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| THE OAKS AT SWEETEN CREEK | 3864 SWEETEN CREEK ROAD ARDEN, NC 28704 |

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| E 000 | Initial Comments<br><br>An unannounced COVID-19 Focused Survey and complaint investigation were conducted on 10/06/20 with exit from the facility on 10/06/2020. Additional record review and interviews occurred through 10/13/20. The survey team returned to the facility on 10/19/2020 to validate the corrective action plan and completed the exit with the Administrator by phone on 10/20/2020. Therefore the survey exit date was changed to 10/20/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# SRJN11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Survey and complaint investigation were conducted on 10/06/20 with exit from the facility on 10/06/2020. Additional record review and interviews occurred through 10/13/20. The survey team returned to the facility on 10/19/2020 to validate the corrective action plan and completed the exit with the Administrator by phone on 10/20/2020. Therefore the survey exit date was changed to 10/20/20. There were four allegations investigated and they were unsubstantiated. Event ID# SRJN11.<br><br>Past non-compliance was identified at:<br><br>CFR 483.80 at tag F 886 at a scope and severity of L.<br><br>Non-compliance began on 09/18/20. The facility came back in compliance effective 09/30/20. | F 000 | | |
| F 885 SS=E | Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) | F 885 | | 11/9/20 |

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

Electronically Signed | 11/06/2020

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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| F 885 | Continued From page 1<br><br>§483.80(g) COVID-19 reporting. The facility must—<br><br>§483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—<br><br>(i) Not include personally identifiable information;<br>(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and<br>(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, family and staff interview, the facility failed to inform resident representatives and families by 5:00 PM the next calendar day following the occurrence of a confirmed staff COVID-19 infection on 09/18/20 for 1 of 60 staff reviewed for COVID-19 reporting.<br><br>Findings included:<br><br>Review of the facility's respiratory surveillance line list revealed one staff member tested positive | F 885 | On 9/28/20, the Administrator informed residents, their representatives, and families of the status of positive residents and/or staff via activation of automated telephone call. The Administrator confirmed calls utilizing the system's call log summary report.<br><br>On 11/4/2020, the Administrator conducted a Quality Improvement monitoring of all residents and staff with a | |

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| F 885 | Continued From page 2<br>for COVID-19 on 09/18/20.<br><br>During a telephone interview on 10/13/20 at 2:55 PM the Administrator explained resident representatives and families were notified of positive COVID-19 infections in the facility via automated telephone calls and then he followed up the call with a letter. The Administrator stated he wrote a letter to residents and their families on 09/19/20 informing them of the employee who had tested positive for COVID-19 but was not certain what date the letter was actually mailed.<br><br>During a telephone interview on 10/14/20 at 10:48 AM, a Family Member (FM) explained they had saved all mail correspondence from the facility and had received letters dated 08/19/20, 09/27/20 and 10/09/20 informing them of COVID-19 infections in the facility. In addition, the FM stated they had saved all automated telephone messages from the facility and had only received calls on 09/29/20 and 10/02/20 related to COVID-19 infections. The FM confirmed they had not received an automated call or letter from the facility informing them a staff member had tested positive for COVID-19 on 09/18/20.<br><br>During a follow-up telephone interview on 10/14/20 at 12:12 PM, the Administrator stated other than the letter dated 09/19/20, he had no additional documentation to show that residents, families and representatives were notified by 5:00 PM the next calendar day following the positive employee COVID-19 test result on 09/18/20. | F 885 | positive covid-19 test since 9/18/2020 to ensure all residents, their representatives, and families had been notified by 5:00 PM the following calendar day. Any issues identified were addressed.<br><br>The Administrator was re-educated by the Regional Director of Clinical Services on 10/20/2020 of regulation F885 to inform residents, their representatives, and families of those residing in the facility by 5:00 PM the next calendar day following the occurrence of either a single confirmed infection of covid-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This reporting is to continue on a weekly basis during an outbreak at the facility.<br><br>The Administrator or designee will conduct quality improvement monitoring of timely reporting to residents, their representatives, and families of those residing in the facility of positive covid-19 test results 3 times a week for one month, then once a week for one month, then monthly for three months, starting 11/9/2020.<br><br>Audit results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee by the Executive Director or designee monthly for six months. Revision of the plan will be made as identified by the committee, related to an occurrence of a positive covid-19 test result. The QAPI Committee consists of the Executive Director, Director of | |

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| F 885 | Continued From page 3 | F 885 | Nursing, and Medical Director at a minimum.<br><br>Completion date to be 11/9/2020. | |
| F 886 SS=L | COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with<br>COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms<br>consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the<br>transmission of COVID-19.<br><br>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for | F 886 | | 11/6/20 |

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| F 886 | Continued From page 4<br>conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing:<br>(i) Document that testing was completed and the results of each staff test; and<br>(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms<br>consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.<br><br>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state<br>and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, interviews with the Local Health Department Nurses, an interview with the facility's Medical Director, and review of the facility's COVID-19 Pandemic Plan, the facility failed to conduct required COVID-19 testing on 84 of 84 residents after receiving a positive test result for Nurse Aide #1 on 9/18/2020. Additionally, after completing 76 staff tests on 9/16/2020 and receiving a positive | F 886 | Past noncompliance: no plan of correction required. | |

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| F 886 | Continued From page 5 | F 886 | | |

result for Nurse Aide #1 on 9/18/20 the facility failed to continue testing staff every 3 days to 7 days. These failures occurred during a COVID-19 pandemic. From 09/18/20 to 10/12/2020 a total of 53 residents and 18 staff tested positive for COVID-19.

Findings included:

A review of the facility's policy titled, "COVID-19 Pandemic Plan" revised 09/21/20 under the section titled, "Testing", read in part: "Centers will follow Federal and State regulations for testing of staff and residents." Under the section titled, "Outbreak Testing" read in part: "Test all staff and residents in response to an outbreak (defined as any single new infection in staff or any nursing home onset infection in a resident)."

On 09/16/20 the facility tested sixty staff for the COVID-19 virus utilizing a Real-Time Reverse Transcription Polymerase Chain Reaction (RT-PCR) test (a test considered highly sensitive for the identification of COVID-19). On 09/18/20 one positive COVID-19 result was reported to the facility which identified Nurse Aide (NA) #1. On 09/17/20 sixteen staff were tested utilizing the RT-PCR test and each of these staff tests were negative.

Review of the facility's COVID-19 test results revealed no further staff were tested for the virus from 09/18/20 to 09/27/20 with the exception of NA #1 being retested on 9/22/20 and 9/23/20.

Review of the facility's COVID-19 test results from 09/18/20 to 09/26/20 revealed the facility did not test any residents for the COVID-19 virus during this time period.

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During a telephone interview on 10/08/20 at 9:54 AM the Director of Nursing (DON) explained she called the Administrator at 8:00 PM on 09/18/20 to inform him of NA #1's positive COVID-19 test result. She then called NA #1 and directed her not to return to work and to self-quarantine.

During a telephone interview on 10/07/20 at 3:26 PM the Administrator revealed on 09/18/20 at 8:00 PM he received a message from the DON informing him NA #1 tested positive for COVID-19. The administrator stated he communicated this information to his Local Health Department (LHD) by leaving a voice message with LHD Nurse #2.

A conference telephone interview was conducted on 10/08/20 at 11:29 AM with the Administrator and DON. The administrator stated the facility did not test residents on 09/21/20 when their COVID-19 Pandemic Plan was revised because they were going by the guidance from the Local Health Department which was 2 or more positive results constituted an outbreak. The DON revealed their Corporate Nurse Consultant provided clarification on 09/25/20, of what constituted an COVID-19 outbreak. The DON explained their nurse consultant defined an outbreak as being one positive test result and the facility began testing all staff and residents on 09/27/20.

On 09/27/20 the facility began testing residents using the Rapid Point of Care (POC) test (a test used for quick detection of an active infection of COVID-19 with moderate sensitivity). The POC results noted that on 09/27/20 one resident was identified as having COVID-19 while at the

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hospital. The POC results from 09/27/20 to 10/04/20 noted a total of 43 residents had tested positive for the COVID-19 virus.

On 09/28/20 the facility began using the Real-time Reverse Transcription Polymerase Chain Reaction (RT-PCR) to test residents for the COVID-19. Review of the 09/28/20 RT-PCR resident test results revealed 27 of 79 residents tested positive for COVID-19, Additionally, from 09/29/20 to 10/02/20 a total of 7 of 82 staff who were tested using the RT-PCR test were positive for COVID-19. On 10/06/20 thirty residents were tested using the RT-PCR test and none of these residents tested positive for COVID-19.

A telephone interview on 10/8/20 at 1:24 PM with Local Health Department (LHD) Nurse #2 revealed she was the facility's contact but did not work from 09/04/20 through 10/07/20. LHD Nurse #2 stated when she received a phone call, during this time period that she was not working, her phone's voice message would have provided the caller with instructions to call an alternate phone number if assistance was needed.

On 10/07/20 at 11:24 AM a telephone interview was conducted with the Local Health Department (LHD) Nurse #1. Nurse #1 explained she received results from the state surveillance system on 09/26/20 that confirmed NA #1 resulted positive for COVID-19 on 09/23/20. Nurse #1 revealed she contacted the facility on 09/28/20 and was informed testing of residents had begun and the facility was in an outbreak. LHD Nurse #1 recommended the facility test all staff and residents and indicated the facility began testing for COVID-19 on 09/28/20 and sent her those results. Nurse #1 confirmed the test

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results in the state system for NA #1 was for the 1 positive test on 09/23/20. She stated the facility should report any positive case to their LHD. Nurse #1 revealed if she would have received the lab results of NA #1 being positive on 09/18/20 that would constitute facility wide testing of all staff and residents and her recommendation would have been to begin facility wide testing.

A telephone interview was conducted with the facility's Medical Director on 10/09/20 at 12:28 PM. During the interview the facility's Medical Director revealed his criteria was to do what was best for the resident. When the facility first identified NA #1 as being positive for COVID-19 resident testing should have been implemented without delay. The Medical Director indicated the delay in testing and isolating positive residents may have contributed to the facility's outbreak of COVID-19. The Medical Director did not recommend retesting after a positive result was received instead stated the guidance was for health care personnel to self-quarantine and residents be placed on isolation and/or the COVID-19 unit.

The facility provided the following Performance Improvement Plan with the plan of correction date of 09/30/2020.

The facility staff failed to conduct required COVID-19 testing of 84 residents after receiving a positive test result from nurse aide #1 on 9/18/2020. After completing 76 staff tests on 9/16/2020 a positive nurse aide #1 result came back on 9/18/2020 and the facility failed to continue testing staff every 3 days to 7 days. All residents and staff have the potential of being impacted due to the noncompliant practice on

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9/18/2020. Residents #1 and #3 were identified as having the potential of being impacted. On 9/19/2020 resident #1 developed a temperature of 102 degrees Fahrenheit. She was then moved to room 113 B on the quarantine hall due to a refusal for COVID testing. Resident #1 was under hospice care and the resident's responsible party was notified and requested comfort care only. Resident #1 did receive a COVID test on 9/28/2020 with a result of positive and resident #1 passed on 10/1/2020.

On 9/16/2020, 60 samples were collected from staff. On 9/17/2020, 16 samples were collected from staff. Nurse Aide (NA#1) received a COVID-19 positive result on 9/18/2020. On 9/18/2020 59 staff results were negative. On 9/18/2020 DON alerted Administrator of (NA#1) positive results and also alerted Nurse Aide (NA#1) of results and advised to call her MD and to self-quarantine. Nurse Aide stated understanding. On 9/21/20, 16 samples were reported back as negative. On 9/26/2020 Resident #3, of Room Number 204, was discharged to the hospital for hypoxia. On 9/27/2020 facility received notification from family that resident #3 tested positive for COVID in hospital. On 9/27/2020 Rapid Point of Care testing was done on 20 residents with 11 resident positive results and 9 resident negative results. On 9/28/2020 79 residents were tested with PCR testing. On 9/30/2020 27 residents test results positive and 52 residents test results negative. On 9/28/2020 1 staff tested with PCR with a result on 10/1/2020 that was negative. On 9/29/2020 58 staff were tested with PCR testing with results on 10/2/2020 of 4 positive and 54 negatives. On 9/30/2020 17 staff were tested with PCR testing with results on 10/3/2020 of 3

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positive and 14 negatives. On 10/6/2020 46 staff test with PCR testing with results on 10/8/2020 of 2 positive and 44 negatives. On 10/5/2020 38 residents were tested with PCR testing. On 10/8/2020, 9 resident test results were positive and 29 resident test results were negative. On 10/7/2020 10 staff were tested with PCR testing with results on 10/9/2020 of 2 positive and 8 negatives. On 10/8/2020 4 staff were tested and are currently pending.

During the period of 9/18/2020 till 10/12/2020 the facility has confirmed 53 residents positive COVID cases and 18 staff positive COVID cases.

On 9/27/2020 the Regional Director of Clinical Services provided education to the Executive Director and Director of Clinical Services on conducting outbreak testing for one positive resident and/or staff to include immediate testing of all negative residents and staff and then continued testing every 3-7 days for at least two consecutive weeks with no new positive results. On 9/29/2020 the Regional Director of Clinical Services provided education to the facility's Interdisciplinary Team (Quality Assurance Performance Improvement Team) to include but not be limited to the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Medical Director and at least 1 direct care staff member to review CMS's process on COVID testing and the facility's pandemic plan (revision date 9/28/2020) to include outbreak testing and regulation F 886. The facility infection control policy and procedure (pandemic plan) was updated on 9/28/2020 and is current with CMS guidance on facility testing requirements. The plan is as follows; the facility will immediately conduct outbreak testing for one positive resident

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and/or staff to include immediate testing of all negative residents and staff and then continued testing every 3-7 days for at least two consecutive weeks with no new positive results. Testing of all staff and residents in response to an outbreak will ensue with any single new infection in staff or resident. For routine testing, the Administrator and/or Director of Nursing and/or Assistant Director of Nursing, who is responsible for testing, will monitor the county positivity rate every other week and adjust the frequency of performing routine staff testing based on the county positivity rate; <5% testing will occur once a month, 5%-10% testing will occur once a week and >10% testing will occur twice a week. If the 48-hour turn-around time cannot be met by the processing lab for any reason, the center will have documentation of its efforts to obtain quick turnaround testing results and contact with the local and state health department. Staff experiencing symptoms will be tested and restricted from facility pending results. Residents with signs or symptoms will be tested and placed on transmission-based precautions pending results. For any residents who refuse testing, those residents will be moved to a "warm" unit for persons under investigation and placed on transmission-based precautions for the duration of the pandemic. For staff members who refuse testing, they will be sent home until they are either tested or until the pandemic has ended.

The DON and/or designee conducted COVID testing for all negative staff members starting on 9/28/2020, 9/29/2020 and 9/30/2020. Staff tested was reconciled against the staff roster to verify all staff were tested. The 4 PRN staff that were not tested on 9/30/2020 were identified and have been notified they have been removed from the

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|---|---|---|---|
| | 345477 | A. BUILDING _____ B. WING _____ | C 10/20/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE OAKS AT SWEETEN CREEK | 3864 SWEETEN CREEK ROAD ARDEN, NC 28704 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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schedule until they are able to produce a negative COVID test result that coincides with the current test week. Staff testing continued on 10/6/2020, 10/7/2020 and 10/8/2020. The next scheduled testing will be provided on 10/12/2020 and continue every 3 to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. Staffing agencies were contacted to inform their staff assigned to the facility to be tested in the facility and/or to bring test results done within prior 7 days with them when reporting for duty for the 1st time. Newly hired staff members must provide initial COVID test results prior to their start date to the Director of Nursing and/or Assistant Director of Nursing. If they have not been tested the facility will complete the initial testing prior to work and any subsequent testing every 3 to 7 days or at the frequency indicated by the county positivity rate.

The Director of Nursing and/or designee conducted COVID testing for all negative residents starting on 9/27/2020 and 9/28/2020. Resident testing continued on 10/5/2020. The next scheduled testing will be provided on 10/12/2020 and continue every 3 to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.

On 9/29/2020 The Executive Director, Director of Nursing and/or Assistant Director of Nursing validated (Quality Monitoring) and will continue weekly times 8 weeks, then every other week times 4 weeks and monthly times three months of all negative staff and/or residents that have been tested based off the current CMS guidance on

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facility testing requirements. The CMS guidance is as follows; the facility will immediately conduct outbreak testing for one positive resident and/or staff to include immediate testing of all negative residents and staff and then continued testing every 3-7 days for at least two consecutive weeks with no new positive results. Testing of all staff and residents in response to an outbreak will ensue with any single new infection in staff or resident. For routine testing, the Administrator and/or Director of Nursing and/or Assistant Director of Nursing, who is responsible for testing, will monitor the county positivity rate every other week and adjust the frequency of performing routine staff testing based on the county positivity rate; <5% testing will occur once a month, 5%-10% testing will occur once a week and >10% testing will occur twice a week. If the 48-hour turn-around time cannot be met by the processing lab for any reason, the center will have documentation of its efforts to obtain quick turnaround testing results and contact with the local and state health department. Staff experiencing symptoms will be tested and restricted from facility pending results. Residents with signs or symptoms will be tested and placed on transmission-based precautions pending results. For any residents who refuse testing, those residents will be moved to a "warm" unit for persons under investigation and placed on transmission-based precautions for the duration of the pandemic. For staff members who refuse testing, they will be sent home until they are either tested or until the pandemic has ended.

The Regional Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 9/29/2020. The Director of Nursing will report on

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the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, CNA, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.

The Facility alleges the removal of the immediate jeopardy on 9/30/2020.

On 10/19/20 the facility's action plan was validated by the following: Interviews with the facility's Interdisciplinary Team which included the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, and other Department Heads of what constitutes an outbreak and testing requirements. Review of the Quality Assurance Performance Improvement Meeting conducted by the Regional Director of Clinical Services on 09/29/20 with the Interdisciplinary Team on the subject titled, "COVID Positive Cases and Mitigation of Transmission of the Virus." Review of the facility's Pandemic Plan revised on 09/28/20 which defined a COVID outbreak and routine testing and using the CMS county positivity rate. Interviews with the Interdisciplinary Team on the facility's surveillance plan of COVID to include

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| F 886 | Continued From page 15<br>delegation of monitoring and reporting to Quality Assurance Performance Improvement Committee. The facility's date of Immediate Jeopardy removal on 09/30/20 was validated. | F 886 | | |