' t know that the resident did not have an order for dialysis.

On 5/12/20 at 9:43 AM, interview with the dialysis Nurse at the Spencer, NC location was conducted. The Nurse revealed that Resident #20 had received dialysis on 4/21/20, 4/23/20, 4/25/20, 4/28/20 and 4/30/20. She indicated that she was informed by the facility that Resident #20 had refused dialysis on 4/16/20 and 4/18/20. The dialysis nurse reported that the facility did not send the communication book with the resident during the treatments.

Attempts to contact Nurse #2, who was assigned to Resident #20 on 4/25/20, and Nurse #3, who was assigned to the resident on 4/23/20, were unsuccessful.

On 5/12/20 at 2:07 PM, the current Director of Nursing (DON) was interviewed. She stated that

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resident on dialysis should have a doctor ' s order to receive dialysis treatment and the order should include the number of dialysis treatments per week. She didn ' t realize that the orders had dropped off during the transition to a new company and new computer system for electronic records in February 2020. She added that after it was brought to her attention during the survey, the facility reinstated the order to all current residents receiving dialysis.

On 5/19/20 at 10:06 AM, a follow up interview was conducted with the current DON. She stated that the dialysis clinic did not inform her of the change in the dialysis schedule/location for Resident #20. They might have informed the transportation person of the change. She expected the transportation person to notify the nurse of the change in the dialysis schedule and expected the nurse to change the order for the application of the lidocaine cream. The current DON stated that she didn ' t know why the order for the Lidocaine cream was not changed. The current DON stated the facility was using the communication sheet to communicate with the dialysis clinic. The nurse was supposed to fill out the sheet in the dialysis binder and sent the binder with the resident during the dialysis treatment. The current DON stated that she didn ' t know why the dialysis binder was not sent with the resident to dialysis after 4/8/20.

On 5/21/20 at 11:20 AM, interview with the Administrator was conducted. She stated that the facility ' s protocol was for dialysis orders to be in place. She reported that she thought the orders for dialysis were dropped off when the facility changed ownership and the electronic records were switched. She added that the orders were

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not entered into the electronic records and she had no record of orders that may have been in place previously. She stated that she expected the facility to have a consistent communication with the dialysis clinic. The system was for the facility nurse to complete the communication sheet and the dialysis binder was sent with the resident each time they went to dialysis. Then the dialysis clinic would complete the form and the binder was returned to the facility with the resident. The Administrator added that when COVID 19 happened and dialysis schedule had changed, the staff were not used to prepping the residents for dialysis and education was not provided to send the binder with the resident. She reported that since the issue was brought to her attention during the survey, the staff had been provided with education.

On 5/21/20 at 11:50 AM, the Physician was interviewed. He stated that he doesn ' t always write orders for dialysis however he would expect the facility ' s normal protocol regarding dialysis orders to be followed and if the facility ' s protocol was to have orders then he would write the order.

2. Resident #22 was initially admitted to the facility on 10/18/18 and most recently readmitted on 4/4/20. Her diagnoses included End Stage Renal Disease (ESRD) and dialysis dependence.

The most recent Minimum Data Set (MDS) completed for Resident #22 was a quarterly assessment dated 1/30/20. Her cognition was intact, and she was on dialysis.

A Risk Meeting nursing note dated 2/6/20

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completed by former Unit Manager (UM) #1 indicated Resident #22 was continued on dialysis 4 times a week.

Resident #22's active care plan included the focus area of the risk for impaired renal function and complications related to hemodialysis. The interventions included, in part, transferring resident to hemodialysis unit for treatments, sending communication book to dialysis and reviewing book upon return, and monitoring her dialysis access site every shift and as needed.

2a. The physician's order summary from 3/1/20 through 5/7/20 revealed no physician's orders for Resident #22 to have dialysis treatment or for staff to monitor her dialysis access site.

A phone interview was conducted on 5/8/20 at 9:24 AM with former UM #1. She stated that it was the facility's normal protocol to have physician's orders for dialysis treatment as well as physician's orders to monitor and assess the resident's access site at least once per shift.

A phone interview with the Director of Nursing (DON) was conducted on 5/8/20 at 11:26 AM. She stated that the facility's normal protocol was to have physician's orders for dialysis treatment that included the days the resident was to attend dialysis as well as orders for assessing the resident's access site. Resident #22's physician's order summary from 3/1/20 through 5/7/20 that included no physician's orders for dialysis treatment and no orders for assessing the resident's access site were reviewed with the DON. She was unable to explain why there were no physician's orders for dialysis treatment or

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assessing the access site.

On 5/8/20 physician's orders for Resident #22's dialysis treatment and assessing of her access site were entered into the electronic medical record and were signed by the Medical Director on 5/9/20.

A follow up interview was conducted with the DON by phone on 5/18/20 at 1:46 PM. She revealed that after her previous interview on 5/8/20 at 11:26 AM she realized there were no physician's orders for dialysis treatment or assessment of the access site for any of the current dialysis residents (Residents #22 and #40) at the facility. She stated she spoke with the Medical Director that afternoon and received physician ' s orders that were entered into the electronic record on 5/8/20 and signed by the Medical Director on 5/9/20 for Resident #22. The DON explained that the facility ' s corporate ownership changed in February 2020 and she believed that the dialysis orders were missed when the electronic medical records system was transferred to the current system.

During an interview with the Administrator on 5/21/20 at 11:20 AM she verified former UM #1's interview and the DON's interview that the facility's normal protocol was to have physician's orders for dialysis treatment that included the days the resident was to attend dialysis as well as orders for assessing the resident's access site. She explained that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working

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on correcting issues as they became aware of them.

A phone interview was conducted with the Medical Director on 5/13/20 at 12:58 PM. He stated that every facility he provided services for had different protocols related to physician's orders for dialysis treatment and assessing of the access sites. He reported that his normal procedure was to follow the facility's protocol.

2b. Resident #22 was discharged to the hospital on 3/29/20 and was readmitted to the facility on 4/4/20.

The dialysis communication documentation for Resident #22 from 4/4/20 through 5/7/20 revealed no evidence of routine communication with the dialysis center.

On 5/8/20 at 8:09 AM via electronic correspondence the Administrator indicated that the facility's protocol for routine communication with the dialysis center was maintained in a binder. She wrote that each dialysis resident had their own binder which was sent back and forth with the resident to the dialysis center on each visit.

A phone interview was conducted on 5/8/20 at 9:24 AM with former Unit Manager (UM) #1. She stated that the facility's normal protocol for routine communication with the dialysis center was for a binder to be sent back and forth with the resident to the dialysis center on each visit. She reported that each resident at the facility who was on dialysis had their own binder. She explained that each binder was kept at the nurse's station. She

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F 698	Continued From page 48 further explained that this binder contained communication forms that were completed by a facility nurse prior to the resident leaving for dialysis, a portion was completed by the dialysis center staff post-dialysis treatment, and then the final portion was completed by the facility nurse upon return to the facility. Former UM #1 reported that the form contained pertinent information such as an assessment of the resident's access site, the resident's weight, and vital signs. A phone interview with the Director of Nursing (DON) was conducted on 5/8/20 at 11:26 AM. She verified the Administrator and former UM #1's reports that the facility's normal protocol for routine communication with the dialysis center was for a binder to be sent back and forth with the resident to the dialysis center on each visit. She revealed that on 5/7/20 when evidence of routine communication with the dialysis center was requested for review she realized there were no communication forms for Resident #22 since her readmission on 4/4/20. She further revealed that staff had not been sending the communication binder with Resident #22 to the dialysis center from 4/4/20 through 5/7/20. The DON stated that there were multiple new staff at the facility as well as changes that occurred with the times Resident #22 attended dialysis. She explained that due to these changes, different staff were preparing Resident #22 for dialysis transport and they were not familiar with the facility's protocol to complete the communication form prior to dialysis, send the binder with the resident for the dialysis staff to complete post dialysis, and then to review the information from the dialysis center and complete the remainder of the form when the resident returned from dialysis.	F 698		

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During an interview with the Administrator on 5/21/20 at 11:20 AM she stated that she expected all staff to follow the facility's protocol for ongoing routine communication with the dialysis center. She reiterated the DON's report that the facility had multiple new staff at the facility and they had not been educated on the facility's protocol for maintaining routine communication with the dialysis center. The Administrator added that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them.

3. Resident #40 was admitted to the facility on 12/19/18 with diagnoses that included End Stage Renal Disease (ESRD) and dialysis dependence.

The quarterly Minimum Data Set (MDS) assessment dated 2/18/20 indicated Resident #40's cognition was intact, and he was on dialysis.

Resident #40's active care plan included the focus area of the risk for complications related to hemodialysis 3 days per week. The interventions included, in part, monitor vital signs pre and post dialysis treatment and monitor access site.

3a. The physician's order summary from 3/1/20 through 5/7/20 revealed no physician's orders for

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F 698	Continued From page 50 Resident #40 to have dialysis treatment or for staff to monitor his dialysis access site. A phone interview was conducted on 5/8/20 at 9:24 AM with former Unit Manager (UM) #1. She stated that it was the facility's normal protocol to have physician's orders for dialysis treatment as well as physician's orders to monitor and assess the resident's access site at least once per shift. A phone interview with the Director of Nursing (DON) was conducted on 5/8/20 at 11:26 AM. She stated that the facility's normal protocol was to have physician's orders for dialysis treatment that included the days the resident was to attend dialysis as well as orders for assessing the resident's access site. On 5/8/20 physician's orders for Resident #40's dialysis treatment and assessing of his access site were entered into the electronic medical record and were signed by the Medical Director on 5/9/20. A follow up interview was conducted with the DON by phone on 5/18/20 at 1:46 PM. She revealed that after her previous interview on 5/8/20 at 11:26 AM related to the facility ' s normal protocol for physician's orders for dialysis residents she realized there were no physician sorders for dialysis treatment or assessment of the access site for any of the current dialysis residents (Residents #40 and #22) at the facility. She stated she spoke with the Medical Director that afternoon and received physician's orders that were entered into the electronic record on 5/8/20 and signed by the Medical Director on 5/9/20 for Resident #40. The DON explained that the facility's corporate ownership changed in	F 698		

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February 2020 and she believed that the dialysis orders were missed when the electronic medical records system was transferred to the current system.

During an interview with the Administrator on 5/21/20 at 11:20 AM she verified former UM #1's interview and the DON's interview that the facility's normal protocol was to have physician's orders for dialysis treatment that included the days the resident was to attend dialysis as well as orders for assessing the resident's access site. She explained that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them.

A phone interview was conducted with the Medical Director on 5/13/20 at 12:58 PM. He stated that every facility he provided services for had different protocols related to physician's orders for dialysis treatment and assessing of the access sites. He reported that his normal procedure was to follow the facility's protocol.

3b. The dialysis communication documentation for Resident #40 from 4/1/20 through 5/7/20 revealed the last communication form completed by facility staff was dated 4/10/20. Communication forms dated 5/1/20 and 5/4/20 were completed by the dialysis center's staff, but not completed by the facility's staff.

On 5/8/20 at 8:09 AM via electronic correspondence the Administrator indicated that

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the facility's protocol for routine communication with the dialysis center was maintained in a binder. She wrote that each dialysis resident had their own binder which was sent back and forth with the resident to the dialysis center on each visit.

A phone interview was conducted on 5/8/20 at 9:24 AM with former Unit Manager (UM) #1. She stated that the facility's normal protocol for routine communication with the dialysis center was for a binder to be sent back and forth with the resident to the dialysis center on each visit. She reported that each resident at the facility who was on dialysis had their own binder. She explained that each binder was kept at the nurse's station. She further explained that this binder contained communication forms that were completed by a facility nurse prior to the resident leaving for dialysis, a portion was completed by the dialysis center staff post-dialysis treatment, and then the final portion was completed by the facility nurse upon return to the facility. Former UM #1 reported that the form contained pertinent information such as an assessment of the resident's access site, the resident's weight, and vital signs.

A phone interview with the Director of Nursing (DON) was conducted on 5/8/20 at 11:26 AM. She verified the Administrator and former UM #1 ' s reports that the facility's normal protocol for routine communication with the dialysis center was for a binder to be sent back and forth with the resident to the dialysis center on each visit. She revealed that on 5/7/20 when evidence of routine communication with the dialysis center was requested for review she realized there were no completed communication forms for Resident

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#40 from 4/11/20 through present. The DON stated that there were multiple new staff at the facility as well as changes that occurred with the times Resident #40 attended dialysis. She explained that due to these changes, different staff were preparing Resident #40 for dialysis transport and they were not familiar with the facility's protocol to complete the communication form prior to dialysis, send the binder with the resident for the dialysis staff to complete post dialysis, and then to review the information from the dialysis center and complete the remainder of the form when the resident returned from dialysis.

During an interview with the Administrator on 5/21/20 at 11:20 AM she stated that she expected all staff to follow the facility's protocol for ongoing routine communication with the dialysis center. She reiterated the DON's report that the facility had multiple new staff at the facility and they had not been educated on the facility's protocol for maintaining routine communication with the dialysis center. The Administrator added that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them.

4. Resident #25 was admitted to the facility on 3/29/20 with diagnoses that included End Stage Renal Disease (ESRD) and dialysis dependence.

The admission Minimum Data Set (MDS) assessment dated 4/3/20 indicated Resident #25's cognition was intact, and he was on dialysis.

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Resident #25's care plan included the focus area of the risk for complications related to hemodialysis initiated on 4/8/20. The interventions included, in part, encourage resident to go to scheduled dialysis appointments on Monday, Wednesdays, and Fridays, check and change dressing daily at access site and document, and monitor vital signs as indicated.

Resident #25 expired at the facility on 4/12/20.

4a. The physician's order summary from 3/29/20 through 4/12/20 revealed no physician's orders for Resident #25 to have dialysis treatment or for staff to monitor his dialysis access site.

A phone interview was conducted on 5/8/20 at 9:24 AM with former Unit Manager (UM) #1. She stated that it was the facility's normal protocol to have physician's orders for dialysis treatment as well as physician's orders to monitor and assess the resident's access site at least once per shift.

A phone interview with the Director of Nursing (DON) was conducted on 5/8/20 at 11:26 AM. She stated that the facility's normal protocol was to have physician's orders for dialysis treatment that included the days the resident was to attend dialysis as well as orders for assessing the resident's access site.

A follow up interview was conducted with the DON by phone on 5/18/20 at 1:46 PM. She revealed that after her previous interview on 5/8/20 at 11:26 AM related to the facility's normal protocol for physician's orders for dialysis

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residents she realized there had been no physician's orders for dialysis treatment or assessment of the access site for Resident #25 during his stay at the facility (3/29/20 through 4/12/20) or for any of the current dialysis residents at the facility. She stated she spoke with the Medical Director that afternoon and received physician's orders for the current dialysis residents (Residents #22 and #40) that were entered into the electronic record on 5/8/20 and signed by the Medical Director on 5/9/20 for Resident #25. The DON explained that the facility's corporate ownership changed in February 2020 and she believed that the dialysis orders were missed when the electronic medical records system was transferred to the current system.

During an interview with the Administrator on 5/21/20 at 11:20 AM she verified former UM #1's interview and the DON's interview that the facility's normal protocol was to have physician's orders for dialysis treatment that included the days the resident was to attend dialysis as well as orders for assessing the resident's access site. She explained that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them.

A phone interview was conducted with the Medical Director on 5/13/20 at 12:58 PM. He stated that every facility he provided services for had different protocols related to physician's orders for dialysis treatment and assessing of the

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access sites. He reported that his normal procedure was to follow the 's protocol.

4b. The dialysis communication documentation for Resident #25 from 3/29/20 through 4/12/20 revealed 1 communication form dated 4/1/20 for Resident #25.

Documentation from the dialysis center indicated Resident #25 attended dialysis on 3/30/20, 4/1/20, 4/3/20, 4/6/20, 4/8/20, and 4/10/20.

On 5/8/20 at 8:09 AM via electronic correspondence the Administrator indicated that the facility's protocol for routine communication with the dialysis center was maintained in a binder. She wrote that each dialysis resident had their own binder which was sent back and forth with the resident to the dialysis center on each visit.

A phone interview was conducted on 5/8/20 at 9:24 AM with former Unit Manager (UM) #1. She stated that the facility's normal protocol for routine communication with the dialysis center was for a binder to be sent back and forth with the resident to the dialysis center on each visit. She reported that each resident at the facility who was on dialysis had their own binder. She explained that each binder was kept at the nurse's station. She further explained that this binder contained communication forms that were completed by a facility nurse prior to the resident leaving for dialysis, a portion was completed by the dialysis center staff post-dialysis treatment, and then the final portion was completed by the facility nurse upon return to the facility. Former UM #1 reported that the form contained pertinent

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information such as an assessment of the resident's access site, the resident's weight, and vital signs.

A phone interview with the Director of Nursing (DON) was conducted on 5/8/20 at 11:26 AM. She verified the Administrator and former UM #1's reports that the facility ' s normal protocol for routine communication with the dialysis center was for a binder to be sent back and forth with the resident to the dialysis center on each visit. She revealed that on 5/7/20 when evidence of routine communication with the dialysis center was requested for review she realized there was only one communication form completed for Resident #25 during his stay at the facility (3/29/20 through 4/12/20). The DON stated that there were multiple new staff at the facility and they were not familiar with the facility ' s protocol to complete the communication form prior to dialysis, send the binder with the resident for the dialysis staff to complete post dialysis, and then to review the information from the dialysis center and complete the remainder of the form when the resident returned from dialysis.

During an interview with the Administrator on 5/21/20 at 11:20 AM she stated that she expected all staff to follow the facility's protocol for ongoing routine communication with the dialysis center. She reiterated the DON ' s report that the facility had multiple new staff at the facility and they had not been educated on the facility's protocol for maintaining routine communication with the dialysis center. The Administrator added that the facility's corporate ownership changed in February 2020, she began working at the facility in mid-February 2020, and there was also a change in the DON during this time. She

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F 698	Continued From page 58 reported that with the numerous changes she and the current DON were working on correcting issues as they became aware of them.	F 698		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		6/10/20

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F 880	Continued From page 59 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility ' s "COVID-19 Policy/Plan for Facilities", and interviews with resident, family, staff, Medical Director, and Nurse Practitioner, the facility failed to update, have and to follow current Infection Control guidance provided by the CDC (Centers	F 880	Past noncompliance: no plan of correction required.	

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for Disease Control and Prevention) and CMS (Centers for Medicare and Medicaid Services) by failing to have new admissions and readmissions separated from current residents for 12 of 12 residents (Residents #2, #11, #19, #22, #25, #27, #32, #33, #34, #35, #36, and #39) who were admitted and/or readmitted to the facility from 3/11/20 through 4/4/20. In addition, the facility also failed to fully implement CDC and CMS guidance for the use of facemasks for staff and residents until 5 days after the guidance was released (4/2/20). This system failure occurred during the COVID-19 pandemic and had a high likelihood of affecting all residents by placing them at an increased risk of developing and transmitting COVID-19. The facility ' s first COVID-19 positive resident was identified on 4/7/20 (Resident #19). On 4/10/20 mass COVID-19 testing of facility residents was completed which showed a total of 100 out of 124 residents were COVID-19 positive. As of 5/13/20 a total of 105 residents had tested positive for COVID 19.

The findings included:

CMS (Centers for Medicare and Medicaid Services) guidance from "QSO-20-14-NH" dated 3/9/20, in accordance with CDC (Centers for Disease Control and Prevention) guidance, indicated the following:

"Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can

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serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room)."

1. The following facility corporate policy titled, "COVID-19 Policy/Plan for Facilities" dated 3/11/20, indicated the following information related to new admissions:
"Each facility will attempt to locate new admissions to a common part of the facility for a waiting period of 5 days prior to being placed in a room within the general resident community."

This 3/11/20 facility corporate policy did not incorporate the CDC and CMS guidance (effective 3/9/20) of placing residents who entered the facility in quarantine for 14 days.

A review of the admissions/readmissions list from 3/11/20 through 3/18/20 revealed 3 residents (Residents #27, #32, and #33) were admitted and/or readmitted to the facility on general population halls that were not designated for quarantine purposes.

1a. Resident #27 was admitted to the facility from the hospital on 3/11/20. Her admission diagnoses included Atrial Fibrillation, Cerebral Vascular Accident and Multiple Myeloma (cancer formed in the white blood cells and accumulates in bone marrow) in remission. Review of Resident #27 ' s electronic medical record indicated she was admitted to a semi-private room with a roommate (Resident #37) within the general population on 300 hall indicating that Resident #27 was not quarantined.

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Review of a nursing note dated 3/14/20 at 7:10 PM read Resident #27 complained about wanting to move into another room. The note read her requested would be communicated to management. Review of Resident #27 ' s electronic medical record indicated she was moved from the 300 hall to the 200 hall into another semi-private room with a roommate (Resident #22) on 3/16/20. The 200 hall was a general population hall indicating that Resident #27 was not quarantined.

Resident #27 ' s admission Minimum Data Set (MDS) dated 3/18/20 indicated her cognition was intact.

Review of a nursing note dated 3/18/20 at 2:46 PM read Resident #27 was encouraged to wear a mask when she was out of her room since she was susceptible to infection.

Resident #27 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #27 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included placing Resident #27 in a private room with a dedicated bathroom as available or cohort with other residents in separate wing/hall who were confirmed COVID-19 positive.

Resident #27 was swabbed for COVID-19 on 4/10/20 and with positive results received on 4/13/20.

In a telephone interview on 5/12/20 at 10:26 AM, former UM #1 confirmed Resident #27 was admitted on 3/11/20 into room within the general population with a roommate (Resident #37). On 3/16/20 Resident #27 moved into a different

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semi-private room with a new roommate (Resident #22) on a general population hall.

In a telephone interview on 5/12/20 at 1:38 PM, Nursing Assistant (NA) #3 stated she had not recalled Resident #27 being on any form of quarantine after admission (3/11/20) and she had not worn anything but gloves when caring for Resident #27 while working with her on the 300 and 200 hall during the 14-day timeframe after her admission.

In a telephone interview on 5/12/20 at 2:16 PM, Occupational Therapy (OT) stated that she had no recollection of Resident #27 being quarantined on admission but rather she was admitted into a semi-private room with a roommate within the general population of the facility on 3/11/20. She stated it was her understanding that the Administrator and DON made decisions regarding placement of new admissions and readmissions.

In a video phone call with Resident #27 on 5/12/20 at 3:32 PM, she stated that she was not on any type of quarantine during the 14-day timeframe after her admission (3/11/20).

In a telephone interview on 5/12/20 at 3:50 PM, Resident #27 ' s emergency contact stated she was under the impression that Resident #27 was going to be placed in a private room on admission for a quarantine purposes, but that had not occurred.

During a phone interview with the Medical Director on 5/13/20 at 12:58 PM he reported that his expectation was for Resident #27 to have been placed on a 14-day quarantine on

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admission to facility (3/11/20) in accordance with CDC and CMS guidelines.

1b. Resident #32 was originally admitted to the facility on 11/18/19. His diagnoses included diabetes, atrial fibrillation, and cellulitis (a spreading bacterial infection underneath the skin surface). Review of Resident #32 ' s electronic medical record indicated he was hospitalized from 3/3/2020 through 3/12/2020. The resident ' s record also specified he was readmitted to the facility to his private room on the 300 hall in the general population indicating Resident #32 was not quarantined. Resident #32 expired in the facility on 3/15/20.

A Significant Change in Status Minimum Data Set (MDS) assessment, dated 2/17/20, indicated Resident #32 was cognitively intact and required total assistance with mobility and transfers. He had 2 venous/arterial ulcers as well as surgical wounds and received intravenous antibiotics.

A phone interview was conducted with Nurse #5 on 5/12/2020 at 5:10pm, who recalled Resident #32 was readmitted to the same private room on the 300 hall in the general population. She could not recall any special precautions taken by the staff when providing his care.

On 5/13/2020 a phone interview occurred with Nurse Aide (NA) #1 at 9:35am. She was familiar with Resident #32 and stated when he was readmitted from the hospital (3/12/20), he returned to the same private room, within the general population of the facility. NA #1 could not recall any special precautions taken when rendering personal care. She added he was

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bedbound on readmission from the hospital.

A phone interview was held with NA #2 on 5/13/2020 at 9:42am, who was familiar with Resident #32. She confirmed he was readmitted from the hospital on 3/12/20 to the same private room within the general population of the facility and was bedbound. NA #2 added that no special precautions were taken when providing his care.

1c. Resident #33 was admitted to the facility on 3/18/20 with diagnoses that included Cerebral Vascular Accident (CVA) with left sided hemiplegia/paresis. The admission list for March 2020 indicated Resident #33 was admitted (3/18/20) from the hospital. Review of Resident #33 ' s electronic medical record indicated he was admitted to a private room within the general population on the 500 hall indicating that he was not quarantined.

The admission Minimum Data Set (MDS) assessment dated 3/25/20 indicated Resident #33 ' s cognition was intact, and he was independent with Activities of Daily Living (ADLs).

Resident #33 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #33 ' s care and symptoms be managed per CDC guidelines and facility protocol. Interventions included initiating droplet and contact precautions and to restrict resident to his room to the extent possible.

Record review indicated Resident #33 had a planned discharge to the community on 4/10/20.

A phone interview was conducted with Nurse #7

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on 5/12/20 at 3:40 PM. She stated that she was familiar with Resident #33 and recalled that he was admitted (3/18/20) to a private room within the general population of the facility. She indicated that Resident #33 was not quarantined on admission. She reported that Resident #33 left his room for rehabilitation via a self-propelled wheelchair. Nurse #7 was unable to explain why Resident #33 was not quarantined for 14 days after his admission (3/18/20).

A review of the facility ' s census for 3/11/20 through 3/18/20 revealed the 100-hall had a total of 26 beds (12 double occupancy rooms and 2 single occupancy rooms) and all beds were open and available during this timeframe.

Record review revealed the first COVID-19 positive facility resident was identified on 4/7/20 (Resident #19). On 4/10/20 mass COVID-19 testing of facility residents was completed with results returning on 4/13/20 and 4/14/20. A facility listing of residents with COVID-19 test results as of 4/15/20 included a total of 124 residents. This list revealed 100 of 124 residents were COVID-19 positive.

During an interview with the Administrator on 4/25/20 at 1:35 PM she stated that the 100-hall was a closed hall prior to the pandemic and that the facility ' s plan was to utilize this hall for quarantine purposes related to COVID-19.

A phone interview was conducted on 5/6/20 at 3:21 PM with the Administrator. She was asked to confirm the facility ' s corporate policy for COVID-19 related to new

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admissions/readmissions. She stated that from 3/11/20 to 3/18/20 the facility ' s corporate policy was for new admissions to be placed in a section of the facility that was separate from the general population for a waiting period of 5 days prior to being placed in a room within the general population. She stated that during this 5-day timeframe, these residents were to be placed in a private room with a private bathroom and quarantined to their room. The Administrator indicated that the purpose of this 5-day quarantine and separation from the general population within the facility was to protect current residents from new admissions as these residents were coming in from environments that increased their possibility of being exposed to the virus (COVID-19). When asked if this facility policy applied to readmissions she stated that readmissions were to be placed on the 100-hall if they were symptomatic for COVID-19. She was unable to explain why the facility ' s corporate policy had not applied to readmissions as these residents were also coming from environments that increased their possibility of being exposed to the virus (COVID-19). The Administrator was also unable to explain why the 3/11/20 facility corporate policy was for a 5-day quarantine rather than a 14-day quarantine as indicated in the CDC and CMS guidance dated 03/09/20. She was additionally unable to explain why the 100-hall, which was empty, was not utilized for quarantine placement of new admissions and/or readmissions in order to separate these residents from the general population of the facility.

On 5/11/20 at 3:57 PM via electronic correspondence the Administrator indicated that the former DON and the former Unit Managers (UMs) were responsible for room placement

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decisions for admissions/readmissions in March 2020.
Phone interviews were attempted with the former Director of Nursing (DON) on 5/6/20 at 5:07 PM and 5/11/20 at 3:27 PM. She was unable to be reached.

A phone interview was conducted with former UM #2 (primarily assigned to the 500 and 600 halls) on 5/11/20 at 4:30 PM. She stated that she made recommendations to the former DON and Administrator for room placement of new admissions/readmissions in March 2020 through the beginning of April 2020, but the management had not heeded her clinical recommendations. She stated that she believed new admissions/readmissions should have been quarantined to a private room away from the general population. UM #2 explained that these new admissions/readmissions were at high risk for coming into contact with the virus (COVID-19) while at the hospital and/or in the community.

A phone interview was conducted with former UM #1 (primarily assigned to the 100, 200, and 300 halls) on 5/12/20 at 10:26 AM. She stated that room placement decisions throughout the COVID-19 pandemic were made by management and she had not agreed with their decisions. She explained that she believed new admissions and/or readmissions should have been placed in quarantine as they were at high risk for coming into contact with the virus (COVID-19) while at the hospital and/or in the community.

A phone interview was conducted with the Infection Control Preventionist/Staff Development Coordinator (ICP/SDC) on 5/13/20 at 12:10 PM. She stated that in March 2020 the facility was not

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F 880	Continued From page 69 quarantining any new admissions and/or readmissions related to COVID-19. She reported that she had no input in room placement decisions. She stated that the former DON, Medical Director, and Administrator were making room placement decisions. The ICP/SDC revealed that throughout March 2020 the facility was not following the guidance from the CDC and/or CMS. A phone interview was conducted with the Medical Director on 5/13/20 at 12:58 PM. He stated that he was not involved in any decision-making regarding room placement of new admissions and/or readmissions during the COVID-19 pandemic. He reported the facility had their own COVID-19 corporate plan that they were following. The Medical Director indicated his expectation was for the facility to follow CDC and CMS guidance regarding placement of new admissions and readmissions. On 5/13/20 the following information was provided and received via electronic correspondence with the Administrator: - At 2:20 PM the Administrator was asked if she was aware the facility was not following CDC and CMS guidance that was effective on 3/9/20 which indicated that if possible, the facility was to dedicate a unit/wing exclusively for any residents coming or returning from the hospital where they were to remain for 14 days with no symptoms prior to being integrated into the general population. - At 3:27 PM the Administrator responded, "I do believe that was a recommendation and not a requirement on 3/9". She revealed that she was not aware the facility was not in compliance with guidance from the CDC and CMS.	F 880		

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On 5/14/20 at 10:48 AM via electronic correspondence the Administrator revealed that as of 5/13/20 a total of 105 facility residents had tested positive for COVID-19 out of a census high of 127.

In a follow up interview on 5/21/20 at 11:20 AM, the Administrator confirmed that from 3/11/20 through 3/18/20 the facility ' s corporate policy for COVID-19 related to admissions and readmissions was not in accordance with the CDC and CMS guidelines. She additionally confirmed that the CDC and CMS guidelines for admissions/readmissions were not followed from 3/11/20 through 3/18/20. The Administrator indicated that new admissions/readmissions should have been placed in a designated section of the facility and quarantined for 14 days. She confirmed the 100-hall was open and available as a quarantine section of the facility from 3/11/20 through 3/18/20.

2. The facility corporate policy titled, "COVID-19 Policy/Plan for Facilities" was revised on 3/18/20. The section of the policy related to new admissions that stated, "Each facility will attempt to locate new admissions to a common part of the facility for a waiting period of 5 days prior to being placed in a room within the general resident community" was struck through indicating that it was no longer part of the facility corporate policy. There was no mention in this revised policy (dated 3/18/20) of the separation of new admissions/readmissions from the general population for quarantine purposes. This revised facility corporate policy included the addition of the following related to new admissions:

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"The Infection Preventionist and/or the Director of Nursing will assist in placing the newly admitted resident in a location within the facility that considers the reasons for admission, any associated risks for infection and the protection of the new resident as well as other residents and staff."

This 3/18/20 facility corporate policy did not incorporate the CDC and CMS guidance (effective 3/9/20) of placing residents who entered the facility in quarantine for 14 days.

The facility corporate policy titled, "COVID-19 Policy/Plan for Facilities" was revised again on 3/28/20 with the addition of the following related to referrals for admissions:

"As of 3/28, the facility is not admitting residents with known positive tests or who have been tested by the hospital until they are symptom free and have a negative test. This includes residents who are sent to the emergency room due to symptoms of COVID 19 such as fever, new onset shortness of breath. Staff is encouraged to complete a careful assessment to rule out other causes of symptoms and to prevent any unnecessary emergency visits or hospital stays. While we are focused on not contributing to overwhelming the hospitals, we are also committed to keeping the facilities free of infection."

This 3/28/20 facility corporate policy continued to not incorporate the CDC and CMS guidance (effective 3/9/20) of placing residents who entered the facility in quarantine for 14 days.

CMS guidance, dated 4/2/20, titled "COVID-19

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Long-Term Care Facility Guidance" indicated CMS and CDC recommended immediate actions to keep patients and residents safe. These actions included, in part, the following:

"Long-term care facilities should ensure all staff are using appropriate [Personal Protective Equipment (PPE)] when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE.

For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility.

Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE.

If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 diagnosis or symptoms.

Patients and residents who must regularly leave the facility for care (e.g., hemodialysis patients) should wear facemasks when outside of their rooms."

The facility corporate policy for COVID-19 regarding PPE use that was in place at the time of the above 4/2/20 CMS guidance indicated:

"The [Infection Preventionist] will assist in determining the correct use of PPE by staff, determine the need for and the type of isolation

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required and assure staff has received appropriate training and guidance in caring for any resident who has the potential to infect others. The [Infection Preventionist] will establish and monitor any isolation required including proper PPE and required posting of the type of isolation to serve as notice to others."

A review of the admissions/readmissions list from 3/19/20 through 4/3/20 revealed 8 of 8 residents (Residents #2, #11, #19, #25, #34, #35, #36, and #39) who were admitted and/or readmitted to the facility were placed on general population halls that were not designated for quarantine purposes.

2a. Resident #35 was admitted to the facility on 3/19/20 with diagnoses that included Alzheimer ' s disease, hypertension (HTN), and chronic kidney disease stage 3. The admission list for March 2020 indicated Resident #35 was admitted (3/19/20) from home. Review of Resident #35 ' s electronic medical record indicated she was admitted to a private room within the general population on the 600 hall indicating that he was not quarantined.

Nursing notes dated 3/20/20, 3/21/20 and 3/22/20 indicated Resident #35 wandered in the common area of the 600 hall.

The admission Minimum Data Set (MDS) assessment dated 3/26/20 indicated her cognition was moderately impaired and she was independent with Activities of Daily Living (ADLs). She was receiving Speech Therapy (ST), Physical Therapy (PT), and Occupational Therapy (OT).

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A nursing note dated 3/26/20 completed by MDS Nurse #2 indicated Resident #35 was ambulatory with rolling walker and was out of her room daily.

Resident #35 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #35 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included initiating droplet and contact precautions, supply resident with face mask and encourage resident to wear if she must leave the room, and to restrict resident to her room to the extent possible. These interventions were initiated on 4/8/20.

A phone interview with MDS Nurse #2 was conducted on 5/13/20 at 12:10 PM. She stated she was familiar with Resident #35 and stated that she was admitted to a private room on a general population hall (600 hall) for rehabilitation. She stated there was no quarantine in place for the resident at the time of admission (3/19/20).

A phone interview was conducted with OT on 5/13/20 at 12:20 PM. She recalled working with Resident #35 and stated that she was not quarantined on admission (3/19/20).

2b. Resident #19 was admitted from the hospital on 3/23/20. Review of the electronic medical record indicated he was admitted onto the 300 hall into a semi-private room with no roommate but within the general population. Her admission diagnoses included Congestive Heart Failure, Diabetes and a history of a pulmonary embolism.

Resident #19 ' s admission Minimum Data Set

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(MDS) dated 3/30/20 indicated she was cognitively intact. She required limited assistance with transfer, ambulation and locomotion on and off the unit.

Review of a nursing note dated 4/6/20 at 10:12 AM read, Resident #19 complained of shortness of breath, a dry cough and generalized weakness. The Physician was notified, and she was sent to the hospital for an evaluation.

Review of a nursing note dated 4/6/20 at 11:30 PM read Resident #19 returned from the emergency room on 4/6/20 at 6:15 PM.
Review of the emergency room discharge note dated 4/6/20 indicated Resident #19 was seen for shortness of breath, cough and minimal yellow sputum. She was negative for a fever, chills of chest tightness. Resident #19 exhibited no evidence of respiratory distress, but she was tested for COVID-19. The note continued Resident #19 was living in a facility that could quarantine. There was no need for admission at this time.

Review of the electronic medical record revealed Resident #19 was readmitted from the emergency room on 4/6/20 into the same semi-private room without a roommate into the general population on 300 hall.

Review of a nursing note dated 4/7/20 at 9:19 PM read the hospital notified the facility that Resident #19 had tested positive for COVID-19 in the emergency room on 4/6/20. The Physician was notified and Resident #19 remained on droplet precautions. Resident #19 requested to go to the hospital at 8:45 PM. The Physician was notified of Resident #19 ' s request to go to the hospital and

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she was transported to the hospital at 9:00 PM.

In a telephone interview on 5/11/2020 at 4:30 PM, the former Unit Manager (UM) #2 stated Resident #19 tested positive for COVID-19 at the emergency room on 4/6/20 and returned to the facility the same day back into the same room.

An interview occurred with the Administrator on 5/21/2020 at 11:15 AM regarding Resident #19 ' s emergency room visit on 4/6/2020 where she was tested for COVID-19 and returned to the facility with symptoms present. The Administrator was unable to explain why the 3/28/2020 facility corporate policy related to COVID-19 that indicated residents tested in the emergency room due to symptoms of COVID-19 would not be readmitted until they are symptom free and have a negative test result.

2c. Resident #34 was admitted from the hospital on 3/25/20. Review of the electronic medical record indicated he was admitted into a semi-private room with Resident #16 on the 300 hall in the general population. Resident #34 ' s diagnoses included Dementia, Depression and a history of a pulmonary embolism.

Resident #34 ' s admission Minimum Data Set dated 4/1/20 indicated he was cognitively intact. He was coded as requiring extensive staff assistance with his activities of daily living and non-ambulatory.

Resident #34 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #34 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions

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included placing Resident #34 in a private room with a dedicated bathroom as available or cohort with other residents in separate wing/hall who were confirmed COVID-19 positive.

In a telephone interview on 5/12/20 at 10:26 AM, former Unit Manager (UM) #1 confirmed Resident #34 was admitted on 3/25/20 into room within the general population with a roommate (Resident #16).

In a telephone interview on 5/13/20 at 11:29 AM, Social Worker (SW) #1 stated Resident #34 was admitted from the hospital on 3/25/20 into a semi-private room with Resident #16. SW #1 stated at one point, the facility was placing new admissions into private rooms for 3 days then moving them into semi-private rooms. She stated this practice stopped and she was unable to recall why or exactly when it stopped. SW #1 stated she thought at the time of Resident #34 ' s admission, she was waiting on a private room to open up but the other resident did not end up going home.

In another telephone interview on 5/13/20 at 1:56 PM. SW #1 indicated when Resident #34 was admitted, there were no open private rooms or semi-private rooms other than the rooms on the 100-hall. She stated 100 hall was designated for quarantine purposes, so he was placed in the room with a roommate (Resident #16). She was unable to explain why Resident #34 was placed in a room within the general population rather than on the designated quarantine hall.

In a telephone interview on 5/13/20 at 12:58 PM with the Medical Director he reported that his expectation was for Resident #34 to have been

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placed on a 14-day quarantine on admission to facility (3/25/20) in accordance with CDC and CMS guidelines.

2d. Resident #25 was admitted to the facility on 3/29/20 with diagnoses that included end stage renal disease and dependence on renal dialysis. The admission list for March 2020 indicated Resident #25 was admitted (3/29/20) from the hospital. Review of Resident #25 ' s electronic medical record indicated he was admitted to a semi-private room with a roommate (Resident #38) within the general population on the 500 hall indicating that Resident #25 was not quarantined.

Review of the electronic record indicated that on the same the day as Resident #25 ' s admission (3/29/20), he moved to a different semi-private room on the 500 hall with a new roommate (Resident #21).

A nursing note dated 3/31/20 indicated Resident #25 attended dialysis on Monday, Wednesdays, and Fridays.

On 4/1/20 Resident #25 was moved from the 500 hall to the 600 hall in a private room. The 600 hall was a general population hall and was not being utilized for quarantine purposes.

The admission Minimum Data Set (MDS) assessment dated 4/3/20 indicated Resident #25 ' s cognition was intact, and he was independent for Activities of Daily Living (ADLs).

Resident #25 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #25 ' s care and symptoms be managed per CDC

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she was able to state that it was sometime after 4/4/20 when staff began wearing masks.

A phone interview with Social Worker (SW) #1 was conducted on 5/13/20 at 2:00 PM. She was asked to explain Resident #25 ' s room assignments. She stated that there were roommate differences with his first placement on admission (3/29/20) so his room was moved to another semi-private room on the same hall (500 hall) on the same day as admission. She reported that on 4/1/20 she realized there was an open private room on the 600 hall so Resident #25 was moved to that room. SW #1 revealed that there were multiple open rooms on the 100-hall at the time of Resident #25 ' s admission. She was unable to explain why Resident #25 was placed in 3 different rooms (2 on the 500 hall and 1 on the 600 hall) within the general population rather than on the designated quarantine hall when he was admitted.

2e. Resident #11 was admitted to the facility on 3/31/20 with diagnoses that included Alzheimer ' s disease. The admission list for March 2020 indicated Resident #11 was admitted (3/31/20) from home. Review of Resident #11 ' s electronic medical record indicated he was admitted to a semi-private room with a roommate (Resident #26) within the general population on the 300 hall indicating that Resident #25 was not quarantined.

The admission Minimum Data Set (MDS) assessment dated 4/7/20 indicated Resident #11 had moderately impaired cognition and required supervision only for locomotion on the unit and was independent for locomotion off the unit. He utilized either a walker or wheelchair for

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locomotion.

Resident #11 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #11 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included initiating droplet and contact precautions, supply resident with face mask and encourage resident to wear if she must leave the room or be transported from the facility, and to restrict resident to his room to the extent possible. These interventions were initiated on 4/8/20.

Record review indicated Resident #11 expired at the facility on 4/21/20.

A phone interview was conducted with Resident #11 ' s Responsible Party (RP) on 5/6/20 at 8:15 AM. She reported that prior to his admission she was informed Resident #11 would be admitted to a private room and quarantined for 14 days prior to being integrated into the general population. The RP reported that on 4/4/20 she went to visit Resident #11 at the facility, but that due to visiting restrictions she had to visit him through the glass windows in the lobby area. She stated that Resident #11 was not wearing a mask during this visit on 4/4/20.

A phone interview was conducted with former Unit Manager (UM) #1 on 5/12/20 at 10:26 AM. She confirmed that Resident #11 was admitted to a semi-private room with a roommate. She stated that she thought this was an inappropriate placement for Resident #11 as he was coming from the community and should have been quarantined for a period 14 days. She indicated that upon admission, Resident #11 self-propelled

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his wheelchair throughout the facility and wore no mask. She was unable to recall the date that residents began wearing masks, but she was able to state that it was sometime after 4/4/20 when staff began wearing masks.

A phone interview was conducted with Nursing Assistant (NA) #11 on 5/12/20 at 10:47 AM. She stated that she was familiar with Resident #11 and that he was not quarantined on admission (3/31/20).

A phone interview was conducted with NA #12 on 5/12/20 at 11:15 AM. She stated that Resident #11 was not quarantined on admission. She additionally stated that at the time of admission (3/31/20) he was able to self-propel his wheelchair and did so without a mask in place throughout the common areas of the facility.

2f. Resident #2 was originally admitted to the facility on 1/2/19. Review of the electronic medical record indicated she was hospitalized and readmitted to the facility on 3/31/2020 with diagnoses that included dementia and gastrointestinal hemorrhage. Resident #2 ' s record also specified she was readmitted to her original semi-private room with a roommate (Resident #1) within the general population on the 600-hall, indicating Resident #2 was not quarantined.

The annual Minimum Data Set (MDS) assessment dated 1/6/2020 indicated Resident #2 had moderately impaired cognition and was dependent on staff for mobility and all personal care.

Resident #2 was care planned for suspected

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COVID-19 on 4/8/2020. The goal was for Resident #2 ' s care and symptoms to be managed per CDC guidelines and facility protocol. Interventions included initiating droplet and contact precautions.
The electronic medical records revealed Resident #2 expired at the facility on 4/14/2020.

Review of Resident #2 ' s death certificate dated 4/20/2020 indicated her immediate cause of death was dementia.

On 5/8/2020 at 3:38 PM, via electronic correspondence with the Administrator, she indicated Resident #2 was not quarantined when readmitted to the facility on 3/31/2020. The Administrator went on to explain Resident #2 returned with hospice care and due to her diagnoses of Alzheimer ' s Disease, anxiety and depression it was decided to place her where she was most comfortable, her same room with roommate. The Administrator added Resident #2 went to the hospital due to rectal bleed and did not have any respiratory symptoms.

A phone interview occurred with Nurse Aide (NA) #4, on 5/12/2020 at 12:47 PM. She was able to recall that Resident #2 was placed back in her original room with a roommate on readmission from the hospital. She added Resident #2 was not quarantined upon readmission to the facility and there were no special precautions in place when providing care to the resident.

On 5/12/2020 at 5:10 PM, a phone interview occurred with Nurse #5 who was familiar with Resident #2. She verified Resident #2 returned to her original room with a roommate upon readmission from the hospital and was not

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quarantined. Nurse #5 added there were no special precautions present when providing care to Resident #2.

2g. Resident #36 was admitted to the facility from the hospital on 4/1/2020 with diagnoses that included muscle weakness, dysphagia (difficulty swallowing) and lack of coordination. Review of the electronic medical record indicated she was admitted to a semi-private room with a roommate (Resident #37) within the general population on the 300 hall, indicating Resident #36 was not quarantined.

The admission Minimum Data Set (MDS) assessment dated 4/8/2020 revealed Resident #36 to be cognitively intact and received extensive to total assistance with mobility and all personal care.

Resident #36 was care planned for COVID-19 on 4/8/2020. The goal was for Resident #36 ' s care and symptoms to be managed per CDC guidelines and facility protocol. Interventions included initiating droplet and contact precautions.
A phone interview occurred with Nurse Aide #1 on 5/13/2020 at 9:35 AM. She was familiar with Resident #36 and recalled her being admitted to a semi-private room with a roommate within the general population. NA #1 could not recall any special precautions taken when rendering personal care.

2h. Resident #39 was admitted to the facility on 4/3/20 with diagnoses that included heart failure. The admission list for April 2020 indicated

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Resident #39 was admitted (4/3/20) from the hospital. Review of Resident #39 ' s electronic medical record indicated he was admitted to a private room within the general population on the 600 hall indicating that Resident #39 was not quarantined.

An admission note completed by Nurse #6 dated 4/3/20 indicated Resident #39 was admitted post hospitalization for flu and staff were utilizing masks as a precaution.

The 4/10/20 admission Minimum Data Set (MDS) assessment indicated Resident #39 ' s cognition was intact, and she was independent for locomotion on and off the unit.

Resident #39 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #39 ' s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included initiating droplet and contact precautions, supply resident with face mask and encourage resident to wear if she must leave the room or be transported from the facility, and to restrict resident to his room to the extent possible. These interventions were initiated on 4/8/20.
Record review indicated Resident #39 was discharged from the facility and admitted to the hospital on 4/19/20.

A phone interview was conducted on 5/13/20 at 10:59 AM with Nurse #6. Nurse #6 stated that she thought Resident #39 was admitted following hospitalization for the flu and that staff wore masks when providing care. She confirmed that when the resident was admitted, she was placed on the 600 hall within the general population of

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the facility. She additionally confirmed that this hall was not designated for quarantine purposes. Nurse #6 was unable to explain why Resident #39 was not admitted to the section of the facility designated for quarantine purposes.

Review of the facility ' s census for 3/19/20 through 3/28/20 indicated the 100-hall had a total of 26 beds (12 double occupancy rooms and 2 single occupancy rooms) and all beds were open and available during this timeframe. On 3/29/20 the first resident (Resident #31) was moved to the 100-hall due to respiratory symptoms. There continued to be open beds on the 100 hall from 3/29/20 through 4/3/20.

Record review revealed the first COVID-19 positive facility resident was identified on 4/7/20 (Resident #19). On 4/10/20 mass COVID-19 testing of facility residents was completed with results returning on 4/13/20 and 4/14/20. A facility listing of residents with COVID-19 test results as of 4/15/20 included a total of 124 residents. This list revealed 100 residents were COVID-19 positive.

During an interview with the Administrator on 4/25/20 at 1:35 PM she stated that the 100-hall was a closed hall prior to the pandemic and that the facility ' s plan was to utilize this hall for quarantine purposes related to COVID-19.

A phone interview was conducted on 5/6/20 at 3:21 PM with the Administrator. She was asked to confirm the facility ' s corporate policy for COVID-19 related to new admissions/readmissions. She stated that from 3/19/20 to 4/3/20 the
the facility ' s corporate policy was for the Director

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of Nursing (DON) to assist in placing newly admitted residents in a location within the facility that considered the reasons for admission, any associated risks for infection and the protection of the new resident as well as other residents and staff. The Administrator reported the former DON was responsible for these clinical decisions for room placement. She indicated that it was important to separate new admissions from the general population within the facility to protect current residents from new admissions as these residents were coming in from environments that increased their possibility of being exposed to the virus (COVID-19). The Administrator was unable to explain why the facility corporate policy made no mention of the separation of readmitted residents from the general population as these residents were also coming from environments that increased their possibility of being exposed to the virus (COVID-19). The Administrator was also unable to explain why the facility corporate policy, revised on 3/18/20 and 3/28/20, was not in accordance with 14-day quarantine included in the in the CDC and CMS guidance that was effective 3/9/20. She was additionally unable to explain why the 100-hall, which was empty from 3/19/20 through 3/28/20 and continued to have numerous open beds through 4/3/20, was not utilized for quarantine placement of new admissions and/or readmissions in order to separate these residents from the general population of the facility.

Per electronic correspondence with the Administrator on 5/11/20 at 12:56 PM she indicated that masks were required for all staff as of 4/4/20. She wrote that residents were asked to start wearing masks on 4/4/20, but that it was not a requirement at that time. She stated that prior

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to 4/4/20 staff were instructed that if they had a resident coughing they could ask the resident to wear a mask during care. She stated that on 4/7/20, the facility received notification of the first resident who tested positive for COVID-19 and that was when masks were provided to all residents and were required to be in place when the residents were out of their rooms.

Phone interviews were attempted with the former DON 5/6/20 at 5:07 PM and on 5/11/20 at 3:27 PM. She was unable to be reached.

On 5/11/20 at 3:57 PM via electronic correspondence the Administrator indicated that the former Unit Managers (UMs) assisted the former DON with room placement decisions for admissions/readmissions from March 2020 through 4/3/20.

A phone interview was conducted with former UM #2 (primarily assigned to the 500 and 600 halls) on 5/11/20 at 4:30 PM. She stated that she made recommendations to the former DON and Administrator for room placement of new admissions/readmissions in March 2020 through the beginning of April 2020, but the management had not heeded her clinical recommendations. She stated that she believed new admissions/readmissions should have been quarantined to a private room away from the general population. UM #2 explained that these new admissions/readmissions were at high risk for coming into contact with the virus (COVID-19) while at the hospital and/or in the community.

A phone interview was conducted with former UM #1 (primarily assigned to the 100, 200, and 300 halls) on 5/12/20 at 10:26 AM. She stated that

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room placement decisions throughout the COVID-19 pandemic were made by management and she had not agreed with their decisions. She explained that she believed new admissions and/or readmissions should have been placed in quarantine as they were at high risk for coming into contact with the virus (COVID-19) while at the hospital and/or in the community.

A phone interview was conducted with the Infection Control Preventionist/Staff Development Coordinator (ICP/SDC) on 5/13/20 at 12:10 PM. She stated that in March 2020 through the beginning of April 2020 the facility was not quarantining any new admissions and/or readmissions related to COVID-19. She reported that she had no input in room placement decisions. She stated that the former DON, Medical Director, and Administrator were making room placement decisions. The ICP/SDC revealed that throughout March 2020 and early April 2020 the facility was not following the guidance from the CDC and/or CMS related to placement of admissions/readmissions. She stated that she was unable to recall the exact date that PPE began to be worn by staff and/or residents related to COVID-19.

A phone interview was conducted with the Medical Director on 5/13/20 at 12:58 PM. He stated that he was not involved in any decision-making regarding room placement of new admissions and/or readmissions during the COVID-19 pandemic. He reported the facility had their own COVID-19 corporate plan that they were following. The Medical Director indicated his expectation was for the facility to follow CDC and CMS guidance regarding placement of new admissions and readmissions. He additionally

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indicated he expected the facility to follow CDC and CMS guidance related to the use of PPE.

On 5/13/20 the following information was provided and received via electronic correspondence with the Administrator:
- At 2:20 PM the Administrator was asked if she was aware the facility was not following CDC and CMS guidance that was effective on 3/9/20 which indicated that if possible, the facility was to dedicate a unit/wing exclusively for any residents coming or returning from the hospital where they were to remain for 14 days with no symptoms prior to being integrated into the general population.
- At 3:27 PM the Administrator responded, "I do believe that was a recommendation and not a requirement on 3/9". She revealed that she was not aware the facility was not in compliance with guidance from the CDC and CMS.

On 5/14/20 at 10:48 AM via electronic correspondence the Administrator revealed that 105 facility residents had tested positive for COVID-19 out of a census high of 127 as of 5/13/20.

In a follow up interview on 5/21/20 at 11:20 AM, the Administrator confirmed that from 3/19/20 through 4/3/20 the facility ' s corporate policy for COVID-19 related to admissions and readmissions was not in accordance with the CDC and CMS guidelines. She additionally confirmed that the CDC and CMS guidelines for admissions/readmissions were not followed from 3/19/20 through 4/3/20. The Administrator indicated that new admissions/readmissions should have been placed in a designated section

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of the facility and quarantined for 14 days. She confirmed the 100-hall had open beds and was available as a quarantine section of the facility from 3/19/20 through 4/3/20. The Administrator additionally confirmed that the facility was not following the CDC and CMS guidance, effective on 4/2/20, for staff to wear masks while in the facility and residents to wear masks when out of their rooms. She verified that staff were not required to wear masks until 4/4/20 and residents were not required to wear masks when out of their rooms until 4/7/20. She was unable to explain why this CDC and CMS guidance dated 4/2/20 related to PPE use was not fully implemented until 4/7/20.

3. CMS guidance, dated 4/2/20, titled "COVID-19 Long-Term Care Facility Guidance" indicated CMS and CDC recommended immediate actions to keep patients and residents safe. These actions included, in part, the following:

"Long-term care facilities should ensure all staff are using appropriate [Personal Protective Equipment (PPE)] when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE.

For the duration of the state of emergency in their State, all long-term care facility personnel should wear a facemask while they are in the facility.

Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE.

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If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 diagnosis or symptoms.

Patients and residents who must regularly leave the facility for care (e.g., hemodialysis patients) should wear facemasks when outside of their rooms."

The facility corporate policy titled, "COVID-19 Policy/Plan for Facilities", that was in place at the time of the above 4/2/20 CMS guidance related to PPE use indicated:

"The [Infection Preventionist] will assist in determining the correct use of PPE by staff, determine the need for and the type of isolation required and assure staff has received appropriate training and guidance in caring for any resident who has the potential to infect others. The [Infection Preventionist] will establish and monitor any isolation required including proper PPE and required posting of the type of isolation to serve as notice to others."

This above facility corporate policy for COVID-19 was revised on 4/4/20 with the addition of the following information related to new admissions and readmissions:

"All residents will be isolated for a minimum of 14 days following admission or readmission in an area of the building designated for residents at high risk."

This 4/4/20 revised facility corporate policy for COVID-19 also included the addition of the following information under the heading, "Use of

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Personal Protective Equipment and Isolation Strategies":

"All Staff will be required to wear a surgical/isolation mask at all times while in the facility ...Any resident placed in isolation for COVID 19 for a positive COVID result or as a Person Under Investigation will be kept in Enhanced Droplet Isolation (also referred to as Airborne Isolation without the use of AIIR) or Airborne precautions modified for available PPE until such time as the physician determines such isolation is no longer clinically appropriate ...This isolation utilizes private room or cohort with approved roommate situation with Surgical Mask or N95 if available, eye protection, gloves, gown at all times when in the presence of the resident."

This 4/4/20 facility corporate policy had not addressed the CDC and CMS guidance (effective 4/2/20) for all residents, regardless of COVID-19 diagnosis and/or symptoms, to wear masks when out of their rooms.

A review of the admissions/readmissions list for 4/4/20 indicated 1 resident, Resident #22, was readmitted to the facility and placed on general population hall that was not designated for quarantine purposes.

Resident #22 was most recently readmitted to the facility on 4/4/20 (originally admitted to the facility 10/18/18) with diagnoses that included end stage renal disease and dependence on renal dialysis. The admission list for April 2020 indicated Resident #22 was readmitted (4/4/20) from the hospital. Review of Resident #22 ' s electronic medical record indicated she was readmitted to a semi-private room (the same room she was in

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prior to hospitalization) with a roommate (Resident #27) within the general population on the 200 hall indicating that Resident #22 was not quarantined.

The most recent Minimum Data Set (MDS) assessment for Resident #22 was a quarterly dated 1/30/20. This MDS indicated her cognition was intact and she required supervision of 1 for assistance with locomotion on and off unit. She was on dialysis.

Dialysis documentation indicated Resident #22 attended her dialysis appointment on 4/6/20.

Record review revealed the first COVID-19 positive facility resident was identified on 4/7/20 (Resident #19). On 4/10/20 mass COVID-19 testing of facility residents was completed with results returning on 4/13/20 and 4/14/20. A facility listing of residents with COVID-19 test results as of 4/15/20 included a total of 124 residents. This list revealed 100 residents were COVID-19 positive.

A phone interview was conducted on 5/6/20 at 3:21 PM with the Administrator. She was asked to confirm the facility ' s corporate policy for COVID-19 related to new admissions/readmissions. She stated that on 4/4/20 the facility ' s corporate policy was for all admissions/readmissions to be placed in an area of the building that was designated for residents at risk. She stated that this designated area was the 100-hall. She explained that it was important to separate these new residents from the general population within the facility to protect current residents as the new residents were coming in from environments that increased their possibility

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of being exposed to the virus (COVID-19). The readmission of Resident #22 on 4/4/20 to a semi-private room with a roommate on a general population hall (200 hall) was reviewed with the Administrator. She revealed that there were available rooms on the 100-hall on 4/4/20 when this resident was readmitted. The Administrator was unable to explain why the facility corporate policy was not followed when Resident #22 was placed within the general population (200 hall) rather than on the designated quarantine hall (100 hall) when she returned from her hospital stay on 4/4/20.

A phone interview was conducted on 5/8/20 at 9:24 AM with former Unit Manager (UM) #1 (primarily assigned to the 100, 200, and 300 halls). She was asked why Resident #22 returned to her previous room with a roommate and within the general population of the facility (200 hall) after her hospitalization (3/29/20 to 4/4/20 hospital) and was not quarantined. Former UM #1 stated that she "had no idea why". She indicated that she had not agreed with this decision, but management had not heeded her opinion. She stated that Resident #22 was a dialysis resident and she self-propelled her wheelchair throughout the facility before and after her 4/4/20 readmission. She stated she recalled that Resident #22 had not worn a mask after her readmission (4/4/20) when she was out of her room until after all residents were required to wear masks (4/7/20).

Per electronic correspondence with the Administrator on 5/11/20 at 12:56 PM she indicated that masks were required for all staff as of 4/4/20. She wrote that residents were asked to start wearing masks on 4/4/20, but that it was not

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a requirement at that time. She stated that on 4/7/20, the facility received notification of the first resident who tested positive for COVID-19 and that was when masks were provided to all residents and were required to be in place when the residents were out of their rooms.

Phone interviews were attempted with the former Director of Nursing (DON) on 5/6/20 at 5:07 PM and on 5/11/20 at 3:27 PM. She was unable to be reached.

A phone interview was conducted with former UM #2 (primarily assigned to the 500 and 600 halls) on 5/11/20 at 4:30 PM. She stated that room placement decisions throughout the COVID-19 pandemic were made by management and she had not agreed with their decisions. She stated that she believed new admissions/readmissions should have been quarantined to a private room away from the general population. UM #2 explained that these new admissions/readmissions were at high risk for coming into contact with the virus (COVID-19) while at the hospital and/or in the community.

A phone interview with Nursing Assistant (NA) #12 on 5/13/20 at 12:00 PM indicated Resident #22 was admitted to a general population hall (200 hall) with a roommate and was not quarantined when she was readmitted on 4/4/20. NA #12 reported that Resident #22 had not worn a mask when she was outside of her room after her 4/4/20 readmission until the facility required masks for all residents on 4/7/20. She added that Resident #22 was able to self-propel her wheelchair and she left the facility regularly for dialysis with no mask in place until 4/7/20.

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A phone interview was conducted with the Infection Control Preventionist/Staff Development Coordinator (ICP/SDC) on 5/13/20 at 12:10 PM. She reported that she had no input in room placement decisions during the pandemic. She stated that the former DON, Medical Director, and Administrator were making room placement decisions. The ICP/SDC stated that she was unable to recall the exact date that masks and other PPE began to be worn by staff and/or residents related to COVID-19.

A phone interview was conducted with the Medical Director on 5/13/20 at 12:58 PM. He stated that he was not involved in any decision-making regarding room placement of new admissions and/or readmissions during the COVID-19 pandemic. He reported the facility had their own COVID-19 corporate plan that they were following. The Medical Director indicated his expectation was for the facility to follow CDC and CMS guidance regarding placement of new admissions and readmissions. He additionally indicated he expected the facility to follow CDC and CMS guidance related to the use of PPE.

On 5/13/20 the following information was provided and received via electronic correspondence with the Administrator:
- At 3:31 PM the Administrator was asked to explain why the facility ' s corporate policy dated 4/4/20 related to COVID-19 used the term "isolation" rather than "quarantine".
- At 4:04 PM the Administrator responded, "The language used in the policy reflected the language used by the CDC and CMS at that time."

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F 880	Continued From page 98 On 5/14/20 at 10:48 AM via electronic correspondence the Administrator revealed that 105 facility residents had tested positive for COVID-19 out of a census high of 127 as of 5/13/20. In a follow up interview on 5/21/20 at 11:20 AM, the Administrator verified that as of 4/4/20 the facility corporate policy related to COVID-19 was for new admissions/readmissions to be placed in a designated section of the facility and quarantined for 14 days. She confirmed that this 4/4/20 facility corporate policy was not followed when Resident #22 was readmitted to the facility on a general population hall (200 hall) rather than on the designated quarantine hall (100 hall). She confirmed the 100-hall had open beds at the time of Resident #22 ' s readmission on 4/4/20. She was unable to explain why this facility corporate policy was not followed. The Administrator additionally confirmed that the facility was not following the CDC and CMS guidance, effective on 4/2/20, for staff to wear masks while in the facility and residents to wear masks when out of their rooms. She verified that staff were not required to wear masks until 4/4/20 and residents were not required to wear masks when out of their rooms until 4/7/20. She was unable to explain why this CDC and CMS guidance dated 4/2/20 related to masks/PPE use was not fully implemented until 4/7/20. The facility provided the following plan of correction for past non-compliance: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:	F 880		

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All residents were at risk from the failure to adhere with correct and adequate infection control processes as guided by the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid (CMS). CMS guidance from the "QSO-20-14-NH indicated that "if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital". The deficient practice occurred when residents were admitted or readmitted and were not separated and/or not quarantined to a specific unit and/or required to stay in a private room from other residents in the facility for 14 days in addition the admitted and readmitted residents were not required to mask if and when they were out of their room from 3/11/2020 to 4/4/2020 per the CDC guidance and facility protocol.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 4/7/2020 the facility received information that two residents had tested positive for COVID-19 in the hospital and a nurse reported being contacted by a testing center and advised she had tested positive. A separate unit was established on 4/7/2020 for quarantine of residents who were symptomatic, roommates of those who were symptomatic, newly admitted or readmitted residents. No resident that was admitted prior to 4/7/2020 would be moved out of their room unless directed to do so by the physician. In the event of potential facility wide testing, room moves would be coordinated in collaboration with the Regional Director of Clinical Services and Administrator to ensure roommates who are positive were together and roommates which are negative are roomed together.

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Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

As on 4/7/2020 each admission or readmission would be placed in the appropriate location for quarantine of 14 days unless the facility becomes a "hot bed" meaning no area is free from COVID-19. At that time a decision would be made to either return the resident, if they left the facility, back to their room or quarantine them on the designated hall. This decision would be in consultation with the Medical Director, Infectious Disease physician at the hospital and the Health Department.

On 4/7/2020 the facility Administrator, Regional Clinical Consultant and the Assistant Director of Nursing re-educated current employees that consisted of clinical staff, housekeeping, activities, social work, business office staff, dietary, therapy, department managers and agency staff, as they entered into the facility regarding the updates to the corporate COVID-19 guidelines which included: all healthcare providers were to wear masks while in the facility, all residents should be wearing a mask when out of the facility and their rooms, and to quarantine/isolate any new admissions/readmissions for 14 days.
As of 4/7/2020 all new admissions were stopped.

Indicate how the facility plans to monitor its performance to make sure the solutions are sustained:

In the event of multiple positives in the facility, the Infectious Disease physicians, Emergency

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Manager, Health Department, Medical Director, facility Administrator and Director of Nursing would continue to tele-conference each day or nearly daily to determine the best course of action based on all available information. According to this group, a facility that has many positive cases in in "mitigation" phase, rather than "containment" and in cases of full outbreak, all residents may be considered exposed or to be persons under investigation. In that event, readmissions would be permitted to return to their own rooms with former roommates who had been fully exposed. These decisions were made by the Administrator and Nursing Administration in collaboration with the above described group of consultants.

On 4/7/2020 a conference call was held with the local Department of Health and progressed to a call including Infectious Disease physicians, the facility Medical Director, Administrator and Director of Nursing that were scheduled for Mondays, Wednesdays and Fridays which are ongoing.

All efforts were thus made to manage the level of illness and symptoms. As the facility moved toward a recovery phase a standard would be established in collaboration with the consulting group to determine at what point and by what criteria the affected residents would be "recovered" and the facility would again consider new admissions. The facility would not begin to admit new residents until the outbreak was considered fully resolved. At the 4/7/2020 discussion point the Health Department estimated that would be two incubation periods or 28 days from the last date of a positive test result. In addition, the CDC guidance would inform the facility about the number of days since onset of

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symptoms, hours or days without fever and hours or days since respiratory symptoms had resolved. These criteria would be used to determine when an individual resident was recovered and inform decisions when the facility would be fully recovered to begin considering new admissions.

Beginning 4/7/2020, the facility will continue to update, review and revise processes minimally with Quality Assurance and Process Improvement (QAPI) committee monthly. The Director of Nursing and Administrator would monitor readmissions to ensure appropriate room placement occurred starting on 4/7/20. The Administrator and/or Director of Nursing would continue to maintain and review the resident symptom log and update as symptoms were indicated, which began on 3/29/2020. Nursing staff would continue to monitor residents daily for signs of respiratory symptoms, to include monitoring temperature for elevation.

The facility alleged full compliance with this plan of correction effective date 4/7/2020.

As part of the on-site validation process on 5/21/2020, the plan of correction was reviewed which included dates and content of the in-services that were conducted, an updated resident log of symptoms, staff interviews and observations.

The facility provided a Performance Improvement Project, titled "COVID 19 Outbreak" with initiation date of 4/7/2020 due to 1 agency nurse and 2 residents in the hospital testing positive for COVID 19. The following were implemented based on the 3 positive COVID 19 test results:

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1) Swab residents for COVID-19. This was completed on 4/10/2020
2) Notify the Department of Health. This was completed on 4/7/2020.
3) Obtain hospital results on residents currently there. This was completed on 4/7/20 thru 4/10/2020.
4) Open 100 hall, which was completed on 4/8/2020.

Multiple staff were interviewed and verified they had received education on COVID-19 to include the importance of quarantine and use of masks for residents when out of their rooms. Observations revealed staff wearing appropriate PPE and residents wearing masks appropriately when out of their rooms.

The validation process determined the facility ' s compliance date was 4/10/20.