STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056361	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37797 Based on interview and record review, the facility failed to notify the physician of the positive test results for four days for one of 37 residents (Resident 1) who tested positive for COVID-19 during the first 10 days of a facility outbreak. This resulted in a delay of four days in starting the antiviral for a vulnerable resident with comorbities. Findings: During a record review and concurrent interview on 5/26/22 at 1:15 p.m., Director of Nursing (DON) described the symptoms experienced by each of the residents on the line list for the facility's COVID-19 outbreak. The line list, dated 5/25/22, indicated Resident 1 tested positive for COVID-19 on 5/20/22, along with six other residents on that day. DON stated Resident 1 had respiratory symptoms at his baseline and that he was experiencing an increased cough and runny nose. During an interview on 5/27/22 at 11:30 a.m., Licensed Nurse J stated residents' positive COVID tests were reported to upper management including the DON. When asked who reported the positive COVID test results to the resident's physician, Licensed Nurse J stated it depended on the scenerio. Licensed Nurse J stated, It could be the nurse or the DON, it just depends who's involved. Licensed Nurse J stated the DON ultimately makes sure it is reported, and they try to report it within 24 hours or the same day. Licensed Nurse J stated it had been so chaotic lately with so many residents positive for COVID at once that they could not report to the physician immediately. During an interview on 5/27/22 at 1:15 p.m., when asked where they were documenting physician notification of residents' positive COVID tests, DON stated the physcians had been notified by text or phone, but documentation of physician notification had been delayed due to prioritizing patient care. DON stated now that staffing was better, she could get caught up on documentation of the notifications. DON stated, I know if it's not documented, I didn't do it. DON stated the physician's order for an antiviral for COVID-19 was the only documentation of notification at this point. DON stated that the medical director wanted any residents positive for COVID to be on an antiviral even if they did not have severe symptoms due to the congregate living situation and the residents' comorbidities. Review of Resident 1's medical record revealed a physician order for an antiviral medication for COVID-19 dated 5/24/22 by Physician A. Review of Resident 1's progress notes revealed no documentation Physician A was notified of his COVID-positive status. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/23/22 at 1 p.m., DON verified there was a delay of four days in notifying Physician A of Resident 1's COVID-positive status. DON stated Physician A wanted to be notified of her patients' positive test results and get antivirals for COVID ordered for them timely. DON stated the nurse in the Yellow Zone (unit for residents who have been exposed to COVID-19 but have not yet tested positive) or herself were responsible for notifying the physician of a positive test result, but there was no designated person. DON stated in future outbreaks she would make sure they had someone designated as responsible for this task. Review of facility policy and procedure Change of Condition Notification, last revised 4/1/15, revealed, A Licensed Nurse will notify the Attending Physician of routine laboratory, diagnostic test results as soon as possible after received. a. Document notification on the reports and progress notes.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on interview and record review, the facility failed to report to the Department one allegation of physical abuse for one of two sampled residents (Resident 32). This failure prevented the Department from timely investigating the abuse allegation involving Resident 32. Findings: During a review of Resident 32's, Admission Record, dated 7/29/16 indicated Resident 32 was admitted to the facility on [DATE] with a history of Parkinson's' disease (a disorder of the central nervous system that affects movement, often including tremors), paranoid disorder (an unrealistic distrust of others or a feeling of being persecuted), schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly) and high blood pressure. During a review of Resident 32's Quarterly MDS (Minimum Data Set, a clinical assessment process which provides comprehensive assessment of resident's functional capabilities and helps staff identify health problems) dated 2/21/22, indicated Resident 32 had a BIMS (Brief Interview of Mental Status) score of 99, meaning she was unable to answer any of the questions due to having severe cognitive impairment. During an observation on 7/20/22 at 8:33 a.m., with Resident 32, she was in the dining room without other residents and was observed yelling to herself. Resident 32 was observed to be having a conversation with herself, answering questions while walking around the room independently. Resident 32 was observed to calm down quickly without staff intervention and remained having an internal conversation. During a review of Resident 32's, Activity Progress Note, dated 2/1/22 indicated Resident 32 had punched another resident as she was passing, and it was unclear why since the other resident was not speaking with Resident 32. The progress note indicated a nurse was informed of the incident. During an interview on 7/20/22 at 4:30 p.m., Director of Nursing (DON) stated she thought the incident had not been reported because the resident who was punched denied the event occurred. DON stated if the incident had occurred as indicated in the medical record, then the event should have been reported to the Department and she could not find a record of the report. During an interview on 7/20/22 at 4:55 p.m., Administrator stated he had only been hired at the facility a few weeks before and could not find a record of the report. Administrator stated he was told the resident who was punched had denied the event occurred and could not provide further details. During an interview on 7/21/22 at 11:39 a.m., Certified Nursing Assistant B (CNAB) stated Resident 32 would often speak to herself, but the staff would intervene to prevent violence among the residents. CNAB stated she had never seen Resident 32 become aggressive with other residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/21/22 at 12:48 p.m., Licensed Staff A stated she had never witnessed Resident 32 hitting or punching another resident. Licensed Staff A stated she would report any type of event to management. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program, dated 1/30/20, the P&P indicated, To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment .Staff must not permit anyone to engage in verbal, mental or physical abuse .III Training A. All employees, contractors and volunteers will be trained through orientation and ongoing training sessions, no less than annually, on the following topics: Who is a covered individual responsible for reporting .III. Identification and recognition of signs and symptoms of abuse/neglect .VI. Reporting and documentation of abuse and neglect .X Penalties associated with failure to report .D The Facility posts information regarding procedures for reporting concerns or suspicion of abuse throughout the facility for Facility Staff .A. Staff, residents and families will be able to report concerns, incidents .E. The Facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met .C. The Facility maintains a Compliance Hotline to allow anonymous reporting of abuse .A. The Facility promptly and thoroughly investigates reports of resident abuse .A. Facility Staff are Mandatory Reporters .B. Administrator, or his/her designee, as Abuse Coordinator i. In order to facilitate reporting, ensure confidentiality, and promote order at the Facility, the Administrator, or his/her designee of the Facility shall be the individual who reports known or suspected instances of abuse of residents at the Facility to proper authorities .ii. Facility Staff will report known or suspected

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39792 Based on observation, interview and record review, the facility failed to provide showers as scheduled for two (Resident 26 and 43) out of 4 sampled residents. The failure had the potential to resulted in residents being dirty and unkempt. Findings: 1. During a review of Resident 26's, Admission Record:, dated 6/23/19, indicated Resident 26 had been admitted to the facility on [DATE] with a history of chronic kidney disease, immunodeficiency (a state in which the immune system's ability to fight infectious disease and cancer is compromised or absent) and obstructive sleep apnea (intermittent air flow blockage during sleep). During a review of Resident 26's Quarterly MDS (Minimum Data Set, a clinical assessment process which provided a comprehensive assessment of resident's functional capabilities and helped staff identify health problems), dated 3/23/22, indicated Resident 26 had a BIM (Brief Interview of Mental Status) score of 12, indicating mild mental or cognition impairment. During an interview on 7/19/22 at 11:01 a.m., with Resident 26 and his Family Member (FM), Resident 26 was observed to be laying down asleep with FM sitting in chair quietly beside the bed. Resident 26 woke up and started a conversation. Resident 26 stated he was being provided shower assistance twice a week without any problems. FM stated she had been there sitting in his room all day for the past five days and Resident 26 had not had a shower within those five days. FM stated she had observed Resident 26 was offered a shower twice, Resident 26 was asleep and requested to shower later but staff did not return to offer shower assistance. FM stated Resident 26 would need a shower and she could tell he had not had a shower during her absence between those daily visits. During an interview on 7/21/22 at 10:01 a.m., with Certified Nursing Assistant C (CNA), CNA C stated Resident 26 would require minimal assistance with showers but was unable to complete them himself. CNA C stated Resident 26 refused showers and there was a book where shower refusals were documented and then there was another book where the staff were supposed to document when a shower had been provided. CNA C stated Resident 26 did not like to get up in the morning and his showers were scheduled for the evening shift or later in the afternoon. During an interview on 7/21/22 at 11:39 a.m., with CNA B, CNA B stated Resident 26 would sometimes refuse to take a shower but the staff were expected to ask a resident three times before they were allowed to document there was a refusal. CNA B stated some other staff members only ask residents once if they want a shower and then document the resident refused, we were required to have the resident sign a refusal form if they did not want a shower. During an interview on 7/21/22 at 12: 48 p.m., with Licensed Nurse (LN) A, LN A stated Resident 26 did not refuse showers very often as much as she could remember. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 43's, Admission Record, dated 9/13/18, indicated Resident 43 was admitted to the facility on [DATE] with a history of epilepsy (a disorder in which nerve cell activity in the brain is disturbed causing seizures (a sudden uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements or feelings and in level of consciousness) and muscle weakness. During a review of Resident 43's Quarterly MDS (Minimum Data Set, a clinical assessment process which provided a comprehensive assessment of resident's functional capabilities and helped staff identify health problems), dated 6/15/22, indicated Resident 43 had a BIMS (Brief Interview of Mental Status) score of 14 out of 15 possible, indicating no mental or cognition impairment. During an interview on 7/21/22 at 3:26 p.m., Resident 43 stated she was not being provided her twice weekly scheduled showers. Resident 43 stated she was not sure when she was supposed to be provided showers (which days of the week) and stated she was being provided showers this week but this had been the first time. During an interview on 7/26/22 at 2:56 p.m., Certified Nursing Assistant (CNA) D, stated Resident 43 sometimes would want a shower on the scheduled shower day and sometimes Resident 43 would not want a shower on her scheduled shower day. CNA D stated in caring for Resident 43, she would need a pre-arranged scheduled time to prepare for a shower, like would it be okay to have a shower in two hours. CNA D stated Resident 43 would refuse to have shower if the staff just presented themselves and told her it was time to take a shower. During an interview on 7/26/22 at 2:25 p.m., Licensed Staff (LS) A stated if a resident refused to have a shower, she would then encourage them to take a shower. LS A stated if a resident refused to have a shower, then she would request that the Resident sign a shower refusal form and if they (resident) were unable to sign the form, then she would sign the form. LS A stated she had not worked with Resident 43 and did not remember asking Resident 43 to sign a shower refusal form. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent document and record review on 7/27/22 at 10:02 a.m., with Director of Nursing (DON), DON stated there were multiple documents which the staff used to indicate if a Resident was provided a shower, was not provided a shower or refused. DON stated these are the documents the facility would use, 1) ADL (Activity of Daily Living) Flow Sheet where the staff document daily and specifically which shift a task like showers was completed, 2) Shower Assessment Worksheet where staff, specifically the CNA, would document the date a shower was given and if a resident refused how many times the resident had been offered to have a shower, the nurse would sign the form as acknowledgment and the DON would sign the form as way of tracking which residents were refusing showers each day (one form per day), 3) Shower Schedule where the date, day of the week and the room number were documented and the staff member who assisted the resident in having a shower would initial next to the room number (documented by the week per page) and 4) Shower Refusal Sheet where the date and signatures from Resident, CNA, Nurse and DON would be documented on the form (single page document for each date of occurrence). DON stated at one point, there was also a shower log which she would document which residents were being provided showers and which residents were not to ensure all residents were getting their scheduled showers (the log was not observed nor provided during the survey). DON stated the residents in the facility were being provided scheduled showers two times a week (scheduled days of the week, like Wednesday and Saturday) to be spaced about 72 hours apart. A review of Resident 26's, ADL Flowsheet, dated, May 2022, was reviewed and indicated Resident 26 was assisted with two showers (5/4/22 and 5/13/22) for the month. A review of Resident 26's, Shower Assessment Worksheet, dated 5/13/22 ad 5/25/22 indicated Resident 26 had two showers that month. DON stated there was a discrepancy regarding how the staff would documents Resident 26 having showers (5/25/22 was not documented on both forms). DON stated there were no refusals documented on the form or on the ADL Flowsheet (staff would mark an R to indicate refusal). DON stated Resident 26 would have had an opportunity to have seven to nine showers (for the month); but per the shower schedule Resident 26 had two showers documented on the ADL Flowsheet and the third date (5/25/22) was documented on the Shower Assessment Worksheet. DON stated if Resident 26 was in the isolation unit during the month of May, 2022, then he should have been provided an opportunity for showers two times a week and being in an isolation unit would not have made a difference. A review of Resident 26's, ADL Flowsheet dated June 2022 was reviewed and indicated Resident 26 had four showers (6/17/22, 6/19/22, 6/20/22 and 6/24/22) out of eight scheduled shower opportunities. DON stated Resident 26 should not have had two showers, two days in a row (6/19/22 and 6/20/22) since showers were scheduled 72 hours apart. DON stated there were no documented refusals on the ADL Flowsheet for the month of June (2022). DON stated she could not explain why Resident 26 was not provided his scheduled showers. A review of Resident 26's, Shower Assessment Worksheet, dated 6/24/22 indicated Resident 26 had one shower for the month of June since there was no shower assessment worksheets to correspond with the showers documented on the ADL Flowsheet. DON stated the shower schedule was adjusted to ensure all the residents were given their scheduled showers. DON could not explain why Resident 26 was not provided his scheduled showers and could not explain the discrepancy in documentation. A review of Resident 26's, ADL Flowsheet, dated July 2022, was reviewed and indicated Resident 26 had four showers (7/1/22, 7/5/22, 7/14/22 and 7/22) out of seven scheduled showers. A review of Resident 26's, Shower Assessment Worksheet dated 7/1/22 indicated he refused, 7/5/22 indicated he had a shower and 7/15/22 indicated he had shower for a total of three documented showers out of seven scheduled showers. DON stated she could not explain the discrepancy in documentation regarding 7/1/22 where one document indicated Resident 26 was provided a shower and another document indicated Resident 26 had refused a shower; but DON did state Resident 26 was not provided all of his scheduled showers. DON could not explain why Resident 26 had not received all of his scheduled showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/27/22 at 11:14 a.m., with DON, Resident 43's, ADL Flowsheet, dated May 2022, was reviewed and indicated Resident 43 was provided two showers (5/11/22 and 5/29/22) for the month of May. DON stated the ADL Flowsheet documentation was not as accurate as the shower schedule document. A review of Resident 43's, Shower Schedule dated from 5/2/22 to 5/31/22 was reviewed and Resident 43 was given one shower on 5/11/22. A review of Resident 43's, Shower Assessment Worksheet, dated 5/11/22 and 5/29/22 indicated she had two showers out of eight scheduled showers. DON stated during the month of May (2022), the facility had a widespread COVID-19 (an illness caused by a novel coronavirus which causes severe acute respiratory syndrome) outbreak so there was a lot going on in the building. DON stated the documentation across the multiple forms to address if a resident was getting their scheduled showers was not consistent, but she stated the Shower Schedule weekly document where the staff would initial the room number to denote date when a resident had a shower was the most accurate document. DON was observed looking through multiple pages to see if there was documentation to indicate Resident 43 had more showers provided on other days than the scheduled days and could not find documentation. A review of Resident 43's, Shower Schedule dated from 6/1/22 to 6/29/22 indicated Resident 43 had three showers (6/4/22, 6/15 and 6/18/22 out of nine scheduled showers. A review of Resident 43's, Shower Schedule, dated 7/1/22 to 7/23/22, indicated she was provided five showers (7/2/22, 7/6/2, 7/9/22, 7/20 and 7/23/22) but was not provided showers the week of 7/11/22 to 7/16/22. DON stated she could not explain why Resident 43 was not provided showers the week of 7/11/22 to 7/16/22. DON stated the shower assessment worksheet should correspond with the shower schedule documentation and could not explain the discrepancy in documentation regarding the two forms. During a review of the facility's policy and procedure titled, ADL (Activities of Daily Living), dated 7/1/14, indicated, To provide consistency in documentation of resident status and care given by nursing staff .III. The CNA (Certified Nursing Assistant) will document the care provided on the facility's method of documentation, manually or electronic. During a review of the facility's policy and procedure titled, Showering and Bathing, dated 1/1/12, indicated, A tub or shower bath is given to the residents to provide cleanliness, comfort and to prevent body odors.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on observation, interview, and record review, the facility failed to ensure one of five residents sampled for falls review (Resident 4) received care and services to prevent falls in accordance with Resident 4's fall risk factors and professional standards of practice. For Resident 4, who had a documented history of falls, poor gait, poor balance, and muscle weakness: (1) The facility failed to perform a fall risk evaluation after Resident 4 fell on [DATE] while Resident 4 was attending physical therapy, and after a nursing assessment on 5/22/22 indicated Resident 4 had poor balance and unsteady gate; (2) The facility failed to accurately evaluate Resident 4's risk for falls when a nursing assessment dated [DATE] indicated Resident 4 had no previous falls, when Resident 4 had fallen two days earlier on 5/20/22; (3) The facility failed to review, update, and develop a fall prevention care plan after Resident 4 fell on [DATE], leaving in place an outdated fall care plan dated 12/31/21; (4) The facility failed to accurately document Resident 4's falls when a nursing note dated 6/5/22, at 2:46 a.m. , indicated Resident 4 had a fall on 6/5/22, at 3:30 a.m., and the Director of Nursing was notified of the fall on 6/5/22 at 2:58 a.m; (5) The facility failed to review, update, and develop a fall prevention after Resident 4 fell again on 6/5/22, relying on an Occupational Therapy care plan created on 6/16/22 to address Resident 4's muscle weakness; (6) The facility failed to timely and accurately evaluate Resident 4's risk for falls when a fall risk assessment for the 6/5/22 fall was completed on 6/20/22, 15 days after the fall, and the fall risk assessment indicated Resident 4 had no gait and or balance problems and no decreased muscular coordination; (7) The facility further failed to accurately evaluate Resident 4's risk for falls when Resident 4's MDS ASSESSMENTS (a standardized, federally mandated clinical assessment tool that drives the creation of care plans and interventions for residents), dated 3/25/22 and 6/24/22, did not indicate Resident 4 had falls at the facility since admission; (8) The facility failed to implement fall prevention interventions for Resident 4 to address her fall risk factors of poor balance, poor gait, and muscle weakness after Resident 4's second fall on 6/5/22, and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	(9) The facility failed to ensure Resident 4 was properly supervised and assisted during transfers and ambulation in her room on 7/15/22 when a Physical Therapy Student (PTS) assigned to escort Resident 4 to the gym did not assist, supervise, and apply a gait belt to Resident 4 during her transfer and ambulation from her bed to the hallway, which resulted in Resident 4 falling to the floor, breaking her leg and experiencing severe pain; this failure was compounded by the fact that Resident 4 had previously sustained another fall with injury, also while ambulating and in the care of physical therapy staff, two months earlier, on 5/20/22, which should have alerted the PTS of the need for increased supervision and assistance for Resident 4 during physical therapy. These failures resulted in Resident 4 sustaining two falls at the facility, on 6/5/22 and on 7/15/22, with the last fall resulting in Resident 4 breaking her left leg and experiencing sustained severe pain for up to seven days after the fall. Findings: A review of Resident 4's FACESHEET indicated she was admitted on [DATE] with diagnoses including diabetes mellitus, hypertension, memory deficit following cerebrovascular disease and chronic pain. A review of Resident 4's PROGRESS NOTES indicated physician note dated 12/23/21, at 12:58 p.m., titled SNF VISIT NOTE, indicating Resident 4 had sustained a fall, as follows: Called by RN [Registered Nurse] due to fall and pain and [Resident] was reaching and fell on to her right wrist and right shoulder. A review of Resident 4's care plans (documents instructing staff on how care for residents) indicated one nursing care plan related to falls, dated 12/23/21, titled The resident has had an actual fall . poor balance . The care plan listed the following interventions: determine and address causative factors, monitor for pain, bruises and change in mental status, and physical therapy consult. A review of Resident 4's FALL RISK EVALUATION dated 12/29/21, at 2:37 p.m., performed after Resident 4's fall on 12/23/22, indicated Resident 4 was not at a high risk for falls and had normal gait and balance. A review of Resident 4's MDS ASSESSMENT (a standardized, federally mandated clinical assessment tool that drives the creation of care plans and interventions for residents), dated 3/25/22, indicated Resident 4 needed the supervision and assistance of one person to transfer out of bed and for ambulation and locomotion. The MDS section titled FALL HISTORY had no falls documented for Resident 4. A review of Resident 4's FALL RISK EVALUATION dated 4/5/22, at 2:37 p.m., indicated Resident 4 was not at a high risk for falls and had normal gait and balance. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 5/20/22, at 7:37 p.m., titled ALERT NOTE, indicating Resident 4 had a fall that day while under the care of physical therapy staff. The note indicated Resident 4 fell outside on the sidewalk into the grass. The note further indicated Resident 4 suffered an abrasion on the left upper forehead, complained of headache, left knee pain, and bilateral wrist pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 4's PROGRESS NOTES indicated nursing note dated 5/22/22, at 2:53 a.m., titled WEEKLY EVALUATION, indicating the following: gait is unsteady, balance is poor, and range of motion impairment (how far you can move or stretch a part of your body) on both legs. The note indicated Resident 4 had no falls since previous WEEKLY EVALUATION. A review of Resident 4' PROGRESS NOTES indicated nursing note dated 6/5/22, at 2:46 a.m., titled POST FALL EVALUATION, indicating Resident 4 had a fall in her room on 6/5/22, at 3:30 a.m., while ambulating from the toilet to the bed in her room. The note indicated: Resident states she was coming out of the restroom and was weak and fell . The note indicated the fall was unwitnessed. The note further indicated: Reason for the fall was evident: .weakness. The note further indicated the fall resulted in hip injury/discomfort and required emergency room /hospitalization . The note indicated Resident 4 had a history of falls. The note concluded Resident [4] was weak and unable to make it back to bed after coming out of restroom. A review of Resident 4's PROGRESS NOTES indicated physician note dated 6/9/22, but signed on 6/10/22, at 8:48 a.m., written by Resident 4's physician, titled FU [Follow Up] COVID and Fall, indicating: FU Fall . [Resident 4] is tearful and worried about her weakness . Has been feeling more weaker and with balance difficulty . A review of Resident 4's CARE PLANS indicated care plan created by the Occupational Therapist (OT) dated 6/16/22, titled, The resident has a decreased ability to perform self-care related to decreased ROM [range of motion], impaired activity tolerance, weakness . and contained the following interventions: Activities of Daily Living retraining, discharge planning, establish functional maintenance plan, OT treatment as indicated, pain modalities as needed, resident/family/caregiver education, and upper extremity therapeutic exercises . A review of Resident 4's FALL RISK EVALUATION, dated 6/20/22, at 1:44 p.m., indicated Resident 4 was at a HIGH RISK for falls. The evaluation, however, indicated Resident 4 had no balance problems standing or walking, had no decreased muscular coordination, had no change in gait when walking through doorways, and did not require the use of assistive devices (cane, walker, etc.) A review of Resident 4's MDS assessment dated [DATE] but completed on 6/11/22, indicated Resident 4 required STAFF SUPERVISION during transfers and locomotion and used a walker (a mobility device). The MDS section titled FALL HISTORY was blank, with no falls documented for Resident 4 in the past 6 months. Review of the Journal of the American Medical Association, Prevention of Falls in Older Adults, [NAME] 2018, a specialized literature, indicated that a recent history of falls is the single best predictor of future falls. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/15/22, at 9:32 a.m., titled POST FALL EVALUATION, indicating Resident 4 had a fall in her room on 7/15/22 at 9:32 a.m. while ambulating with physical therapy. The note indicated the fall was witnessed. The note further indicated the fall resulted in a fracture of her left fibula (calf bone), pain and the hospitalization of the resident. The note further indicated Was a safety evaluation completed/documented prior to the fall: No and Safety teaching documented before the fall: No. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/15/22, at 11:54 p.m., titled SYSTEM NOTE, indicating: Resident was sent to [Hospital] for X-rays of Left Foot and ankle . [Hospital] called the facility approximately at 4:30 p.m. to report Resident was found to have a left Fibula fx [fracture] and she would be returning with a walking boot, a walker, and a prescription for pain medications. Resident returned to the facility at 1740 hours [5:40 p.m.] A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/16/22, at 4:04 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10, with 0 being no pain, and 10 the worst pain]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/16/22, at 9:59 p.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/17/22, at 4:41 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/17/22, at 6:55 p.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 8 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/18/22, at 11:30 a.m., titled IDT NOTE, indicating Resident had assisted fall w/injury 7/15: was in room, walked to doorway to meet with therapy and stated that she became light-headed and felt legs weak and would not support her, was supported/guided to floor by therapy. C/o [complains of] LLE [lower left extremity] pain; transferred to [Hospital] ED for eval and tx [treatment]; confirmed fibula fragility fracture . A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/19/22, at 00:49 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 7 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/20/22, at 2:37 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 8 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/21/22, at 6:08 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 7 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/22/22, at 9:48 p.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 9 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated nursing note dated 7/24/22, at 4:17 a.m., titled ADMINISTRATION NOTE, indicating Resident 4's pain on her left leg was 7 [on a scale of 0-10]. A review of Resident 4's PROGRESS NOTES indicated physician note dated 7/25/22, at 6:22 p.m., written by Resident 4's physician, titled PHONE NOTE, indicating Received a call from [DON] [Resident 4] is in a lot of pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/25/22, at 2:05 p.m., the DON stated Resident 4 fell on [DATE], at 9:30 a.m., and broke her left fibula (the calf bone) because of the fall. The DON described the incident as follows: in the morning of 7/15/22 Resident 4 was in her room waiting for physical therapy; a Physical Therapy Student (PTS) went to Resident 4's room and stood at the doorway; the PTS called Resident 4 and waited for her at the doorway; Resident 4 got out of bed and started walking towards the doorway, unassisted and unsupervised by staff, and without a gait bell (belt used by a caregiver on a patient with mobility issues to assist with transfers); when Resident 4 reached the door her legs gave way and she fell to the floor; the PTS assisted Resident 4 to the ground. During the same interview on 7/25/22, at 2:05 p.m., the DON reviewed Resident 4's clinical record. The DON stated Resident 4 had a history of falls, muscle weakness, unsteady gait, and poor balance. The DON stated for a resident with these risk factors appropriate fall interventions included increased staff supervision, frequent checks, and educating the resident to use the call light and requesting staff assistance prior to getting up and ambulating. The DON was asked if these interventions were part of Resident 4's care plans and were implemented. The DON reviewed Resident 4's clinical record and confirmed there were only two fall care plans created for Resident 4, the first created on 12/23/21 by nursing staff, and the other on 6/16/22 by the Occupational Therapist. The DON confirmed none of the care plans contained the fall prevention interventions of increased staff supervision, frequent checks, and educating the resident to use the call light and request staff assistance prior to getting up and ambulating. The DON confirmed the only three fall prevention evaluations completed for Resident 4, on 12/29/21, 4/5/21 and 6/20/21. During an observation on 7/26/22, 9:30 a.m., Resident 4 was lying in bed. During a concurrent interview, Resident 4 was alert and oriented, and described the 7/15/22 fall as follows: she was in bed waiting for physical therapy; the PTS came to her room but did not come in, she stood outside the doorway; physical therapy staff did not enter resident rooms because they did not want to go through the trouble of applying gowns, gloves, mask and faceshield (required of staff when entering resident rooms in the facility); from the door, the PTS indicated it was time for physical therapy; there was no staff in the room to help her get out of bed; she got out of bed and started walking unassisted towards the PTS who was waiting at the door; she had no gait belt; when she reached the doorway she felt weakness in her legs, lost her balance, and fell to the floor; the PTS did not assist her to do the floor; Resident 4 tried to grab the door frame for support but to no avail; after the fall she felt severe pain on her left leg, 12 on a 0-10 scale. During an observation on 7/26/22, at 9:55 a.m., the Physical Therapy Assistant (PTA) was outside Resident 21's room, standing in the doorway. During a concurrent interview, the PTA stated she was waiting for Resident 21 to come out to take him to physical therapy. While PTA was waiting outside resident's room, Resident 21 transferred himself unassisted to a wheelchair and was pushing himself towards the door. During an interview on 7/26/22, 10:08 a.m., the Occupational Therapist (OT) stated he was treating Resident 4 and was familiar with her health conditions and physical limitations. The OT stated he started treating Resident 4 on 6/16/22, after her 6/5/22 fall, to improve her range of motion. The OT stated Resident 4 always complained of weakness. The OT stated Resident 4 needed a gait belt (a speciazlied belt placed by a caregiver around a person with mobility issues during transfers to prevent and mitigate falls) during transfers and close staff supervision when ambulating because of her muscle weakness and poor strength. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of facility policy and procedure titled FALL MANAGEMENT PROGRAM, dated 3/13/21, indicated: As part of the Admission Assessment, the licensed nurse will complete a fall risk evaluation. If a fall risk factor is identified, document interventions on the Resident's care plan. Document interventions for every Resident regardless of fall risk evaluation score. A licensed nurse will conduct a new fall risk evaluation quarterly, annually, upon identification of significant change in condition, post fall and as needed. The Interdisciplinary Team (IDT) and/or the licensed nurse will develop a care plan according to the identified risk factors and root causes . The IDT will initiate, review and update the Resident's fall risk status and care plan at the following intervals: on admission, quarterly, annually, upon identification of a significant change of condition, post fall and as needed. The licensed nurse will evaluate the Resident's response to the interventions on the Weekly Summary and update the Resident's care plan as necessary. Following every resident fall, the licensed nurse will perform a post-fall evaluation and update, initiate or revise the Resident's care plan as necessary. The IDT will review the circumstances surrounding the fall then summarize their conclusions on an IDT note. In an effort to prevent more falls, the IDT will review and revise the care plan as necessary.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37797 Based on interview and record review, the facility failed to ensure it employed nursing staff with appropriate competencies and skills to care for facility residents when: (1) The facility failed to provide initial orientation, initial and annual competency/skills checks, and regular performance evaluations to six of six nursing staff sampled for verification of orientation, training and competencies: three Licensed Nurses (Licensed Nurses A, F and G) and three Certified Nursing Assistants (CNAs B, N and O); and (2) The facility failed to ensure it had an ongoing and functional staff orientation and training program when (a) the staff whose job description was to direct the facility's staff orientation, training and competencies, the Director of Staff Development (DSD), worked part-time, also worked as a nursing supervisor, and as a floor nurse, and indicated her only responsibilities were to ensure staff physical exams and tuberculosis screening were current; and (b) the residual responsibility for staff orientation, training, and competency evaluations were assigned to the Director of Nursing (DON), who in addition to being a full-time DON, was also responsible for infection prevention and control, worked as a floor nurse when staffed called in sick or did not show up, and had an outside part-time job; (c) the facility failed to have written policies establishing and outlining processes and procedures for orienting, training, evaluating, and verifying the skills and competencies of its staff. These failures placed all residents at risk of poor nursing care and not having their healthcare needs met. Findings: (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 7/26/22, 11:54 a.m., the Director of Nursing (DON) stated she and the Director of Staff Development (DSD) were responsible for the orientation, training, and skills and competency evaluation of staff. The DON stated she also had duties as infection preventionist, worked as a floor nurse when staff called off, and had an outside part-time job. The DON stated the DSD worked part time at the facility and in addition to DSD duties also worked as a nursing supervisor and floor nurse. The DON stated the nursing staff was a mixture of in-house and registry staff. The DON was asked to explain the process for orientation, training, skills and competency evaluation of staff. The DON stated they had two processes, one for registry staff and one for in-house staff. For registry staff the DON stated the facility relied on the staffing agencies to select and provide competency staff to the facility. Once the registry staff reported to work, they received an administrative orientation to the facility which included use of the time clock, breaks, and the facilities administrative policies. Following this orientation the registry staff shadowed an experienced staff, a preceptor, for one or two shifts, longer if needed, and thereafter worked independently. The DON stated the preceptor evaluated the registry staff's performance during the shadowing period and if there were deficits the DON was made aware. The DON stated the process for direct hire or in-house staff was similar but the orientation and shadow period was longer, depending on the level of experience of the staff. The DON stated there were annual competencies and skills evaluations for all staff, but these had not been done for some time. The DON was asked for the facility's policies and procedures governing the orientation, training, skills and competency evaluation. The DON provided two documents: a CNA [Certified Nursing Assistant] ORIENTATION SKILLS CHECKLIST and a LICENSED NURSE ORIENTATION SKILLS CHECK AND ANNUAL SKILLS CHECK. The DON stated there were no other policies and procedures. During an interview on 7/26/22, at 2:46 p.m., the DSD stated she was the Director of Staff Development at the facility. The DSD stated she worked about 20 hours per week at the facility but stated the DSD role was a full-time job. The DSD stated she also worked a nursing supervisor and as a floor nurse at the facility. The DSD stated her only DSD duties at the facility were ensuring staff were current with physical examinations and tuberculosis screening. The DSD stated the DON did everything else. During an interview on 7/26/22, at 3:24 p.m., the DSD and DON were asked for all the orientation, training, and skills/competencies evaluations of six sampled current nursing staff: Certified Nursing Assistants (CNAs) B, N and O and Licensed Nurses A, F and G. The following information and records were provided: For CNA B, registry staff, working at the facility since 3/3/20, there were no records of orientation to the facility and/or skills/competency or performance evaluations. For CNA N, registry staff, working at the facility since 6/19/22, there was one self-assessment skills checklist completed by CNA N where she indicated experience, no experience, or highly skilled for different skills. There were no other records of orientation and skills/competencies evaluations. For CNA O, in house staff, working at the facility since 8/29/07, there were no records of skills/competencies/performance evaluations. For Licensed Nurse A, registry staff, working at the facility since 10/14/21, there was one blank NEW EMPLOYEE ORIENTATION form. There were no other records of orientation to the facility and skills/competency or performance evaluation. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	For Licensed Nurse F, registry staff, working at the facility since 6/24/22, there was one online self-completed CLINICAL assessment dated [DATE], and one online self-completed GERIATRIC & LONG TERM CARE assessment dated [DATE]. A review of the latter indicated Licensed Nurse F stated, under the question AGE OF PATIENTS CARED FOR, for the age bracket 19 to [AGE] years: MAY NEED SOME REVIEW/OCCASIONALLY DONE (1-2 times/month). A review of the facility residents Facesheets indicated 11 of 52 (20%) residents were under this age bracket. There were no other records of orientation and skills/competencies evaluations. For Licensed Nurse G, in house staff, working at the facility since 12/2/20, there were no records of orientation to the facility and/or skills/competency or performance evaluations. A review of facility policy and procedure titled DIRECTOR OF STAFF DEVELOPMENT - JOB DESCRIPTION, undated, indicated: POSITION DESCRIPTION .the Director of Staff Development is responsible for planning, implementation, direction and evaluation of the facility's educational programs for all employees and quality assurance and improvement in the facility. GENERAL DUTIES AND RESPONSIBILITIES . ORIENTATION . coordinates theoretical and clinical orientation to all new employees . TRAINING . coordinates and conducts an effective on-going in-service plan to all employees .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 37797 Based on observation, interview, and record review the facility failed to implement an effective infection control program when staff were not wearing masks inside the facility, staff touched their mask after touching a mask contaminated with SARS-CoV-2 (the virus that causes COVID-19), and housekeeping staff entered rooms of residents on contact and droplet precautions without performing hand hygiene between rooms, without wearing the personal protective equipment (PPE) required, and using one rag to clean multiple rooms. This failure potentially caused spread of COVID-19 in a vulnerable population in a facility experiencing an outbreak of COVID-19. Findings: During an observation and concurrent interview on 5/26/22 at 9:50 a.m., a tour of the facility was conducted with Nurse Consultant B. The facility had a Yellow Zone for residents who had been exposed to COVID-19 and a Red Zone for residents who had tested positive for COVID-19. At the entrance to the Red Zone, Licensed Nurse C stated she had 15 residents assigned to her, and the other nurse in the Red Zone also had 15 residents. During an interview on 5/26/22 at 10:17 a.m., County Health Director stated the facility currently had 30 residents positive for COVID-19 out of a total of 54 residents. He also stated two residents had been hospitalized . During a record review and concurrent interview on 5/26/22 at 12 p.m., the line list for the COVID outbreak dated 5/25/22 revealed a total of 11 staff and 37 residents had been infected. The facility COVID mitigation plan stated the facility had a full-time Infection Preventionist (IP). When asked where she was, Nurse Consultant B stated the IP was part-time and did not comment further. During an interview on 5/26/22 at 1:48 p.m., DON stated response testing had just been completed and three more residents had tested positive for COVID. During an interview on 5/26/22 at 3:45 p.m., Administrator stated the facility's IP worked 2.25 hours per week and just does Wednesday reporting and data entry. During an interview on 5/27/22 at 9:30 a.m., when asked who was monitoring infection control practices in the resident care areas, County Health Director stated, Well, they don't have an IP. IPs are few and far between, hard to come by. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and concurrent interview on 5/27/22 at 10:29 a.m., Environmental Services Staff (EVS) D, wearing an N95 mask, rolled his cart down to the end of the hall in the Yellow Zone and stopped at a resident room. All the doors in the hall had signs indicating contact and droplet precautions with additional signage indicating what PPE to wear (gown, gloves, faceshield, and N95 mask) and how to don and doff it. Several sets of drawers containing PPE lined the hallway. EVS D entered the resident room without donning any PPE and began to wipe surfaces, including the resident's bedside table, with a white rag. EVS D went into the bathroom, then came to the cart and got a mop. EVS D mopped the floor, returned the mop to the cart, then entered the resident room across the hall without performing hand hygiene or donning PPE. EVS D performed the same procedure, then rolled his cart to the next room and prepared to enter. When asked what disinfectant he was using, EVS D stated he just used the rags, they were wet with disinfectant, and he pointed at the rags sitting on top of his cart. There were two blue rags and the white rag he just used was wadded up on top of them. EVS D stated he did not know where all the rags went, so he just had these three. When asked if he used three rags to clean all the rooms in the hallway, EVS D stated he just used one rag on all the rooms. EVS D stated, Usually I have a whole stack, but I don't know where all the rags went. When asked how he kept the rags wet, EVS D stated he got them out of a bucket in the laundry room and they stayed wet. EVS D's cart had no bucket on it or inside it. When asked about wearing PPE in the resident rooms, EVS D stated he was not told to use PPE in the rooms, No one has said anything to me about it. When asked about hand hygiene between rooms, EVS D stated, Oh, I guess I should use some and reached for the hand sanitizer dispenser next to him. During an observation and concurrent interview on 5/27/22 at 10:49 a.m., Dietary Staff E had her mask under her chin exposing her nose and mouth and was talking to a dietary staff who had his mask pulled down exposing his nose. When queried, Dietary Staff E stated the dietary staff was new and she needed to explain something to him, so she pulled her mask down so he could hear. During an observation and concurrent interview on 5/27/22 at 10:53 a.m., Laundry Staff G had no mask on and was talking to EVS H. EVS H stated they had rags on backorder. EVS H stated the laundry staff washed and stacked the rags and then put them on a shelf. EVS H pointed at the shelf for the clean rags, which was empty. During an observation and concurrent interview on 5/27/22 at 11 a.m., DON was informed that EVS D was cleaning multiple rooms with one rag, his lack of PPE and hand hygiene, and the shortage of rags. DON stated she would go talk to him. Five minutes later, DON was observed in the business office manager's (BOM) office with the door closed. EVS D was in the same hallway, donning a gown and preparing to enter another resident room. DON was informed, and she asked EVS D to hold on until she gets him some clean rags. BOM brought EVS D some wash cloths, and DON put on a glove and put the two blue rags in the dirty linen. BOM and DON left the hallway. The dirty white rag was still on the cart. When queried, EVS D stated, I guess that should go in the laundry and he picked up the rag with his bare hand, and put it in the dirty linen. EVS D came back to his cart and prepared to enter a resident room. EVS D did not perform hand hygiene. When queried, EVS D stated he already used hand sanitizer, but it can't hurt and used the hand sanitizer outside the resident room door. EVS D entered the resident room without gloves or a faceshield and cleaned the room. EVS D exited the room with the gown on, and without performing hand hygiene, he wheeled his cart around the corner toward the kitchen. EVS D stopped in the hallway outside the therapy room, pulled the gown off and stuffed it in the trash, and continued down the hall without performing hand hygiene. (continued on next page)

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	056361	A. Building B. Wing	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fortuna Rehabilitation and Wellness Center, LP	2321 Newburg Road Fortuna, CA 95540

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/27/22 at 1:49 p.m., BOM stated she was assisting the IP with COVID testing last weekend when she saw the IP reminding EVS D that he needed to wear a gown when entering resident rooms. BOM stated, She told him he has to wear a gown, please wear a gown, I've told you this before. BOM stated she then saw him a few minutes later go in and out of a resident room without wearing PPE. During an observation on 5/27/22 at 2:15 p.m., DON adjusted twice the N95 mask of a Red Zone resident without performing hand hygiene before or after, and then reached up and adjusted her own mask. During an interview on 5/27/22 at 2:50 p.m., DON verified she did touch the resident's mask and then touched her own mask. DON stated she should not touch her mask without performing hand hygiene first. During an interivew on 6/2/22 at 2:08 p.m., when asked how often he observed EVS staff clean a room from start to finish for proper procedure, EVS Director stated they used to do it quarterly, but had not done an observation for a year or two due to being overwhelmed. EVS Director stated they had an IP to help with infection control protocols until recently, now it's me. When asked about the rag shortage, EVS Director stated they had run low on disinfectant wipes, so the staff started using the rags and then throwing them away as if they were disposable. When asked if he knew EVS staff were using one rag to clean all rooms, EVS Director stated he had one staff who needed to retire. EVS Director stated that as soon as he heard about it, he had pulled him off the floor. EVS Director stated he expected staff to wear an N95 at all times when the facility was on lockdown with COVID. Review of facility procedure titled Cleaning Residents' Rooms, dated 1/9/08, indicated housekeeping staff should empty trash, damp wipe surfaces in the resident's room, straighten furniture, clean the bathroom, and then sweep and mop. The procedure does not indicate what staff should do with the cleaning rag after cleaning the bathroom and before cleaning the next room. Review of facility document titled COVID-19 Mitigation Plan, last revised 4/27/22, indicated, Staff should always wear a surgical/procedure mask (an N95 respirator is required in the yellow or red areas) for universal source control while they are in the facility. Yellow Area: Contact and Droplet Precautions . Wear goggles or a face shield for the duration of the shift when providing care to a resident or within six feet of a resident. Gowns should be worn and changed between resident encounters. Gloves are worn and changed between every resident encounter with adherence to hand hygiene. Review of facility policy and procedure titled, Hand Hygiene, last revised 9/2020, indicated, Facility staff . must perform hand hygiene to prevent the transmission of HAIs (healthcare acquired infections). Review of the Centers for Disease Control and Prevention guidance Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings -Recommendations of the HICPAC (Healthcare Infection Control Practices Advisory Committee) (not dated), subheading Hand Hygiene revealed, Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: . a. Immediately before touching a patient. d. After touching a patient or the patient's immediate environment.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 37797 Based on observation, interview, and record review, the facility failed to employ an infection preventionist (IP) who worked at least part-time. This failure resulted in minimal oversight of the infection prevention and control program during an outbreak of COVID-19 in the facility. Findings: During an observation and interview on 5/26/22 at 9:35 a.m., the facility front door was propped open and no one was at the screening table (table set up to document persons entering the building, check temperature for fever, and screen for signs or symptoms of COVID or potential COVID exposure). Nurse Consultant B came to the screening table and stated she had just arrived. Nurse Consultant B stated she was texting the administrator and the director of nursing to inform them of this surveyor's arrival. Nurse Consultant B confirmed Administrator and Director of Nursing (DON) were not at the facility. Nurse Consultant B stated she did not work at the facility, she worked for a shell company. During an observation and concurrent interview on 5/26/22 at 9:50 a.m., a tour of the facility was conducted with Nurse Consultant B and County Health Director. The facility had a Yellow Zone for residents who had been exposed to COVID-19 and a Red Zone for residents who had tested positive for COVID-19. At the entrance to the Red Zone, Licensed Nurse C stated she had 15 residents assigned to her, and the other nurse in the Red Zone also had 15 residents. Nurse Consultant B stated she and County Health Director had just completed a line list yesterday (5/25/22, nine days after the first resident tested positive) and she would email it. During an observation on 5/26/22 at 10:10 a.m., Nurse Consultant B called the corporate IP on speaker phone. The corporate IP stated he had already left the county and would not be coming to the facility. During an interview on 5/26/22 at 10:17 a.m., Administrator arrived to the facility. County Health Director stated the facility currently had 30 residents positive for COVID-19 out of a total of 54 residents. He also stated two residents had been hospitalized . During a record review and concurrent interview on 5/26/22 at 12 p.m., the line list for the COVID outbreak dated 5/25/22 revealed a total of 11 staff and 37 residents had been infected. The first staff member tested positive on 5/10/22, and the first resident tested positive 5/16/22. The facility COVID mitigation plan stated the facility had a full-time Infection Preventionist (IP), IP Nurse. When asked where she was, Nurse Consultant B stated IP Nurse was part-time and did not comment further. During an interview on 5/26/22 at 1:48 p.m., DON stated response testing had just been completed and three more residents had tested positive for COVID. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/26/22 at 3:45 p.m., with Administrator, DON, and Nurse Consultant B, Administrator stated the facility's IP took another position elsewhere, now worked 2.25 hours per week and just does Wednesday reporting and data entry. Administrator stated IP Nurse was available by phone and worked all last weekend. Nurse Consultant B stated the corporate IP and another corporate nurse were here Monday, Tuesday, and Wednesday (5/23/22, 5/24/22, 5/25/22) but they just left to go back. Nurse Consultant B stated she was here indefinitely, but just as a consultant. Nurse Consultant B stated DON was the point-person tracking the outbreak and she was her back-up. Nurse Consultant B stated the medical director had come to the facility, but he was based out of town [118 miles away] and had not been feeling very well. During an observation and concurrent interview on 5/27/22 at 9:20 a.m., DON screened this surveyor at the facility front door and stated she needed to go test someone. Nurse Consutant B was just arriving to the facility. During an interview on 5/27/22 at 9:30 a.m., when asked who was monitoring infection control practices in the resident care areas to prevent further spread, County Health Director stated, Well, they don't have an IP. IPs are few and far between, hard to come by and he stated they did not have an IP in the pipeline that he knew of. During an observation on 5/27/22 at 10:02 a.m., a list titled Administrative Staff, not dated, was posted in the hallway on a bulletin board. The positions IP and DSD (director of staff development) were left blank. During an observation and concurrent interview on 5/27/22 at 11:42 a.m., DON was coordinating the resident testing with the county public health staff, Adminstrator's office was empty, and Nurse Consultant B was on the phone in an office. Nurse Consultant B stated Administrator was not here at the facility, she was on the phone with the county public health department, and then she continued the phone call on speaker phone. The county staff stated she wanted to ask Nurse Consultant B about IP Nurse. The county staff stated she had heard IP Nurse was no longer an employee of the facility, but then on the last call she was told IP Nurse was part time. Nurse Consultant B stated IP Nurse was point-two-five (0.25) and only works a couple hours in the morning, so she will not be able to participate in these calls. During an observation and concurrent interview on 5/27/22 at 1:15 p.m., a county public health staff person informed DON of the names of the residents who had just tested positive for COVID, and DON wrote down the names. When queried, DON stated IP Nurse had given her notice on 4/18/22 that she would no longer be full-time as of 4/27/22. DON stated IP Nurse came in very early in the morning to do reports. During a record review on 5/27/22 at 3 p.m., a print out was provided of the open Infection Control Coordinator position, not dated, posted on the facility website. During a record review and concurrent interview on 6/23/22 at 8:47 a.m., DON stated the Red Zone opened on 5/16/22. Facility documents titled Nursing Sign-in Sheet dated 5/12/22 to 5/27/22 revealed, and DON confirmed, she had worked the following shifts on the floor caring for residents at bedside: 5/14/22 7 a.m. to 3 p.m. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/19/22 11 a.m. to 5 a.m. (18 hours) 5/21/22 7 p.m. to 7 a.m. 5/23/22 7 p.m. to 7 a.m. 5/24/22 7 p.m. to 7 a.m. DON stated, I have a med[ication] cart and I'm on the floor when she had a resident assignment. Review of IP Nurse's time sheets revealed she was clocked-in to work the following hours: 5/20/22 8 a.m. to 10 a.m., and then 10:51 p.m. to 4:32 p.m. (17.25 hours) 5/22/22 8 a.m. to 9:30 a.m. 5/23/22 8 a.m. to 9:30 a.m. 5/24/22 8 a.m. to 9:30 a.m. 5/25/22 5 a.m. to 8 a.m. Review of Nursing Sign-In Sheets dated 5/12/22 to 5/27/22 revealed IP Nurse worked the NOC shift (11 p.m. to 7 a.m.) on 5/20/22 as the Station 1 nurse assigned to care for residents. Review of the 5/25/22 line list for the COVID outbreak revealed Resident 2 had tested positive for COVID on 5/20/22. Resident 2's medical record revealed an antiviral for COVID was ordered on 5/20/22 to be given twice daily for seven days. Resident 2's medication administration record (MAR) revealed she received no doses on 5/20/22, no doses on 5/21/22, one dose on 5/22/22, and then two doses on 5/23/22. Resident 2 was given the antiviral medication twice daily as ordered on four out of the the seven days. During an interview on 6/23/22 at 1 p.m., DON stated the reason Resident 2 missed doses of her antiviral medication was that it was hectic, residents were turning positive in droves, there was a lot of activity, it probably had to do with that. Review of facility document COVID-19 Mitigation Plan, last revised 4/27/22, indicated, The facility has a full-time Infection Preventionist(s) which may be achieved by more than one staff member (but no more than two) sharing the role . If more than one Infection Preventionist is fullfilling the position, one will be the lead and the lead will monitor and improve infection control practices based on public health advisories (local, state, and federal). The Infection Preventionist(s) shall be focused on activities dedicated to infection control . 39792