STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. Building B. Wing	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay View Nursing & Rehabilitation Center	1412 West Fourth Street Red Wing, MN 55066

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation, interview and document review, the facility failed to ensure personal hygiene was maintained in a dignified manner for 1 of 1 residents (R4) reviewed for dignity. Findings include: R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 was cognitively intact and required two staff to assist with bed mobility, transfers, and toileting and further indicated R4 was occasionally incontinent of urine. R4's care plan identified the following: On 10/8/18, R4 needed scheduled assistance with toileting. On 4/30/19, R4 was incontinent of bowel and bladder. On 8/6/19, R4 was to be toileted after lunch to avoid soiling self. On 10/30/19, R4 wished to be changed on demand. Staff were to offer toileting before and after meals. During continuous observation on 9/19/22, from 8:50 a.m. to 12:08 p.m. the following was observed: 8:50 a.m. R4 turned on his call light. 9:15 a.m. an activities assistant (AA)-A inquired about R4's need. R4 stated he was all wet and needed an aide to change him. 9:21 a.m. a nursing assistant (NA)-A looked into the room and asked what R4 needed. R4 again stated he was all wet and needed to be changed. NA-A walked away. 9:29 a.m. two NAs entered the room to assist R4. During this observation period that occured over R4's lunch time, R4 was not offered toileting assistance. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 9/19/22, at 12:08 p.m. R4 stated when he wanted help to go to the bathroom, he had trouble getting to the toilet on time if he had to wait. R4 stated, I often have to sit wet or dirty. I don't like to smell. It's embarrassing. R4 confirmed staff did not offer toileting assistance before or after lunch. When interviewed on 9/19/22, NA-A stated it took time to get help as other aides were busy, and knew R4 did not like waiting. When interviewed on 9/19/22, the director of nursing (DON) stated she expected call lights to be answered in ten to fifteen minutes, and 39 minutes was too long to wait to be changed. The policy for Quality of Life - Dignity dated February 2020, indicated each resident would be cared for in a manner that promoted a sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation, interview, and document review the facility failed to ensure a baseline care plan was developed within 48 hours of admission to identify the risk for injury or falls for 1 of 1 resident (R2) reviewed for falls. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 was admitted on [DATE], with moderately impaired cognitive function, and R2 required assistance of two staff for transfers, bed mobility, and toileting and was frequently incontinent. R2's care plan dated 7/28/22, indicated R2 had an alteration in elimination, but listed no interventions until 8/29/22 and indicated R2 was at risk for falls and listed, Follow PT [physical therapy] and OT [occupational therapy] instructions for mobility function. R2 had not been assessed by PT and OT. When interviewed on 9/19/22, at 12:15 p.m. licensed practical nurse (LPN)-A stated the initial care plan should have been completed in the first 48 hours by the MDS Coordinator. When interviewed on 9/19/22, at 3:15 p.m the director of nursing (DON) stated she added interventions for transfers to the care plan and care card on this day to ensure safe transfers and care for R2. The DON stated the initial care plan should have been completed in the first 48 hours. The Care Planning - Interdisciplinary Team policy dated September 2013, indicated an initial care plan would be completed within 48 hours. The Fall Risk Assessment policy dated March 2018, indicated upon admission, the resident's fall history the previous 90 days would be reviewed and assessment data would be used to identify conditions that may increase the risk of injury from falls. Additionally the staff would evaluate functional and psychological factors that may increase fall risk including ambulation, mobility, gait, balance, excessive motor activity, activity of daily living capabilities, activity tolerance, continence, and cognition and identify and address modifiable falls risk factors and interventions to try to minimize the consequences of risk factors that were not modifiable. The Managing Falls and Fall Risk policy dated March 2018, indicated the staff would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk for falls or with a history of falls. Additionally, the policy indicated if the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to change current interventions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation, interview, and document review the facility failed to implement a comprehensive care plan that included interventions to prevent falls for 1 of 1 resident (R2) reviewed for falls. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE], indicated moderately impaired cognitive function, and R2 required assistance of two staff for transfers, bed mobility, and toileting. R2's Face Sheet printed 9/19/22, indicated diagnoses of COVID-19, dementia, hallucinations, tremors, abnormality of gait, low back pain, rheumatoid arthritis, repeated falls, fractured vertebrae, and osteoporosis with pathological fracture. R2's care plan dated 7/28/22, indicated R2 was at risk for falls. Interventions to prevent falls were as follows: On 7/28/22, follow physical therapy (PT) and occupational therapy (OT) recommendations for mobility function. On 7/28/22, and monitor and document safety. The care plan indicated record possible root cause for falls and educate resident/family/caregivers/IDT as to causes. On 8/2/22, call light adjustment. On 9/8/22, uses a wheelchair with assistance for mobility within facility. On 9/8/22, may walk on weekends with staff using two wheeled walker (2ww) with a gait belt and staff following with a wheelchair. R2's care sheet dated 8/29/22, indicated R2 could ambulate with the assistance of one staff, a walker, and a gait belt. R2's admission care conference interdisciplinary team form dated 8/6/22, was not completed by nursing. The nursing assessment would have included medication management, medication review, medication side effects, pain management, psychotropic medications and side effects, falls risk, and positioning and use of devices for positioning. R2's OT assessment dated [DATE], indicated a history of, Repeated falls. R2's PT assessment dated [DATE], indicated R2 could perform stand pivot transfers with one staff and a 2 ww The recommendation was not on the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's incident report dated 7/31/22, indicated R2 fell in the bathroom while self-transferring, and indicated R2 had an unsteady gait and was recently admitted . No other factors were identified that would have increased R2's fall risk. No injuries were noted. R2's incident report dated 8/2/22, indicated R2 fell trying to get in to bed and indicated R2 had a history of falls, an unsteady gait, weakness, did not always realize his limitations, and was taking several medications that increased his risk for falls. R2 was transferring without assistance. No injuries were noted. R2's PT assessment dated [DATE], indicated staff could walk with R2 on the weekends, use the 2ww and gait belt, and staff could follow R2 with a wheelchair when walking on the unit. The recommendation was not on the care plan. R2's incident report dated 9/2/22, indicated R2 was found on the floor and did not know why he fell . The report indicated R2 had tested positive that day for COVID-19, and was confined to his room with the door shut, and did not always use the call light to ask for assistance. No injuries were noted. R2's progress notes indicated the following: On 9/2/22, at 5:14 a.m. required one staff for bed mobility and toileting, and walked with a walker to the commode. On 9/2/22, at 2:00 p.m. had fallen and lacerated his head. On 9/2/22, at 4:59 p.m. OT treatment was held because R2 had fallen, hit his head, and had a head laceration. On 9/8/22, at 6:22 a.m. required one staff for bed mobility, toileting, and walking to the commode with a 2ww. On 9/8/22, at 9:40 p.m. required two staff to transfer with a walker. On 9/9/22, at 4:55 a.m. required one staff for all activities of daily living (ADLs), and for transfers with a gait belt. On 9/9/22, at 1:06 p.m. required two staff with a walker, and transferred with assistance of two staff. On 9/9/22, at 2:38 p.m. the note indicated causes for past falls, but not the fall on 9/2/22. The recommended intervention was to have the resident out where he is around others and can be monitored, and to keep agitation to a minimum. (R2 was on quarantine for COVID-19). On 9/10/22, at 9:10 p.m. required two staff for cares and transfers with a walker. On 9/11/22, at 9:27 a.m. required two staff for bed mobility, and for toileting to clean and change him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/13/22, at 1:11 p.m. required one staff for grooming, dressing, and transfers with a walker. On 9/14/22, at 9:50 p.m. required two staff to complete ADLs and transfer with a walker. On 9/17/22, at 2:01 a.m. required one staff to complete ADLs and transfers with a walker. On 9/18/22, at 2:24 a.m. required two staff for toileting and transfers with a walker. On 9/18/22, at 10:45 p.m. required one staff for ADLs and had difficulty transferring with two staff and a walker. Staff used a Hoyer lift with two staff for transfers. On 9/19/22, at 5:28 a.m. required two staff for bed mobility and toileting. On 9/19/22, at 1:14 p.m. required one staff for ADLs and was unable to transfer using a walker and two staff. Transferred using hoyer lift and two staff. When interviewed on 9/19/22, at 12:15 p.m. licensed practical nurse (LPN)-A stated staff talked to physical therapy staff about R2's transfers on this date, and expressed two staff were required to transfer R2. LPN-A stated the PT note indicated R2 transfer with a pivot transfer, but staff had been using a Hoyer lift. LPN-A stated the care plan and care sheet should be updated with the most current information for safety. When interviewed on 9/19/22, at 12:38 pm OT-A stated the care sheet was incorrect that R2 required assistance of one person for transfers. OT-A stated R2 required the use of a Hoyer lift for transfers over the weekend, which required two staff for transfers. OT-A stated there should be direction somewhere for staff to know how to care for R2, either on the care sheet or the care plan. OT-A confirmed the previous recommendations made by PT and OT staff were not added to the care plan. When interviewed on 9/19/22, at 2:24 p.m. family member (FM)-A stated some staff use a lift to move R2, and some do not. FM-A did not know what the care plan directed staff to do. When interviewed on 9/19/22, at 3:15 p.m. the director of nursing (DON) stated residents are assessed for their care abilities when they are admitted , and staff utilize the hospital discharge paperwork as a resource for the initial care plan. The DON stated the care plan and care cards should be updated with the most current information, and confirmed the most recent recommendations from PT/OT staff were not in the care plan. The DON confirmed also the nursing assessment from the interdisciplinary team meeting to help determine the care plan was not completed yet from the meeting on 8/6/22 and should have been by this time. The Fall Risk Assessment policy dated March 2018, indicated upon admission, the resident's fall history the previous 90 days would be reviewed and assessment data would be used to identify conditions that may increase the risk of injury from falls. Additionally the staff would evaluate functional and psychological factors that may increase fall risk including ambulation, mobility, gait, balance, excessive motor activity, activity of daily living capabilities, activity tolerance, continence, and cognition and identify and address modifiable falls risk factors and interventions to try to minimize the consequences of risk factors that were not modifiable. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Managing Falls and Fall Risk policy dated March 2018, indicated the staff would implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk for falls or with a history of falls. Additionally, the policy indicated if the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to change current interventions.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44654 Based on observation, interview and document review, the facility failed to identify, assess, and provide appropriated treatment and services to maintain as much bladder function as possible for 2 of 2 residents (R2, R4) reviewed for urinary incontinence. Findings include: R2's admission Minimum Data Set (MDS) dated [DATE], identified R2 was moderately cognitively impaired and required assistance of two staff for bed mobility, transfers, and toileting. The MDS further indicated R2 was frequently incontinent of urine. R2's care plan identified the following: On 7/28/22, R2 had a risk for alteration in elimination. On 8/29/22, R2 would toilet every two hours and as needed (PRN) with the assistance of 1-2 staff. On 9/19/22, the addition of, Assist with EZ Stand and 1-2 with toileting q2hrs and PRN [Assist with EZ Stand and 1-2 staff with toileting every 2 hours and as needed] was added and back-dated to 8/29/22 to the care plan by the director of nursing (DON). R2's care plan lacked instructions about how R2 would be toileted, how to transfer R2 to the toilet, did not indicate R2 was incontinent or if R2 wore an incontinence brief. R2's care sheet dated 8/29/22, indicated R2 was incontinent and used a commode. The care sheet did not indicate if R2 wore an incontinence brief. During continuous observation on 9/19/22, from 8:50 a.m. to 12:08 p.m. staff did not toilet R2. R2 had a commode in his room. When interviewed on 9/19/22, at 12:38 p.m. occupational therapist (OT)-A stated it was a good question about how staff toileted R2. OT-A stated she was having trouble getting R2 to stand, and expected the care sheet and care plan to have information about toileting. R4's annual MDS dated [DATE], identified R4 was cognitively intact and required two staff to assist with bed mobility, transfers, and toileting. The MDS further indicated R4 was occasionally incontinent of urine. R4's care plan identified the following: On 10/8/18, R4 needed scheduled assistance with toileting. On 4/30/19, R4 was incontinent of bladder. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/6/19, R4 was to be toileted after lunch to avoid soiling self. On 10/30/19, R4 wished to be changed on demand. Staff were to offer toileting before and after meals. R4's care plan lacked a toileting schedule or a check and change schedule, and did not indicate if R4 wore an incontinence brief. R4's care sheet dated 8/29/22, indicated R4 was incontinent and lacked further information to care for R4's toileting needs. The care sheet did not indicate if R4 wore an incontinence brief. During continuous observation on 9/19/22, from 8:50 a.m. to 12:08 p.m R4 reported he was wet and needed to be changed twice. No staff offered to toilet R4 before or after meals. When interviewed on 9/19/22, at 12:08 p.m. R4 stated when he wanted help to go to the bathroom, he had trouble getting to the toilet on time if he had to wait. R4 stated, I often have to sit wet or dirty. I don't like to smell. It's embarrassing. R4 confirmed staff did not offer toileting assistance before of after lunch. When interviewed on 9/19/22, at 9:46 a.m. NA-A stated it took time to get help as other aides were busy, and knew R4 did not like waiting. NA-A stated R4 was changed because his clothes were wet. NA-A stated she knew how to care for R4 because she had worked with him before. When interviewed on 9/19/22, at 12:15 pm licensed practical nurse (LPN)-A stated staff had tried to use a urinal and a bed pan for R2. LPN-A confirmed the care card indicated use a commode for R2. LPN-A further indicated the care cards were for all staff to use to indicate how to care for each resident. When interviewed on 9/19/22, at 3:15 p.m. DON stated she had updated R2's care plan and care card and stated they should be updated with each change in cares. The DON stated she would review R4's care plan and care card. The Activities of Daily Living (ADLs) policy dated March 2018, indicated residents who were unable to carry out ADLs would receive the necessary services to maintain personal hygiene. Further, the policy indicated interventions to improve functional abilities would be in place, and would monitored, evaluated, and revised as appropriate.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44654 Based on observation, interview, and record review the facility failed to ensure medications were stored and secured safely in 1 of 1 medication carts observed. Findings include: During observation of a medication cart on second floor on 9/16/22, from 12:20 pm to 12:54 p.m. the cart was left at the crosswalk between the hallways unlocked during that time period. The trained medication aide (TMA) was in a room four doors down the hallway during that time. In addition during that time five staff walked by the unlocked medication cart. One resident was sitting in a wheelchair near the medication cart and could have accessed the medication cart. When interviewed on 9/16/22, at 1:00 pm TMA-A stated she had forgotten to lock the cart. TMA-A stated she knew it was supposed to be locked when she left the medication cart unattended to keep staff and residents from getting medications from it, for safety. The Security of Medication Care policy dated April 2007, indicated the medication cart should be securely locked at all times when out of view.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review, the facility failed to implement all necessary infection control practices to prevent and/or minimize a facility wide outbreak of COVID-19 as directed by the center for disease control and prevention (CDC) for 18 of 74 residents (R2, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20). The facility's systemic system failure resulted in an immediate jeopardy (IJ) with the likelihood of this practice to affect all residents residing in the facility. The immediate jeopardy began on 8/27/22, when the facility's failure to implement appropriate infection control practices to mitigate or reduce the spread of COVID-19 which included implementation of transmission-based precautions (TBP), active surveillance, appropriate usage of personal protective equipment (PPE), and identification of high-risk residents. The IJ was identified on 9/16/22, and the director of nursing (DON), and the interim administrator were notified of the IJ on 9/16/22 at 2:17 p.m. The immediate jeopardy was removed on 9/19/22, at 3:12 p.m. when the facility implemented an acceptable removal plan. However, noncompliance remained at the lower scope and severity level of F, widespread scope, no actual harm with a potential for more than minimal harm that is not immediate jeopardy. Findings include: According to the Staff and Resident Vaccination Record between 8/27/22 and 9/16/22, 18 residents and 17 staff members tested positive for COVID-19. A map of the facility on 9/16/22, identified three floors divided into five units where residents resided. The first floor included the 1-West unit. The second floor included the 2-West unit and the 2-East unit. The third floor included the 3-West unit and 3- East unit. The Staff and Resident Vaccination Record indicated that COVID-19 outbreak started on the 2-West unit when R5 tested positive on 8/27/22. On 8/30/22, R6 who also resided on 2-West tested positive and identified R7 who resided on 2-East also tested positive. On 9/2/22, three more residents tested positive on the second-floor units R2, R10, and R8. On 9/3/22, one resident R9 who resided on the 3-West unit tested positive. On 9/6/22, three more residents tested positive; R12 and R13 who resided on 3-West, and R11 who resided on 2-West. On 9/8/22, two additional residents tested positive; R15 and R14 both resided on the 3-West unit. On 9/9/22, R16 who resided on 2-West tested positive. On 9/13/22, four residents tested positive; R4 and R19 who resided on 2-West, R17 who resided on 2-East, and R18 who resided on 3-East. On 9/16/22, R20 tested positive on 1-West. Between 8/27/22 to 9/16/22, there were 18 residents out of 74 who tested positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility's Staff and Resident Vaccination Record identified on 8/27/22, that activity aide (AA)-A and AA-B tested positive on 8/27/22, AA-C tested positive on 8/28/22. On 8/29/22 housekeeping (HSK)-A tested positive. On 9/1/22, registered nurse (RN)-B tested positive. On 9/6/22 nursing assistant (NA)-H and licensed practical nurse (LPN)-B tested positive. On 9/7/22, maintenance (M)-A and laundry lead (LL)-A tested positive. On 9/8/22, occupational therapy assistant (OTA)-A tested positive. On 9/11/22, LPN-D, trained medication assistant (TMA)-C, NA-I, and NA-J tested positive. On 9/13/22 NA-B tested positive. On 9/15/22 speech therapist (ST)-A tested positive. Between 8/27/22 to 9/15/22, there were 16 staff who tested positive for COVID-19. It was not evident the facility had completed tracking/trending of staff infections in conjunction with resident infections. On 9/16/22, the facility provided infection control surveillance program documentation from 8/27/22 to 9/16/22. The only document that was provided was Staff and Resident Vaccination Record. This record included the dates of when each resident and staff were vaccinated and when each tested positive for COVID-19. The record did not identify onset or resolution of symptoms. Further, the records lacked ongoing infection tracking and trending, did not include an analysis of spread, and lacked evidence of process surveillance strategies. In addition, it was not evident that re-education was provided to staff on COVID-19 prevention strategies to assist in mitigating the risk, even though COVID-19 was identified on several floors. Lastly, the records did not identify an assessment and/or identification of the facility's high-risk residents for additional protection and prevention measures. Implementation of TBP R5's admission record identified diagnoses of congestive heart failure and COVID-19 during his stay on 8/27/22. R5's progress note dated 8/26/22, at 6:12 p.m. identified R5 started to experience new onset illness symptoms. The note included, R5 was not feeling well and asked to be, checked out, as he was worried about his lungs, stated he has been having a non-productive cough. Subsequent progress notes dated 8/27/22, at 1:21 a.m. and 7:23 a.m. identified R5 was administered guaifenesin for congestion and acetaminophen for body aches. At 12:09 p.m. an additional dose of guaifenesin was given for congestion, at 1:12 p.m. was ineffective, still complained of not feeling good. R5's record did not identify implementation of TBP until after R5 was tested for COVID-19 on 8/27/22 at 1:53 p.m. with positive results. Staff and Resident Vaccination Record, identified the facility's COVID-19 outbreak began with R5 in addition to two activity staff (AA-A and AA-B) that were positive on 8/27/22. Staff testing log did not identify if the activity staff had symptoms, or if the activity staff had come into contact with other residents. High-risk residents and lack of implementation of TBP The 2-East unit had eight residents who required the use of a ventilator. Although R7, R8, and R17 who utilized vents and contracted COVID-19 did not experience adverse health effects, their medical records did not identify a risk assessment nor additional precautions implemented to negate the risk of COVID-19 transmission. The facility's policies did not identify the high risk ventilator residents and the facility assessment identified that there was 12 beds available for ventilator residents, who are considered clinically complex and require extensive services. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R7's admission record. identified diagnoses of paraplegia (paralysis of specific areas of your body) and dependent on ventilator (type of mechanical ventilation for breathing). R7's MD order, dated, 3/14/22, R7 to use a ventilator at night, nurse to check vent settings every shift. R7's progress note dated 8/30/22, identified that R7 tested positive for COVID and was placed on TBP. An additional progress note dated 9/5/22, indicated R7 had no symptoms and was taken off of transmission-based precautions as she was not symptomatic. Even though R7 was positive for COVID the facility did not follow CDC recommendations for removal of TBP. According to the CDC, for moderate to severely immunocompromised patients may remain infectious beyond 20 days. For these people, CDC recommends an isolation period of at least 20 days, and ending isolation in conjunction with serial testing and consultation with an infectious disease specialist to determine the appropriate duration of isolation and precautions. R8's admission record, included diagnoses of acute and chronic respiratory failure with hypercapnia (condition of inability to effectively exchange carbon dioxide and oxygen), shortness of breath and dependence on supplemental oxygen., chronic obstructive pulmonary disease, tracheostomy (breathing is done through the tracheostomy tube rather than through the nose and mouth), dependence on ventilator, and dependence on supplemental oxygen. R8's MD order, dated 12/9/20, if desaturates below 90%, check ventilator settings and oximeter connection. If O2 saturation is not corrected in 15 min's, call 911 and notify provider. R8's progress note dated 9/2/22, at 10:15 a.m. identified that R8 tested positive for Covid and was placed on TBP. The medical record did not identify if the facility added additional interventions to mitigate the risk for R8 who was at high risk for contracting COVID-19. R17's admission record, indicated diagnoses of tracheostomy,(an opening created at the front of the neck so a tube can be inserted into the windpipe (trachea) to help you breathe.), dependence of ventilator, and chronic respiratory failure. R17's MD order, dated 2/9/22, identified the use of a Trilogy ventilator, nurse to check vent settings every shift. R17's progress note date 9/10/22, at 7:18 a.m. requested acetaminophen (a medicine that can relieve moderate to severe pain and fever) for a sore throat. R17's medical record did not identify that the facility added additional interventions to mitigate the risk for R17 who was at high risk for contracting COVID-19, R17 developed COVID symptoms on 9/10/22, (which were atypical for R17) and R17 tested positive on 9/13/22, three days after developing symptoms, R17 was then placed on transmission based precautions. Inappropriate infection control practices (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R19 was observed on 9/14/22, at 12:29 p.m. with their room door closed. The door had a contact precaution sign posted. Outside the room was a personal protective equipment (PPE) cart. On the floor next to the cart there were several small brown paper bags labeled with the names of staff and were open to the air. These bags contained a used face shield and an N95 mask. R4 was observed on 9/14/22, at 12:30 p.m. with a contact precautions sign on his door with the dates dates of 9/13/22 to 9/23/22 written on the sign. A PPE cart outside his room with the same paper bags with staff names that contained masks. R4's door was open, R4 was seated in his electric wheelchair in the middle of his room without a mask on. At 1:54 p.m. R4 continued to be seated in his wheelchair watching television in his room with the door open and no mask on. R4 was observed on 9/15/22, at 1:07 p.m. the door was open, and R4 was seated in his wheelchair in his room without a mask on. R4 was observed on 9/16/22, at 8:55 a.m. the door was open, and R4 was seated in his wheelchair in his room without a mask on. During an observation on 9/14/22, at 4:34 p.m., on the 3-West unit where there was four residents (R12, R13, R14, R15) positive for COVID-19, two nursing assistants (NAs) were noted to have face masks on but did not have protective eye wear on. NA-G was seated at the nurse's station with his eyewear on top of his head and NA-F was on the other side of the nurse's desk, next to an unidentified resident seated in a wheelchair, the resident did not have a mask on. NA-F identified they should be wearing eye protection. During an observation on 9/16/22, at 8:32 a.m. OTA-B was noted to be walking down the 3-West hall, had a mask on with no eye protection on. OTA-B stated she was supposed to wear the goggles through patient areas and would put them on. OTA-B verified there was an outbreak of COVID in the facility. During an observation on 9/16/22, at 8:37 a.m. NA-L was seated at the 3-West desk and had no protective eyewear on even though the facility was in high community transmission status. During an observation on 9/16/22, at 8:38 a.m. at the employee entrance LPN-F was observed to test self, she appropriately performed hand hygiene. LPN-B stated she had just checked all the tests that were lying on the table and verified the results. LPN-B stated she threw them away and they were all negative. Assistant director of staff development (ASOD), walked in through the employee entrance, coughing, put her mask on. ASOD then swabbed herself for testing, then laid test the test on the table, and performed hand hygiene. During an observation on 9/16/22, at 11:40 a.m. NA-L was passing out lunches to the residents in their room on 3-West Hall and had no eye protection on. Although other nursing staff were observed in the same area, no one prompted NA-L to put on eye protection. During an observation on 9/16/22, 12:18 p.m. all the residents on 3-West were in their rooms for the noon meal. NA-M passed drinks to the residents who resided on 3-West. NA-M's eye shield was on top of her head. NA-L sat at the nurse's desk without eye protection on. During an observation on 9/16/22, at 12:36 p.m. NA-M's eye protection remained on top of her head as she was removing trays from resident rooms on 3-West. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 9/16/22, at 1:15 p.m. PPE cart outside of R16's room on 2-East unit was noted to have four paper bags that were open and labeled with four different staff names. Each paper bag contained N95 masks. During an interview on 9/14/22, at 12:29 p.m. TMA-A stated the brown paper bags on all the PPE carts was where they kept the face shields and N95's so that they could be reused. TMA-A explained they reused the same N95 for the entire 10 days a COVID positive resident that was on TBP. TMA-A indicated if a resident was positive for COVID their door was supposed to be shut. TMA-A stated R4 was not compliant, he liked to have his door open because of anxiety. TMA-A indicated there was no interventions in place as a result R4 being non-compliant with shutting his door to mitigate risk of COVID-19 spread. During an interview on 9/14/22, at 2:30 p.m. LPN-A verified that R4 tested positive for COVID yesterday (9/13/22). LPN-A stated, R4 did not like to keep his door closed, but should have it closed because he tested positive for COVID. LPN-A then attempted to get R4 to close his door however R4 refused. During an interview on 9/14/22, at 2:44 p.m. the DON verified that they do not test staff for COVID unless they were having symptoms or in outbreak status. DON stated there were 25 staff who were not vaccinated that had medical or religious exemptions; they had been testing twice weekly prior to the outbreak. DON indicated contributing factors of the COVID spread were positive residents who refused to stay quarantined. For example, R19 tested positive yesterday (9/13/22), he continued to go out front to smoke with other residents. DON stated staff would encourage him to keep a mask on. R10 was a resident who refused to stay in her room and wear a mask, so she discharged back home. DON indicated staff tried their best to encourage residents who were not compliant to use a mask and keep their distance from others when they were not in their rooms. DON stated they have had problems with getting all staff to wear PPE appropriately and has been an ongoing problem. DON explained a family member had recently reported they saw a nurse on the evening shift walk into a COVID positive room with no mask on. In response we had all the clinical coordinators of each unit verbally re-educate staff on using appropriate PPE. DON could not recall the date and stated there was no documentation of the education. DON stated the facility had not conducted infection control audits to ascertain breaks in infection prevention measures or if staff appropriately implemented the provided education. DON indicated she was not aware that R4 had been refusing to keep his door shut. DON stated because R4's room is in a high traffic area, his door should remain closed. During a phone interview on 9/14/22, at 3:46 p.m. Infection Control Preventionist (ICP)-A verified she was the Infection preventionist for the facility. ICP-A stated she had not been in the facility since 9/1/22 and had been working remotely. ICP-A verified R5 was the first person to test positive on 8/27/22. He was not feeling good, ICP-A could not articulate when his symptoms started or what they were. ICP-A assumed R5 contracted COVID during an outing with family. ICP-A verified that two activity staff had tested positive the same day. ICP-A stated she had come into work on 8/27/22, tested all the residents and the staff that had been working that day. The rest of the staff were tested on [DATE]. We started testing twice a week on Tuesdays and Fridays. ICP-A explained R5 was a person that would not wear a mask, was not compliant with TBP, and would not stay in his room. ICP-A indicated after the positive result, no additional prevention measures were implemented because staff were already supposed to be doing hand hygiene and wearing appropriate PPE with COVID positive residents. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a phone interview on 9/15/22, at 2:21 p.m, ICP-A stated staff tested themselves when they came in through the employee entrance before their shift. ICP-A indicated she did not track staff symptoms. ICP-A explained staff would leave their tests on the table for her or another nurse to verify the results. ICP-A stated she was not tracking to ensure all staff were following the testing schedule. ICP-A indicated staff knew how to perform the test as they had been doing it for so long. ICP-A stated the first two staff that tested positive on 8/27/22, were from the activity department. ICP-A did not ask if the activity staff had symptoms, they just tested positive. Another activity staff tested positive the next day on 8/28/22. ICP-A stated the eight residents that required the use of a ventilator would be considered high risk residents, however the facility had not put any additional prevention measures in place to protect those residents. ICP-A verified three of the eight ventilator residents had tested positive; R7 was the first one. ICP-A stated R7 was highly involved in activities and did not like to wear her mask. ICP-A verified she was aware that R19 was not following isolation precautions and had been going up and down the halls (where the high-risk residents resided) without a mask and going outside around others to smoke. ICP-A stated the administrator on 9/15/22, put a plan in place that staff need to escort him out and ensure he is wearing PPE and to have him smoke by the employee entrance away from others. ICP-A verified she was aware that R4 tested positive and did not keep his door closed. ICP-A indicated no additional measures had been implemented for R4 and maybe the facility could put a clear zippered door up. ICP-A was not aware that NA-F and NA-G were not wearing appropriate eyewear on a unit with four positive COVID residents. ICP-A stated NA-F and NA-G had not been vaccinated and had exemptions; they should absolutely be wearing appropriate PPE. ICP-A indicated no additional protection measures had been implemented for staff who had exemptions. We have educated and re-educated staff regarding PPE and nothing changes. ICP-A stated after the outbreak on 8/27/22, there was no surveillance and/or tracking and trending analysis completed. ICP-A stated for each COVID positive resident there should be a full assessment each shift during the duration of their COVID to include a set of vital signs, lungs sounds and any signs or symptoms they may be having and was not be done consistently for each positive resident. ICP-A indicated she did not keep a log of the county transmission rate but looked at it every two weeks. The community transmission rate was high in the area during this time period. ICP-A stated she didn't think all the staff had been fit tested for N95's and did not think the facility had the kits to complete the testing. During an interview on 9/16/22, at 9:03 a.m. DON was notified staff were testing themselves with no over sight and not all staff were aware of how long they needed to wait before they read the results. She was also notified staff were not consistently wearing appropriate PPE or performing hand hygiene before, during, and after doing the test. DON stated all staff should be wearing proper PPE such as goggles when walking through patient area especially during an outbreak. DON confirmed staff were re-using N95's for the duration of isolation in absence of a shortage. DON stated they just changed it to one mask per resident per shift instead the 10 days of isolation. DON reported R20, who was a smoker, tested positive this morning. DON guessed R20 he got it from R19 who was non-compliant with masking and going outside. During an interview on 9/16/22, at 1:37 p.m. NA-C indicated the facility had enough N95's, however, they were re-using them. NA-C stated they should not be sitting out in open bags in the hallway. NA-C went into R16's room leaving the dirty masks sitting out. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/16/22, at 1:50 p.m. the administrator verified they were re-using the N95 masks; one mask per shift per resident. Stated the bags outside the rooms should be closed. The administrator identified they have always reused N95 masks and was unaware N95's should only be reused when there is a limited supply. Facility policy titled, Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures, revised July 2020, indicated, this facility follows recommended standard and transmission-based precautions, environmental cleaning, and social distancing practices to prevent the transmission of COVID-19 within the facility. 2. While in the building, personnel are required to strictly adhere to established infection prevention and control policies, including a. hand hygiene; b. respiratory hygiene; c. appropriate use of PPE; g. surveillance and reporting of respiratory infections;. Source Control 1.To address asymptomatic and pre-symptomatic transmission, universal source control is required. A anyone entering the facility is required to wear a face covering. (2) Staff are required to wear face coverings upon entering the facility and prior to leaving the building. a) Staff should wear a facemask at all times when in the facility. b) At the end of shift, staff are required to remove facemask, discard in appropriate receptacle, perform hand hygiene 2. Staff wear eye protection during any resident-care encounters or procedures as per county covid transmission rates. (see attachment 1) 3. For a resident with known or suspected COVID-19: a. Staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available (a facemask is an acceptable alternative if a respirator is not available); and b. Resident is placed in a private room with a dedicated bathroom (if available) and closed door; OR c. Resident is cohorted per national, state, or local public health authority recommendations. 4. If there is moderate to substantial COVID-19 transmission in the surrounding community: a. Staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability). b. Residents are restricted (to the extent possible) to their rooms except for medically necessary purposes. c. When residents have to leave their room, they wear a facemask, perform hand hygiene, limit their movement in the facility, and practice physical distancing. 3. Infection prevention and control self-assessment is guided by the COVID-19 Focused Survey for Nursing Homes. Facility policy titled, Isolation-Categories of Transmission-Based Precautions, revised October 2018, indicated transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to others. 2.Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. 3.The Centers for Disease Control and Prevention (CDC) maintains a list of diseases, modes of transmission and recommended precautions. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures. 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notifications comply with the resident's right to confidentiality or privacy. The IJ that was identified on 9/16/22, at 2:17 p.m. was removed on 9/20/22, at 3:12 p.m. when it could be verified the facility developed and implemented an acceptable removal plan including: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Provided re-education to all staff on appropriate hand hygiene and PPE usage. -Reviewed policy and procedures for N95 mask usage. Developed and implemented a plan for testing staff and provided staff education for appropriate utilization. -Facility identified high risk residents. Additional protection measures were developed and implemented. -Vaccine policy's were reviewed and updated to reflect CDC guidance. Staff was provided education. -Reviewed residents who were non-compliant with isolation and quarantine, interventions were developed, added to the care plans, and implemented by staff. -Developed and implemented a comprehensive surveillance system with tracking, trending, and analysis of infection transmission.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. 38685 Based on interview and document review, the facility failed to inform residents, resident representatives, and families of those residing in the facility by 5:00 p.m. the next calendar day following the occurrence of each single confirmed infection or three or more residents or staff with new onset of respiratory symptoms within 72 hours of each other during facility's COVID outbreak. In addition, the facility failed to include mitigating actions taken by the facility to prevent or reduce risk of transmission in the notification to residents, families, and resident representatives. This had the potential to affect all residents who resided in the facility, their families, and resident representatives. Findings include: Review of list provided by facility dated 9/20/22, revealed the following number of residents or staff who tested positive for COVID-19: 8/27/22, three tested positive 8/28/22, one tested positive 8/29/22, one tested positive 8/30/22, two tested positive 9/1/22, one tested postive 9/2/22, three tested positive 9/3/22, one tested positive 9/6/22, five tested positive 9/7/22, two tested positive 9/8/22, two tested positive 9/9/22, one tested positive 9/11/22, four tested positive 9/13/22, five tested positive 9/15/22, one tested positive 9/16/22, one tested positive. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility's website as of 9/16/22, revealed facility website was updated on 8/31/22 with COVID status updates for 8/28/22, indicating the facility had four staff and one resident who were positive for COVID-19. Further review of facility's website revealed the website was updated on 9/6/22, 9/8/22, 9/16/22, and 9/19/22. On 9/15/22, at 3:53 p.m. resident representative (RR)-A indicated they are not getting many updates from the facility regarding positive COVID-19 cases, so either they are not having positives, or I am not getting updates when they do. On 9/16/22, at 11:04 a.m. infection control preventionist (ICP) stated the facility process for updating residents, families and representatives was she would email the social services director (SSD) every time there was a new positive case in residents or staff. SSD then would send a letter to families and update the facility website and Facebook page. ICP indicated she would update residents regarding continued positive cases of COVID-19 only on testing days (Tuesdays and Fridays) On 9/16/22, at 12:20 p.m. SSD indicated the facility process for updating residents, families, and resident representatives was she would notify families and representatives by email or a phone call at the beginning of the facility's new outbreak. SSD confirmed residents are not updated at that time. Further, SSD indicated families and resident representatives were notified within 24-hours of the first positive case but not following subsequent cases after the outbreak. SSD confirmed she was not aware of the 5:00 p.m. on the next calendar day deadline to notify residents, family, and resident representatives. In addition, SSD stated she updated families and resident representatives following the facility's most recent outbreak on 8/28/22, but could not provide any further details or evidence the notifications were sent out timely. SSD confirmed she did not update the facility's website until 8/31/22, following the new facility outbreak on 8/28/22. On 9/19/22, at 1:32 p.m. director of nursing (DON) indicated SSD was expected to update the website, following each testing day, with the facility's COVID-19 status. DON confirmed she was not aware residents, families, and resident representatives had to be notified by 5:00 p.m. the following calendar day of a new positive case. Review of Centers for Medicare and Medicaid Services document titled Interim Final Rule updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes dated 5/6/20, directs the facility to inform residents, their representatives, and families of those residing in facilities by 5:00 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three of more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other. In addition, this information much 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 include a cumulative updates at least weekly or by 5:00 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. A policy regarding reporting to facility COVID-19 data to residents, family, and resident representatives was requested but not provided by the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview and document review the facility failed to implement outbreak testing, develop, and monitor a tracking system to help identify and prevent the transmission of COVID-19 per CDC guidelines. This resulted in an immediate jeopardy when staff testing's were not completed per standards of practices or monitored prior to them working during an outbreak. This practice resulted with 5 of 5 units in the facility having COVID-19 residents. This had the potential to affect all 74 residents at the time of the survey, staff, and visitors in the facility. The immediate jeopardy began on 8/27/22, when R5 and activity (A)-A and A-B tested positive for COVID-19 and the facility did not implement appropriate testing of staff, did not ensure all staff were testing, and did not track testing during an outbreak. The IJ was removed on 9/19/22, at 3:17 p.m., noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: Review of Staff and Resident Vaccination Record between 8/27/22 and 9/16/22, identified a spread to 5 of 5 units with 18 residents and 17 staff members positive for COVID-19. During a telephone interview on 9/14/22, at 3:46 p.m. Infection Control Preventionist (ICP)-A verified she was the Infection preventionist for the facility. ICP-A stated R5 was the first resident to test positive on 8/27/22. ICP-A stated she had come into work on 8/27/22, to complete outbreak testing. She tested all the residents in the facility, however only tested the staff that had been working that day. The rest of the staff were tested on [DATE], three days after the outbreak. ICP-A indicated because of the outbreak we were testing twice a week on Tuesday and Fridays. Review of staff COVID-19 test logs from 8/4/22 to 9/15/22, identified 55 staff testing entries out of 415 entires did not identify if they were neither positive or negative and were left blank. The testing logs identified only 6 staff were postive however there were 17 total staff members that were positive by the facility. The logs did not identify if positive staff members were sent home or if they were symptomatic. The other 11 postiive staff were not identified in the COVID-19 test logs. Additional logs were requested for 9/16/22 although did not receive. During an interview on 9/14/22, at 2:44 p.m. the DON indicated the facility was testing all staff twice a week for outbreak status. DON indicated prior to the outbreak staff who were not up to date or had exemptions tested twice a week and staff who were up to date would test if they were symptomatic. DON stated there are 25 staff with exemptions who tested twice weekly prior to the outbreak. During a phone interview on 9/15/22, at 2:21 p.m. infection control preventionist (ICP)-A stated, the staff test themselves upon entrance and before their shift. ICP-A said the staff leave their tests at the entrance to be checked and if positive, they have a nurse verify. ICP-A indicated staff were supposed to wait in the entrance for 15 minutes per manufaturer's recommnedations to read the results before entering the facility. (continued on next page)

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	245223	A. Building B. Wing	09/19/2022

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	ICP-A confirmed the facility did not have a system in place to verify and track staff testing and was not comparing who tested with the current staff schedule. IPC-A stated, staff have been doing this for so long staff just know when and how they are supposed to test its like second nature. ICP-A said the first 2 staff who tested positive worked in the activity department and confirmed 8/27/22 was also the same date R5 tested positive. ICP-A was not aware if staff that tested posiive were symptomatic or not. ICP-A stated she had not kept a log of the county transmission rate, however, checked the rate every two weeks. During an interview on 9/15/22, at 4:36 p.m. maintenance-B stated since the outbreak staff tested themselves twice a week at the employee entrance. Maintenance-B explained he would swab his nose and place the test on the table. He was not aware of how long to wait before the test could be read, who was checking the results, or when this was compelted. Maintenance-B stated no one has showed us how to do the tests quite awhile. During an observation on 9/16/22, at 6:29 a.m. of the employee time clock entrance. There was a brown table with a sign-in sheet for the date, name, and results of Covid test. There was a box of BinaxNOW COVID tests, and a container of sanitizing hand wipes. No gloves observed in the immediate area, hand sanitizer on the wall. On top of the same table were three used COVID test cards. The tip of the nasal swab was not visible, the end of the swab was sticking out of the bottom end of the card. All three tests had staff names on them (TMA-C, NA-E and NA-K). None of the tests had identified when the test were performed and/or when the test needed to be read for results. No staff were around to verify results. The sign-in sheet identified test results were negative for all 3 staff identified; the sheet did not include and/or identify an area for verification of the individual results. During an interview on 9/16/22, at 6:29 a.m. NA-E and NA-K indicated they had started their shifts at 6:00 a. m. Neither were able to articulate who was checking the tests for accuracy or when the tests would be checked. During an interview on 9/16/22, at 6:41 a.m. LPN-A stated staff who test for COVID walk in the employee entrance and write test results on a sheet. LPN-A said staff must wait 10 minutes to check the results. LPN-A said if there are tests lying on the table, no one has looked at them yet to verify if they are positive or negative. During an interview on 9/16/22, at 6:47 a.m. registered nurse (RN)-B, stated staff currently test twice weekly. The kits are at the employee entrance and everyone self-tests. RN-B said if there are tests lying on the table, staff just throw them away and make sure the results are written down. RN-B said no one is monitoring the process and staff are responsible for themselves. During an interview on 9/16/22, at 6:57 a.m. LPN-D stated staff walk in the employee entrance on test days, test themselves, wait 15 minutes and then write down the results. LPN-D said some staff wait 15 minutes for the results, some don't. LPN-D said someone will go through the tests later and check them. If it is positive, it usually pops up right away. During an interview on 9/16/22, at 7:54 a.m. NA-E stated she tested this morning and wrote her results down as negative, stated she waited 10 minutes for the results and left her test lay on the table at the employee entrance. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on 9/16/22, at 7:56 a.m. laundry lead (LL)-B walks in through employee entrance with other staff in immediate area, puts mask on, clocks in, goes to the table writes his name on the sign in sheet, swabs his nose, puts mask back on, adds solution and lays his test on the table. No gloves or hand hygiene observed. At 8:02 a.m. LL-B stated, he usually waits 5 minutes for the test results. LL-B stated, mine is negative, leaves test lay on the table and walked to a door with stairs. The test noted to have 1 pink line; indicating negative for COVID-19. During an observation on 9/16/22, at 8:04 a.m. health information (HI)-A walked through the employee entrance with her mask under her nose, wrote her name on the sign in sheet, grabbed a test, swabbed her nose laid the test on the table and walked to the door that led to the stairs without verifying her test results before working. During an interview on 9/16/22, at 8:07 a.m. receptionist (R)-A stated, staff test twice a week, and lay the test on the table, the nurse will come later and check our results. R-A was not sure what the wait time was, R-A said either 10 or 15 minutes. During an observation on 9/16/22, at 8:38 a.m.LPN-B was in the employee entrance and stated she had just checked all the test that were on the table and threw them away. They were all negative. During an interview on 9/16/22, at 8:47 a.m. LPN-F picks a test off the table, it was observed to be HSK-A's test with the time of 9:00 am. LPN-F stated, well it's not even 9:00 yet. Oh well, maybe the test is from yesterday, well it doesn't matter she just literally got done with having COVID. During an interview and document review on 9/16/22, at 9:03 a.m. DON was notified staff who were self-testing and not all staff were aware of how long to wait to read and record the results of the test. DON verified the manufacturer instructions the test staff were using needed to be read for the results in 15 minutes. The instructions read, To ensure proper test performance, it is important to read the result promptly at 15 minutes and not before. Results should not be read after 30 minutes. DON stated, we do not have anyone particularly monitoring the staff testing. DON indicated the need to get someone to do monitoring if staff are not testing according to the instructions. On 9/19/22, at 1:32 p.m. DON indicated she expected staff to be up to date with their vaccinations or an approved exemption before working in the facility and assisting residents. DON indicated having staff not up to date or had an approved exemption would be important to keep residents and staff safe by minimizing the spread of COVID-19. Review of facility policy titled COVID-19 Vaccine Policies and Procedures dated 11/19/21, indicated facility mandated all staff are vaccinated against COVID-19 unless they have a medical or religious exemption to help reduce the risk residents and staff have of contracting and spreading COVID-19. Further review of policy defined fully vaccinated as being 2 weeks or more since completion of primary vaccination series for COVID-19, and boosters or additional doses are not required to be considered fully vaccinated. However, facility policy lacked evidence of updated CDC guidance for recommended booster shots if eligible. In addition, facility policy indicated new hires must have received at minimum the first dose of a two dose COVID-19 vaccine or a one dose COVID-19 vaccine prior to providing any care, treatment, or other services for the facility and/or its patients. However, policy lacked evidence of process for new hires who plan to file an exemption, and the expectation of completion to get an approved exemption prior to providing care, treatment, or other services for the facility and/or its patients (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The IJ which began on 8/27/22, was removed on 9/19/22, at 3:17 p.m. when it could be verified through observation, interview and document review the facility had developed and implemented policies to reflect protocols for testing procedures and tracking to ensure all staff were tested for COVID-19 in a manner consistent with current standards of practice for conducting and tracking COVID-19 tests; education was provided to all staff on current and updated COVID protocols for staff and would continue for continued outbreak testing; and completion of testing and training would be tracked, analyzed, and acted on to ensure compliance with routine and outbreak testing.

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 38685 Based on interview and document review, the facility failed to ensure a policy and procedure to ensure newly hired staff were either vaccinated or had a qualifying exemption prior to providing direct care to residents and failed to ensure 1 of 133 staff were fully vaccinated for COVID-19 or were provided a medical or religious exemption. This resulted in a 99% vaccination rate for the facility which created the potential for the spread of the COVID-19 virus. Findings include: Review of facility's document titled COVID-19 Staff Vaccination Status for Providers dated 9/16/22, one off 133 staff members were not fully vaccinated and did not have an exemption or identified a delay. During an interivew on 9/15/22, at 1:44 p.m. registered nurse (RN)-A indicated upon hire she was offered the COVID-19 vaccine and provided with the non-medical exemption paperwork to complete. RN-A stated she had completed her online orientation modules. On 9/13/22, she had shadowed the floor nurse, RN-A stated I went everywhere she went I was her shadow including into residents ' rooms that were COVID positive. RN-A confirmed she had not completed her exemption paperwork. Facility staff listing identified RN-A's hire date was 9/1/22. Facility schedule identified RN-A worked the day shift on 9/14/22, and was assigned to the 3 [NAME] unit. During an interview on 9/16/22, at 8:38 p.m. infection control preventionist (ICP) indicated she oversaw the staff vaccination log and ensured the staff are vaccinated appropriately. ICP defined completely vaccinated as having the primary series completed and up to date was referring to the booster shot. ICP stated she was unsure of RN-A's vaccination status and stated the facility process for new hires included giving the new staff up to 30 days to decide on vaccination status and/or complete exemption paperwork. During the 30-day period, the new staff were allowed to work in the facility and assist residents. In addition, ICP stated the importance of staff being fully vaccinated was for the safety of the residents and reducing the risk of spreading COVID-19. During an interview on 9/19/22, at 1:32 p.m. director of nursing (DON) indicated she expected staff to be fully vaccinated or an approved exemption before working in the facility and assisting residents. DON stated new hires were expected to determine vaccination status, including having an approved exemption, before being scheduled to work with residents as well. Further, DON confirmed she was not aware of RN-A assisting on the floor with no vaccination status on file, no approved or pending exemption, and no approved delay. DON stated ICP would oversee all staff vaccination records. DON indicated having staff being fully vaccinated or an approved exemption would be important to keep residents and staff safe by minimizing the spread of COVID-19. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility policy titled COVID-19 Vaccine Policies and Procedures dated 11/19/21, did not identify a process for new hires who plan to file an exemption, and the expectation of completion to get an approved exemption prior to providing care, treatment, or other services for the facility and/or its patients. The policy indicated facility mandated all staff are vaccinated against COVID-19 unless they have a medical or religious exemption to help reduce the risk residents and staff have of contracting and spreading COVID-19. Further review of policy defined fully vaccinated as being 2 weeks or more since completion of primary vaccination series for COVID-19, and boosters or additional doses are not required to be considered fully vaccinated. policy lacked evidence of process for new hires who plan to file an exemption, and .