STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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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 - Some	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** 35103 Based on observation, interview, and record review, the facility failed to maintain the privacy and confidentiality of resident COVID-19 status. This deficient practice resulted in a lack of medical record confidentiality when facility residents' COVID-19 status was posted on the outside of 19 resident room doors , visible to all visitors. This deficient practice had the potential to affect all 47 facility residents. Findings include: During initial tour observation on the South Hall on 12/13/21 at approximately 1:00 p.m., yellow and white signs were observed on resident doors. Bright yellow or orange signs posted on rooms 117, 118, 121, 126, 129, and 130, read COVID Recovered, Three Week Nursing Orders (with different dates between 12/3/21 through 12/29/21). A pale-yellow sign on room [ROOM NUMBER] read, COVID-19 Observation. Full PPE (personal protective equipment) required when in room. N95 (face mask) Eye Protection, Gown, Gloves. Observation ends 12/26/21. Keep Door Shut. [NAME] door postings, which read COVID Negative, Clear, or COVID Recovered, were posted on the outside of doors for rooms [ROOM NUMBERS]B. Rooms 119, 120, 121, and 127 had no signage present on the outside of the doors, and no residents resided in rooms [ROOM NUMBERS]. Review of an undated, Physician Order Progress Notes sheet, signed by Medical Director (MD) Z, revealed the following, in part: 1. Please place placards with dates of isolation. Red - Anyone who is trying to escape put Red Placcard (sic) on their wheelchair. 2. Yellow placcard (sic) for next 3 weeks . 3. Green if had Covid + (and) Clear. [NAME] for on COVID wing + no COVID . 35102 During an initial tour observation on the North hall, white signs with black typed letters were found taped to outside of residents' room doors which read Covid Negative Clear. Only room [ROOM NUMBER] and room [ROOM NUMBER] did not have the sign posted and residents resided in both rooms. (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 - Some	During a telephone interview on 12/14/21 at 1:37 p.m., Medical Director (MD) Z was asked about the signage which read Covid Negative Clear that was posted outside of residents' room. MD Z said she could not tell who was Covid positive, who had recovered, and who was negative since the facility did not have lists which would have provided such information for each resident. When asked if the signage potentially posed HIPPA (Health Insurance Poertability and Accountability Act) concerns, MD Z said, Yeah, I guess I really have not thought of it. It was so chaotic I couldn't make sense of it. MD Z said she was last in the facility on November 28th and 29th (2021) when the signs were placed on residents' doors. Review of Rights of Residents in (State) Nursing Facilities (undated) read in part, You have a right to . confidentiality of your personal and medical records. You have a right to secure and confidential personal and medical records.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to timely execute COVID-19 Standing Orders (physician orders) and failed to assess for individual resident qualification for treatment with and timely administration of physician ordered Monoclonal Antibodies for COVID-19 to four COVID-19 positive Residents (#1, #9, #10, #11) of 13 residents reviewed for quality of care. This deficient practice resulted in a delay in laboratory blood testing to assess resident condition, the potential for worsening of condition and/or prolonged duration of their COVID-19 illness. Findings include: Resident #1 Review of Resident #1's Electronic Medical Record (EMR) revealed Resident #1 was admitted to the facility on [DATE] with diagnoses that included: acute kidney failure, chronic atrial fibrillation, weakness and other reduced mobility. Resident #1 had a court appointment guardian who made health care decisions. A diagnosis of COVID-19 was added to the Admission Record, as of 11/18/21. Review of Resident #1's Progress Notes revealed the following, in part: 11/18/21 16:02 p.m. (4:02 p.m.), .Resident's guardian, updated on resident's + (positive) Covid test. He is agreeable to having resident receive the antibody (monoclonal antibody) tx (treatment), recommended by [Medical Director (MD) Z]. 11/19/21 10:40 a.m., Sats (oxygen) at 88% (percent) to 91% on room air. [Resident #1] was started on O2 at 2L (liters) . 11/20/21 16:45 (4:45 p.m.), .Resident continues to be in quarantine due to a positive covid test .O2 sat was 86 this morning without oxygen, currently on 2 liters of O2 via nasal cannula . Lungs are diminished with some wheezes, he has a dry cough with no sputum. He has been very tired and sleeping most of the day . 11/24/21 14:44 (2:44 p.m.), Late Entry (Created 11/26/21 at 9:45 a.m. by the Director of Nursing (DON) . Given 4 divided doses of Casirivimab and Imdevimab (Monoclonal Antibodies). No side effects noted. Review of Resident #1's Casirivimab/Imdevimab Consent Form, consent for the monoclonal antibodies was received via verbal consent by Licensed Practical Nurse (LPN)/Health Information Coordinator M on 11/18/21 at 16:02 (4:02 p.m.). During an interview on 12/13/21 at 3:58 p.m., when asked why monoclonal antibodies were not administered to Resident #1 until 11/24/21, when the physician order had been signed on 11/19/21, the DON said the pharmacy did not deliver the medication until 12/22/21. The DON stated, I can't give you an answer why it (monoclonal antibodies) wasn't given (earlier). It should have made a difference, and it did with a lot of our other residents. The sooner it is given the better the outcome. When asked if Physician Z knew the monoclonal antibody treatment had been delayed, the DON said she did not know if Physician Z was aware of the delay. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the Pharmacy Casirivimab/Imdevimab Intake/Prescriber Order, revealed Resident #1 was identified as COVID-19 positive on 11/18/21, with the physician order for Monoclonal Antibodies signed by the physician on 11/19/21. A photo of the same form was received from the Consultant Pharmacy on 12/15/21 at 2:55 p.m. via electronic transmission, showing the order for Resident #1's Monoclonal Antibodies was not submitted to the pharmacy until 11/22/21 at 11:11 a.m., and delivered the same night (11/22/21) to the facility. Review of the pharmacy Infection Disease Algorithm, Casirivimab/Imdevimab (Monoclonal Antibody) for the Treatment of COVID-19 Algorithm, dated 2021, revealed the following, in part: Does patient require oxygen to treat COVID-19 symptoms? Or if previously on oxygen, has patient required increase in flow rate? (if) 'YES', (Individual) Does not qualify. Follow facility COVID-19 treatment protocol . Review of Standing Orders for Residents Positive for COVID, dated 8/26/21, and signed by Medical Director (MD) /Physician Z revealed the following, in part: 1. D-dimer (blood test to measure D-dimer protein fragment made when a blood clot dissolves in the body) to be drawn day of diagnosis, and day 7 + (and) 14 +21 if upper respiratory symptoms . 2. Azithromycin 250 mg (milligrams), 500 mg x (times) 1 day then 250 mg Daily x 4 days. 3. Decadron 4 mg (milligrams), 1 tablet BID (twice daily) x 3 days then 1 tablet daily x (unidentifiable number) days. 4. Vitamin C (Ascorbic Acid), 500 mg 1 x day x 1 mo. (month). 5. Vitamin B complex, 1 tablet daily x 1 mo. 6. Melatonin 2 mg, one tablet nightly for 10 days. 7. [Anticoagulant] 5 mg twice daily x 5 weeks if D-dimer is elevated, D-dimer - High. Hand-written, Zinc 80 mg 1x daily x 1 month. Hand-written, Vitamin D, 5000 IU daily x 1 month . During an interview on 12/14/21 at 11:40 a.m., the DON confirmed Resident #1 had been on oxygen prior to administration of the monoclonal antibodies. The DON said ADON A had administered the monoclonal antibodies to Resident #1 on 11/24/21 but did not have authorization to document in the Electronic Medical Record (EMR) because she was new to the facility. The DON also reviewed the Monoclonal Antibody algorithm, and when asked if Resident #1 would qualify for administration of the Monoclonal Antibodies, the DON stated, [Resident #1] does not qualify according to the algorithm. The DON also acknowledged the D-dimer testing should have begun on 11/18/21, the date Resident #1 tested positive. During an interview on 12/14/21 at 11:47, ADON A confirmed she had administered the Monoclonal Antibodies to Resident #1 on 11/24/21 but did not document administration on the Electronic Medication Administration Record (eMAR), because she did not have access to the EMR. When asked why a late entry for administration of the medication had not been completed, the ADON A stated, I don't know why. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's D-dimer laboratory report, dated 11/24/21, revealed a High Out of Range score of 5817, with a Reference Range (normal range) shown as 0-500. Review of a Physician Order, completed 11/24/21 by LPN M, revealed the following, D-dimer enclosed. We will proceed with [anticoagulant] 5 mg BID (twice daily) x 3 weeks (COVID-19 Standing Order) due to elevated labs. Review of Resident #1's Casirivimab/Imdevimab [Name Brand] Administration Flow Sheet, revealed Resident #1 received the monoclonal antibodies on 11/24/21 beginning at 1600 (4:00 p.m.), administered by ADON A. Review of Emergency Department (ED) Triage Vital Signs, dated 11/24/21 at 2334 (11:34 p.m.), revealed Resident #1 had a Pulse Ox (oximeter) reading of 98% on 10 Liters (L) of oxygen supplied by NRB (non-rebreather) mask. The ED Summary, Date of Service 11/24/21, revealed, in part: The patient has not been given Decadron for hypoxia with COVID-19, and this was started also . Review of Resident #1's eMAR for November 2021, revealed 10 of the 16 Standing Orders for Resident Positive for COVID were not initiated until on or after 11/24/21. When Resident #1 was admitted to the ED on 11/24/21, the only medication of the COVID Standing Orders administered was Melatonin, with the other medications including Decadron, Ascorbic Acid, Vitamin B complex, Eliquis, and zinc being placed on Resident #1's eMAR following his return from the ED on 11/25/21. Azithromycin and Vitamin D were not added to Resident #1's eMAR at all. During a telephone interview on 12/14/21 at 1:45 p.m., when asked when facility nursing staff were to complete blood draws for D-dimer analysis (related to potential increased blood clotting) for COVID-19 positive residents, Physician Z stated, The nurses draw the D-dimer on day one, day seven, and day 14 . If we are on top of making sure they are not having clotting problems we don't have the number of deaths that we normally do. Physician Z was unaware Resident #1 did not have a D-dimer drawn until day six following Covid-19 diagnosis and said monoclonal antibodies should ideally be administered within 24-48 hours. When advised Resident #1 did not receive the monoclonal antibodies until six days following diagnosis and Resident #1 had been receiving oxygen related to dropping oxygen saturation rates, Physician Z stated, I don't know why the nurses did not do that (draw D-dimer on day of diagnosis and administered Monoclonal Antibody treatment timely) .This is all fairly new to the nurses. During an interview on 12/14/21 at 1:57 pm., when asked if Resident #1 had a D-dimer drawn per Physician COVID-19 Standing Orders, Health Information Coordinator/Licensed Practical Nurse (LPN) M stated, [Resident #1] did not get a day one draw (for D-dimer). There were a bunch of them (residents) that turned positive. The whole building was in disarray .There was so much confusion at the time, and it was a lot of work with moving residents around. LPN M confirmed Resident #1's D-dimer was drawn on 11/24/21, six days following testing positive for COVID-19. Review of a faxed Physician Order, dated 11/25/21 (date of Resident #1's return from the ED), and signed by Physician Z on 12/7/21, (the date the form was faxed in return to the facility), revealed the following: Resident Status: Please sign below order for 'No Code Status' .for [Resident #1] . No Code Status, Comfort Care, 12/7/21. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's 11/25/21 Nursing Progress Note at 17:30 (5:30 p.m.) revealed the following: Received call from [Name] ED that resident (#1) was ready to come back to facility on comfort care, Due to no beds available in ICU, he has been in the ED. MD notes state that the patient has atrial flutter with rapid rate, worsening COVID-19 pneumonia and hypotension .he continues to worsen in the hospital and his prognosis is poor . Resident #9 Review of the facility listing of COVID-19 positive residents beginning 11/18/21 through 11/30/21 revealed Resident #9 tested positive for COVID-19 on 11/18/21. Review of Resident #9's Nursing Progress Notes, revealed Resident #1's responsible party was contacted by telephone on 11/18/21, and notes the responsible party wanted Resident #9 to have the Antibody treatment if she was eligible. Review of a Physician Order, signed 11/19/21 by Physician CC, authorized subcutaneous injections of Monoclonal Antibodies for Resident #9. Review of Resident #9's complete medical record found no documentation that Monoclonal Antibodies had been administered to Resident #9. During a telephone interview on 12/16/21 at approximately 11:00 a.m., the DON, ADON A , and Nursing Home Administrator (NHA) were all present. When asked about the absence of Monoclonal Antibody documentation in Resident #9's record, the DON stated, It (Casirivimab/Imdevimab Monoclonal Antibodies) had not come in from the pharmacy. It was not given by me, and it was not given. Upon review of Resident #9's EMR, the DON confirmed there was no documentation showing Monoclonal Antibodies had been administered to Resident #9, although verbal consent, and a physician order had been obtained. No explanation for why the Monoclonal Antibodies were not given to Resident #9 was provided. Resident #10 Review of the facility listing of COVID-19 positive residents beginning 11/18/21 through 11/30/21 revealed Resident #10 tested positive for COVID-19 on 11/22/21. Review of Resident #10's Nursing Progress Notes, revealed Resident #1's responsible party was contacted by telephone on 11/22/21, and wanted Resident #10 to have the Antibody treatment if she was eligible. Review of a Physician Order, signed 11/22/21 by Physician DD, authorized subcutaneous injections of Monoclonal Antibodies for Resident #10 for treatment of COVID-19. Review of Resident #10's complete medical record found no documentation that Monoclonal Antibodies had been administered to Resident #10. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 12/16/21 at approximately 11:00 a.m., the DON, ADON A, and NHA were all present. When asked about the absence of Monoclonal Antibody documentation in Resident #10's record, the DON stated, It (Casirivimab/Imdevimab Monoclonal Antibodies) was not available on the 24th (of November) when we gave them. Pharmacy should have been notified that we needed it, and when it came it should have been given. Upon review of Resident #10's EMR, the DON confirmed there was no documentation showing Monoclonal Antibodies had been administered to Resident #10, although verbal consent, and a physician order had been obtained. No explanation for why the Monoclonal Antibodies were not given to Resident #10 was provided. Resident #11 Review of the facility listing of COVID-19 positive residents beginning 11/18/21 through 11/30/21 revealed Resident #11 tested positive for COVID-19 on 11/22/21. Review of Resident #11's Nursing Progress Notes, revealed Resident #1's responsible party was contacted by telephone on 11/22/21, and wanted Resident #11 to have the Monoclonal Antibody treatment. Review of a Physician Order, signed 11/22/21 by Physician Z, authorized subcutaneous injections of Monoclonal Antibodies for Resident #11 for treatment of COVID-19. Review of Resident #11's complete medical record found no Casirivimab/Imdevimab Administration Flow Sheet, which documented Monoclonal Antibodies had been administered to Resident #11, nor evidence of the vital sign assessment completed every 15 minutes for one hour. Review of Resident #11's Nursing Progress Notes, revealed a 11/26/21, 9:47 a.m., note that read: Note Text: Given 4 equal doses of Casirivimab and Imdevimab No side effects noted, created by the DON four days following the verbal authorization and signed physician order had been received. Review of Resident #11's eMAR, revealed COVID-19 Standing Order medications were not administered until 11/25/21, except Melatonin administered on 11/24/21, and the D-dimer was not drawn until 11/27/21, when Resident #11 was identified as COVID-19 positive on 11/22/21. During a telephone interview on 12/16/21 at approximately 11:00 a.m., the DON, ADON A, and NHA were all present. When asked about the absence of the Monoclonal Antibody Flow Sheet in Resident #11's record, the DON confirmed a Monoclonal Antibody Flow sheet was not present in Resident #11's medical record, and administration of the Antibodies was not documented on Resident #11's eMAR.

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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** 35103 Based on observation, interview, and record review, the facility failed to properly prevent a facility-wide outbreak of COVID-19. This deficient practice resulted in the transmission of COVID-19, which had the potential to affect all 47 facility residents. This deficient practice has eight noted deficiencies: 1. Failure to ensure staff used Personal Protective Equipment appropriately during and following a COVID-19 outbreak. 2. Failure to complete timely infection control surveillance, infection mapping and analysis. 3. Failure to complete a thorough Outbreak Investigation, outbreak timeline, accurate contact tracing, and staff education related to a COVID-19 outbreak. 4. Failure to accurately monitor employee illness to prevent COVID-19 transmission. 5. Failure to ensure social distancing to in prevention of COVID-19. 6. Failure to ensure compliance with visitor entrance screening protocol. 7. Failure to ensure housekeeping supplies were reconstituted and used effectively to kill the COVID-19 virus. 8. Failure to ensure unvaccinated residents received the COVID-19 upon their consent. The Immediate Jeopardy began on 11/18/21, when eight residents and three staff members tested positive for COVID-19 through rapid testing. Evidence obtained throughout the first two days of the survey (12/13/21 - 12/14/21) confirmed facility staff had not been using PPE appropriately and consistently while providing direct care for facility residents. The Nursing Home Administrator (NHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON) A were informed of the Immediate Jeopardy concern on 12/14/21 at 3:30 p.m. The Immediate Jeopardy was removed on 12/15/21, with the initial implementation of the accepted Abatement Plan. Non-compliance remained at the lower scope and severity of widespread potential for more than minimal harm that is not immediate jeopardy, pending on-site verification of the Plan of Correction. Findings include: PPE On 12/13/21 between 3:45 p.m. and 3:52 p.m., Food and Nutrition Aide (Staff) K was observed with his face mask under his chin once, and under his nose two additional times. Immediately upon seeing this Surveyor, Staff K moved behind the food tray cart and pulled the mask up over his nose. Cook L was also observed, at this same time with mask below her nose during food preparation at the back table in the kitchen. Cook L also, upon seeing this Surveyor, immediately pulled her mask up to cover her nose. When interviewed, at this same time, both Staff K and Cook L, confirmed they were to be wearing their face masks covering their nose during food preparation in the kitchen. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 12/13/21 at 4:20 p.m., Registered Nurse (RN) H was observed standing at a medication cart directly in front of the main nurses' station. RN H quickly pulled down her face mask and sneezed into her bare hands, cupped in front of her face. RN H pulled her face mask back up with her right bare hand on the front of the mask. RN H performed hand hygiene with hand sanitizer but did not wash her hands with soap and water after gross contamination of her hands with the sneeze. On 12/14/21 at 7:50 a.m., Staff K was observed with face mask under his chin and Cook J with mask under her nose. When both Staff K and Cook J saw this Surveyor open the kitchen door (with glass window), they quickly pulled up their face masks to cover their noses. When asked what concern this Surveyor had, Staff K stated, My face mask (not covering face). Cook J stated, When I am done cooking, I pull down my mask sometimes. No hand sanitation was noted following touching of the front of their face masks. During an interview on 12/14/21 at 9:15 a.m., the DON/IP and ADON A were asked about staff not wearing face masks properly in the kitchen during food preparation. ADON A stated, The expectation is to cover their mouth and nose while preparing food in the kitchen. In the office, with their door open, they should have their mask up (covering their mouth and nose). When asked about sneezing, face masks and hand sanitation following a sneeze, ADON A said the face mask should be changed after it was sneezed into, and if the mask was removed and staff sneezed into their hands both the DON/IP and ADON A considered it gross contamination of the staff member's hands that would require hand washing. When asked if either the DON/IP or ADON A were aware of any complaints related to failure to wear proper PPE when the COVID-19 outbreak began, the DON/IP confirmed a staff member had contacted the corporate office and said that we were supposed to have full PPE on and we were told differently. The DON stated, I got an email from (a) call made to corporate that we were not compliant with PPE. [They] said you have to have N95 (face masks), face shields, so we got them on everybody. The DON/IP confirmed they were not wearing full PPE with their facility wide (both halls positive) outbreak of COVID-19 on 11/18/21. During an interview on 12/14/21 at 10:01 a.m., Staff B confirmed she had concerns with inadequate PPE usage at the beginning of the COVID-19 outbreak in November. Staff B said she told the DON/IP that staff needed to be switching to N95 masks. Staff B stated, I saw that people (staff) were still wearing surgical masks. Staff B stated, I think the 18th (of November) was a Thursday, and maybe people were switching over (to N95 face masks) on Friday . I got them (N95 masks) from the central supply and put the N95's out there . Staff B said she reached out to corporate to make sure they were following all the steps to provide guidance for PPE requirements during a COVID-19 outbreak. During an interview on 12/14/21 at 11:04 a.m., when asked what PPE was used at the beginning of the COVID-19 outbreak in November, Housekeeper N stated, I was wearing a surgical mask, and once we were told to go closer to the COVID unit we had to wear the N95 masks. I just wore my regular surgical mask. I had my personal glasses on - no face shield, no goggles - they didn't tell me to wear that, at that time. On 12/14/21 at 8:36 a.m., the DON/IP was observed in her office, next to the nurses' desk, with her surgical mask positioned under her chin in the presence of ADON A. The office door was found wide-open at the time of the observation. (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 12/14/21 at 11:52 a.m., ADON A confirmed direct care staff cared for residents who were COVID-19 positive, who were negative, and/or under observation simultaneously during the same day and shift. The ADON A was asked to describe the PPE donning and doffing procedures as staff were moving between the Visqueen barrier (plastic sheeting used to create temporary wall) which was used to separate COVID-19 positive residents from other residents. The ADON A explained staff removed dirty PPE in the hallway on the side of the COVID-19 positive resident hall and would pass through the barrier without wearing any PPE to enter the other side of the hallway. When asked about possible COVID-19 exposure to both residents and staff since no face covering was worn during this time, ADON A did not respond to the question. During an interview on 12/14/21 at 11:14 a.m., CNA D confirmed she worked caring for residents who were COVID positive on the Quarantine Hall and at the same time cared for COVID negative residents who were on the other side of the Visqueen barrier. CNA D was asked to describe the donning/doffing of PPE when she worked on the Quarantine Unit and needed to enter the other side of the Visqueen barrier. CNA D said that dirty PPE was removed in the hallway of the Quarantine side and then clean PPE was applied before unzipping the Visqueen barrier. When asked about PPE cross-contamination of clean/dirty being in the same area, CNA D said, I realize now it was wrong. During a telephone interview on 12/16/21 at 9:16 a.m., CNA D confirmed she had moved residents to the South Hall the next day following testing for COVID-19 positive residents on 11/18/21. CNA D stated, The residents were still trying to congregate by the nurses' station, (and) staff were wearing surgical masks, and then later in the afternoon (on 11/19/21) the employees were wearing N95s (face masks). 35102 Surveillance During an Entrance Conference on 12/13/21 at 12:30 p.m., the NHA and DON/IP were asked to provide resident line-listing infections (to include COVID-19) for November and December 2021, staff COVID-19 testing for November and December 2021, and a list of staff who have confirmed or suspected cases of COVID-19. The DON/IP said the facility's outbreak began with positive residents on 11/18/21which later affected staff. Review of an untitled and undated document showed that staff were tested on [DATE], 11/8/21, 11/11/21, and on 11/16/21. The document had multiple dashes and blanks without either the DON/IP's or ADON A's initials which would indicate testing was performed. The document does not indicate vaccination status for each staff person to determine which staff were fully vaccinated. Also, the same document does not indicate the COVID-19 results for each staff person. The total number of staff listed on the same document was 40; however, the facility's staff list was 69. During an interview on 12/14/21at 9:15 a.m., the DON/IP was asked to provide individual, staff COVID-19 Rapid Test Result forms to identify which staff was tested , which staff performed the test, which type of test was used, the date and time the test was performed and the results of the test. The DON/IP said, the facility stopped using the form and was unable to provide the data in any other way. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of November 2021 line-listing infections identified 13 residents with COVID-19. The first onset of a resident with COVID-19 was documented for 11/22/21. After four repeated requests beginning on 12/13/21 at 12:30 p.m., on 12/13/21 at 4:24 p.m., on 12/14/21 at 8:19 a.m., and on 12/14/21 at 8:36 a.m. a December 2021 line-listing was never provided. Review of the EMR, identified the first COVID-19 positive residents were on 11/18/21 during the facility's routine bi-weekly point of care (POC) testing and not on 11/22/21 as indicated on the line-listing surveillance. Outbreak Management Review of facility's Outbreak Investigation (undated) read in part, On 11/18/21 testing was completed on all residents d/t (due to) positive staff member. Positive staff member was a floor nurse that had direct contact with residents. During this routine outbreak testing 8 residents tested positive for Covid 19 with rapid tests . Additional residents tested positive: 1 on 11/19/21, 5 on 11/22/21, 1 on 11/23/21, 2 on 11/24/21, and 1 on 11/29/21 . (This indicates 18 residents tested positive in November 2021 and not 13 residents as documented on the November 2021 line-listing. During an interview on 12/13/21 at 3:57 p.m., the DON/IP was asked if the facility had identified the possible cause of outbreak. The DON/IP said, I would think they (Resident #2 and Resident #3) were 80% the cause of the outbreak since they both routinely left the faciity on LOAs (leave of absences) on Sundays. During follow-up interview on 12/14/21 at 8:43 a.m., both the DON/IP and the ADON A confirmed the Outbreak Investigation was completed by Regional Clinical Coordinator S and that neither of them had read the outbreak summary. The DON/IP said, I didn't analyze it. The ADON A said, I didn't review it. During an interview on 12/14/21 at 2:30 p.m., the NHA confirmed she had not read the facility's Outbreak Summary and was unaware who wrote the summary. During an interview on 12/14/21 at approximately 9:30 a.m., the DON/IP and the ADON A confirmed no staff surveillance nor audits were performed for infection control practices during the outbreak such as hand hygiene, smoking practices, PPE use, donning and doffing, and/or appropriate TBP. The DON/IP also confirmed no additional staff education was provided during the outbreak for staff and residents. Outbreak Timeline During an interview on 12/14/21 at 8:43 a.m., the DON/IP was asked to provide a timeline to show what actions were taken to manage the outbreak such as: 1. Date/time notifications were made to the NHA, Medical Director, and local health department 2. Date/time facility-wide testing began and ended 3. Education for all staff, residents, and visitors 3. Staff monitoring for infection control compliance 4. Date/time residents placed in TBP 5. Date/time the Visqueen barrier was set-up for COVID-19 hall 6. Contract tracing of ill staff and 7. Initiation of Monoclonal Antibody Therapy. The DON/IP confirmed a timeline was never completed on 12/14/21 at 8:43 a.m. Employee Illness (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of facility's COVID-19 Rapid Test Results showed that CNA C tested positive on 11/17/21 at 06:02 a. m. The following symptoms were listed as cough and runny nose. During a telephone interview on 12/14/21 at 10:24 a.m., CNA C said she was scheduled to work and came to the facility ill with the following symptoms: sore throat, cough, and runny nose. CNA C said LPN G performed a rapid test inside the facility's vestibule (where entrance screenings were performed) and was found positive. When asked what PPE LPN G wore to perform the test, CNA C said only a surgical mask and gloves. During an interview on 12/16/21 at 9:19 a.m., LPN G confirmed she had incorrectly recorded the wrong date on CNA C's rapid COVID test and indicated she had tested her on 11/18/21 and not on 11/17/21. LPN G said CNA C looked ill and told her she needed to be tested . LPN G confirmed she only wore a surgical mask and gloves and not an N95 (higher filtration mask), face shield or goggles, and a gown. When asked why CNA C would have attempted to come to work ill, LPN G responded, I don't know what she was thinking. Review of November 2021 Employee Infection Control Log showed CNA C on 11/18/21 had symptoms of cough and headache. And under the column Date of Symptoms Resolved read 11/18/21 (the same day she had symptoms of sore throat, cough, and runny nose). During an interview on 12/14/21 at 8:43 a.m., the DON/IP confirmed that no contract tracing was performed for any of the positive staff in November 2021. When asked which staff was identified as positive within one week prior to 11/18/21, the DON/IP did not answer the question. When asked why LPN F was not on the Employee Illness Log when she was positive for COVID-19 on 11/18/21, the DON/IP responded, Another (DON/IP) blunder . During an interview on 12/14/21 at approximately 10:30 a.m., Recreation Director (Staff) R said she sent Activity Aide (Staff) BB home due to the development of fever and feeling unwell around 1:00 p.m. on 11/18/21. Staff R confirmed Staff BB had taken residents in groups out to smoke that day. Review of an e-mail with Subject: Positive Employees sent by DON/IP on 12/1/21 identified Staff BB was tested and found positive on 11/22/21. During an initial tour observation on 12/13/21 at 1:17 p.m., four Residents (#17, #18, #19, and #20) were seated across from the nurses' desk without adherence to social distancing. Licensed Practical Nurse (LPN) AA confirmed the identities of the four residents and confirmed they were not separated by at least six feet. All five residents were not wearing face coverings at the time of the observation. Smoking During an interview on 12/13/21 at 2:07 p.m., CNA D said residents had smoking privileges before, during, and after the facility's COVID-19 outbreak. CNA D said residents were taken outside in groups of three to four approximately five times per day and most residents did not wear a face covering while waiting together to go outside by the back door located by the Rehab Department. During an observation on 12/13/21 at 4:24 p.m., a group of unidentified residents were observed outside, under the pavilion, by the facility's Rehab Department. Residents were actively smoking, seated in close proximity to one another, without social distancing in place. (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 12/14/21 at 10:39 a.m., Housekeeper (Staff) O confirmed she takes residents outside to smoke. Staff O confirmed that all but one resident was in wheelchairs and that the ground was not marked for social distancing. When asked if residents were encouraged to perform hand hygiene upon their return inside the building, Staff O said no but offered it should be done. When asked about residents' mask use, Staff O indicated it was poor. During an observation on 12/14/21 at approximately 1:30 p.m., Recreation Director (Staff) R confirmed seven residents were grouped together, who were waiting to go outside to smoke, located by the Rehab Department, were not socially distanced and were not wearing any facial coverings. Review of the eleven residents who smoked in November 2021 during the facility's outbreak, five residents contracted COVID-19 (Resident #1, #5, #6, #7, and #8). During an interview on 12/14/21 at approximately 9:30 a.m., the ADON A confirmed residents who smoked were still taken out in groups, and not individually, even though group activities were cancelled beginning on 11/18/21. Visitation Screenings During an interview on 12/14/21 at 1:14 p.m., Staff R confirmed responsibility for scheduling and screening visitors. Staff R confirmed that visitors were allowed to enter the building at two separate locations (one in the front and one in the back by Rehab Department). Staff R provided three visitation screening forms, undated, which were located from the back entrance. Review of the visitor screening forms showed many entries with missing dates, missing times, missing which resident was visited, missing temperatures, missing location of the visit, missing health questions screenings, and/or missing COVID-19 exposure. Staff R confirmed the incompleteness of the visitor screening forms were a concern for the transmission of COVID-19. Immediately after the interview with Staff R on 12/14/21 at 1:14 p.m., Staff R was asked to show the visitation screening location by the Rehab Department. Upon walking up to the table located in the vestibule, Staff R said, The hand sanitizer is missing. Housekeeping During an interview on 12/14/21 at 10:39 a.m., Housekeeper (Staff) O was asked to show each cleaning product used during the outbreak and to describe each product's intended use. When asked how long each product was to remain wet prior to wiping to ensure product kill-claim, Staff O said she did not know. When asked about PPE used for the (brand name toilet bowl cleaner), Staff O said she only wore gloves. When asked to read the instructions on the bottle, Staff O said, Am I supposed to have eye protection? I didn't know. I never read it. (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 12/14/21 at approximately 9:30 a.m., the DON/IP and the ADON A were interviewed regarding housekeeping during the outbreak. The ADON A said that the facility's Housekeeping, Laundry, and Maintenance Director left the position on 11/3/21 and the position had not been filled. The ADON A said the facility had three staff persons for housekeeping and said they all worked the day shift. When asked about the outbreak time and need for terminal cleaning and increased high-touch cleaning for evenings and nights, the ADON A said the certified nurse aides were expected to perform those duties. When asked if additional CNAs were added to the schedule, the DON/IP said no. The DON/IP and the ADON A confirmed no staff surveillance was performed. During an interview on 12/14/21 at 11:04 a.m., Housekeeper (Staff) N was unable to identify each cleaning product's kill-claim nor understood that some products were only effective in cleaning and disinfecting specific viruses and bacteria. Staff N said the only time she left the surface wet (without immediately wiping the surface) was when a room was terminally cleaned. Staff N was asked about the reconstituted bleach spray bottle. Staff N said she guessed the amount of bleach and did not use any type of measuring device. The bottle was not marked to identify the proper amount of bleach was needed for a 1:10 dilution. When asked how often the bleach/water mix was made, Staff N said she waited until the bottle was empty before making a new bottle. (Bleach/water solution needs to be reconstituted every 24 hours to ensure proper dilution for kill-claim). COVID Missed Vaccination Review of Resident #6's MDS assessment, dated 9/14/21, showed the following diagnoses: fracture, hyponatremia (low sodium in the blood), hypokalemia (low potassium in the blood), and encephalopathy (brain disease). The 12 BIMS score reflected intact cognition. Review of Resident #6's consent form, dated 9/21/21, showed consent was granted for COVID-19 vaccination but the EMR showed the vaccine had never been administered. Resident #6 contracted COVID-19 on 11/23/21 while residing in the facility. During a telephone conference on 12/15/21 at 3:13 p.m., the NHA was asked why (Resident #6) had not received the COVID-19 vaccine when she consented for it on 9/21/21. The NHA said she had reached out to the pharmacy to set-up a clinic, but it had not been scheduled. When asked if other arrangements had been made such as contacting the local health department, locating a community vaccination clinic, utilizing a walk-in clinic, or through her primary care physician, the NHA said, ok.' The EMR confirmed no other arrangements had been made to ensure Resident #6 received the COVID vaccination, with high community transmission rates, after her admission of approximately two months. References Review of the facility's policy Novel Coronavirus Prevention and Response revised 9/21, read in part: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1.b. Threat detected-the facility will respond promptly and implement emergency and/or outbreak procedures .5. F. Assess visitors and healthcare personnel, regardless of vaccination status, for symptoms of COVID-19, a positive viral test for COVID-19 or who meets criteria for quarantine or exclusion from work .6. b. Ensure proper social distancing, wearing of facemask, and hand hygiene are followed c. iv. Implement heightened surveillance activities . d. Monitor staff for fever or respiratory symptoms. Restrict from work .7. o. Restrict other residents to their rooms (to the extent possible) except for medically necessary purposes. If they leave their room, have them wear a facemask, perform hand hygiene, limit movement in the facility, and perform social distancing (efforts are made to keep them at least 6 feet away). On 12/15/21 the apporved facility abatement plan was initiated which included the following: 1. All residents were assessed for signs and symptoms of respiratory illness. The DON reviewed the 24-hour report to ensure there were no residents exhibiting signs and symptoms that were overlooked. 2. Line Listing was corrected and updated by the DON/designee and reviewed for accuracy by the Regional Clinical Consultant. 3. Staff contact tracing was completed by the DON/designee. 4. There are currently no active resident COVID-19 cases in the facility. 5. The Outbreak Timeline was completed by the DON/designee and reviewed for accuracy by the Regional Clinical Consultant. 6. The Outbreak Summary was corrected and updated by the DON/designee and reviewed for accuracy by the Regional Clinical Consultant. 7. Any current visitors in house have had a COVID-19 screening completed. 8. The Infection Preventionist has returned from leave and is on-site at the facility. 9. The screening log was reviewed by the DON/designee to ensure all staff currently working have been screened for COVID-19 and there are no acutely ill employees working . 11. Staff COVID-19 Testing log was corrected and updated by the DON/designee and reviewed for accuracy by the Regional Clinical Consultant. 12. The dates and source of the COVID-19 outbreak were corrected and updated by the DON/designee and reviewed for accuracy by the Regional Clinical Consultant.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35102 Based on interview and record review, the facility failed to ensure influenza and/or pneumococcal immunization series recommended by the Centers for Disease Control and Prevention (CDC) were appropriately provided for five Residents (#1, #2, #3, #4, and #6) reviewed for immunizations. This deficient practice resulted in unauthorized legal consent, lack of consent, and/or missed vaccinations which had the potential for serious illnesses or complications from influenza and/or pneumococcal immunizations. Findings include: Resident #1 According to the Minimum Data Set (MDS) assessment, dated 10/26/21, showed Resident #1 was admitted with the following diagnoses: coronary artery disease, atrial fibrillation (irregular heart rhythm), urinary tract infection, and weakness. The Brief Interview for Mental Status (BIMS) reflected moderate impaired cognition. The MDS assessment showed an influenza vaccine was received on 10/23/21. The Electronic Medical Record (EMR) showed Resident #1 had an activated legal Guardian X for medical decisions. Review of Resident #1's influenza consent form Vaccine Questionnaire Influenza/Pneumonia/Covid-19 and the separate Pneumococcal Immunization Informed Consent showed Resident #1 signed the forms and not the legal Guardian on 10/21/21. Review of Resident #1's EMR showed the following immunizations were administered at the facility: influenza and pneumococcal (PPSV23) were administered on 10/23/21. Resident #2 Review of Resident #2's MDS assessment, dated 11/9/21, showed the following diagnoses: diabetes, sleep apnea, hypertension, non-Alzheimer's dementia, amnesia, anxiety, and peripheral vascular disease. The 13 score for BIMS reflected intact cognition. The same MDS assessment showed influenza vaccine was received on 10/26/21. Review of Resident #2's Pneumococcal Immunization Informed Consent form showed the Durable Power of Attorney (DPOA) Y provided consent on 8/3/21. The facility had not indicated whether Pneumococcal Polysaccharide Vaccine (PPSV23) or if Pneumococcal Conjugate Vaccine (PCV13) Prevnar 13 was intended to be given since both boxes were left blank. No influenza consent form was completed after review of the EMR. Review of Resident #2's EMR showed the following immunizations were administered at the facility: influenza on 10/26/21 and pneumococcal (PPSV23) were administered on 8/5/21. Resident #3 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3's MDS assessment, dated 11/4/21, revealed the following diagnoses: hypertension, abdominal aortic ectasia (mild aortic dilation), Alzheimer's disease, and non-Alzheimer's disease. Resident #3 had severely impaired cognition. The MDS assessment showed an influenza vaccine was received on 10/26/21. Review of Resident #3's Pneumococcal Immunization Informed Consent form showed the Durable Power of Attorney (DPOA) Y provided consent on 8/3/21. The facility had not indicated whether Pneumococcal Polysaccharide Vaccine (PPSV23) or if Pneumococcal Conjugate Vaccine (PCV13) was intended to be given since both boxes were left blank. No influenza consent form was completed after review of the EMR. Review of Resident #3's EMR showed the following immunizations were administered at the facility: influenza on 10/26/21 and pneumococcal (PPSV23) were administered on 8/5/21. The EMR showed no documentation of Pneumococcal Conjugate Vaccine (PCV13) had been received. Resident #4 Review of Resident #4's MDS assessment, dated 11/23/21, showed the following diagnoses: anemia, heart failure, hypertension, diabetes, non-Alzheimer's dementia, chronic obstructive pulmonary disease (COPD), neutropenia (presence of abnormally few neutrophils in the blood, leading to increased susceptibility to infection), pancytopenia (low number of red and white cells and platelets in the blood), and morbid obesity. The eight BIMS score reflected moderately impaired cognition. The same MDS assessment showed an influenza vaccine was received on 10/26/21. Review of Resident #4's EMR showed the influenza vaccine was administered at the facility on 10/26/21. No influenza consent form was completed after review of the EMR. Resident #6 Review of Resident #6's MDS assessment, dated 9/14/21, showed the following diagnoses: fracture, hyponatremia (low sodium in the blood), hypokalemia (low potassium in the blood), and encephalopathy (brain disease). The 12 BIMS score reflected intact cognition. Review of Resident #6's Pneumococcal Immunization Informed Consent form, dated 9/21/21, showed consent was granted for Pneumococcal Polysaccharide Vaccine (PPSV23) and Pneumococcal Conjugate Vaccine (PCV13) but the EMR showed neither vaccine had been administered. A telephone conference was conducted on 12/15/21 at 3:13 p.m. with the Nursing Home Administrator (NHA), the Director of Nursing (DON)/Infection Preventionist (IP), and the Assistant Director of Nursing (ADON) A. The DON confirmed it was the facility's expectation to obtain appropriate consents for influenza and pneumococcal vaccinations and to identify on the consent which type of pneumococcal vaccine (PPSV23 or PCV13) was intended for administration. The DON also confirmed consent needed to be obtained from the responsible party and not from the resident when they are not legally their own person to make medical decisions. When asked why (Resident #6) had not received the pneumococcal vaccines after consent was received on 9/21/21, the NHA indicated she did not meet CDC's (Centers for Disease Control and Prevention) criteria due to her age. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of CDC's Pneumococcal Vaccine Timing for Adults-June 25, 2020 (cdc.gov), recommended pneumococcal vaccines for immunocompetent persons and for persons with a history of cigarette smoking for individuals who are [AGE] years of age or older. (Resident #6 was at least [AGE] years of age.) Review of the facility's list, Residents Approved for Smoking 12/13/21, identified Resident #6 as one of the current smokers. Review of the facility's policy Influenza Vaccinations dated 12/20, read in part, Individuals receiving influenza vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. Review of the facility's policy, Pneumococcal Vaccine (Series) 12/20, read in part, It is our policy to offer our residents immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations . The type of pneumococcal vaccine (PCV13, PPSV23/PPSV) offered will depend upon the resident's age and susceptibility to pneumonia, in accordance with current CDC guidelines and recommendations.