STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 32801 Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated [DATE], The Department of Health and Human Services, Center for Medicare and Medicaid (CMS) Memo QSO ,d+[DATE]-NH, revised [DATE], Nursing Home Guidance from the Centers for Disease Control (CDC), record review, review of the county community COVID-19 positivity rate, review of facility COVID-19 testing log, review of staff time sheets, review of staffing schedules, review of staff and visitor screening forms, review of resident and staff COVID-19 rapid point of care (POC) test results, review of local health department communication, review of the facility infection control log, review of the facility COVID-19 procedure policy, staff interviews, interview with the local health department and observation the facility failed to implement effective and recommended infection control practices to prevent the transmission of COVID-19 in the facility. The facility failed to ensure staff timely reported signs and symptoms of COVID-19, failed to ensure staff did not provide direct resident care to residents while symptomatic of COVID-19, failed to ensure staff and visitor screening for COVID-19 upon entrance into the facility was monitored, and failed to ensure resident contact tracing was completed to ensure additional precautions were implemented, during a COVID-19 outbreak to help reduce the spread of COVID-19 throughout the facility. This resulted in Immediate Jeopardy on [DATE] when Temporary Nursing Assistant (TNA) #144 inaccurately documented on the facility screening log for COVID-19 she was asymptomatic and proceeded to work/providing direct care to all residents in the facility. TNA #144 worked a 12-hour shift on [DATE] from 6:58 A.M. until 7:13 P.M. On [DATE] TNA #144 again inaccurately documented on the COVID-19 screening at the beginning of her shift she was asymptomatic for signs and symptoms of COVID-19. TNA #144 worked on [DATE] from 7:03 A.M. to 8:00 A.M. at which time she reported to the nurse, she had a scratchy throat and congestion and wanted tested for COVID-19. The facility performed a rapid COVID-19 test per the TNA's request and the TNA tested positive for COVID-19. At that time, TNA #144 reported her symptoms had started on [DATE]. The facility failed to ensure TNA #144, who was symptomatic of COVID-19 was timely removed from providing resident care when she first exhibited symptoms, failed to ensure contact tracing was completed to identify any staff or residents at risk for COVID-19 due to exposure to TNA #144 and failed to ensure any residents/staff with possible exposure were placed in quarantine to prevent the spread of COVID-19 in the facility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In addition, Housekeeper (HK) #114, who worked on [DATE] and [DATE] (with TNA #144) started to exhibit symptoms (stuffy nose/head) of COVID-19 on [DATE] and worked her scheduled shifts on [DATE], [DATE], [DATE], [DATE] and for five hours on [DATE], until she was tested (on [DATE]) via a rapid test which was positive for COVID-19. HK #114 reported she was in every resident's room on [DATE] and [DATE] and did not report her symptoms on the screening log because she did not think a stuffy head was one of the screening questions. HK #114 returned to work on [DATE] on the COVID-19 unit, while still exhibiting symptoms and before her isolation period (provided by the local health department) was completed. The facility failed to ensure HK #114, who was symptomatic of COVID-19 was timely removed from working in resident care areas when she first exhibited symptoms, failed to ensure contact tracing was completed to identify any staff or residents at risk for COVID-19 due to exposure to HK #114 and failed to ensure any residents/staff with possible exposure were placed in quarantine to prevent the spread of COVID-19 in the facility. The facility identified five unvaccinated residents (#9, #15, #18, #22, and #23) who had not had COVID-19 in the past 90 days who were not placed in quarantine following their possible exposure to TNA #144 or HK #114. Two additional residents (#1 and #21), who were unvaccinated were noted to be quarantined because they were new admissions and unvaccinated. The facility identified 16 residents, Resident #1, #3, #6, #12, #13, #14, #15, #16, #18, #20, #21, #23, #25, #27, #28, and #31 and three additional staff, Dietary Aide (DA) #124, Licensed Practical Nurse (LPN) #128 and LPN #129 who subsequently tested positive for COVID-19 from [DATE] to [DATE]. The risk for hospitalization , serious harm and/or death are likely related to a COVID-19 outbreak in the nursing home resident population. This had the potential to affect all 30 residents residing in the facility, with the exception of Resident #4, who was admitted to the facility from the attached Assisting Living (AL) on [DATE] with COVID-19. On [DATE] at 2:25 P.M. the Administrator, Director of Nursing (DON), Regional Quality Assurance (RQA) #149 and Regional Director of Operations (RDO) #151 were notified Immediate Jeopardy began on [DATE] when TNA #144 worked a 12-hour shift providing director care to residents while symptomatic with signs and symptoms of COVID-19. TNA #144 also worked on [DATE] with continued symptoms of COVID-19 providing direct resident care. TNA #144 tested positive for COVID-19 from a rapid test obtained on [DATE]. HK #114, who worked with TNA #144 on [DATE] and [DATE] subsequently developed symptoms of COVID-19 and tested positive for COVID-19 on [DATE]. HK #114 was symptomatic and returned to work on [DATE], before an isolation period was finished. Continued observations during the onsite investigation revealed the facility was not following acceptable infection control practices to prevent the spread of COVID-19 related permitting symptomatic staff to provide direct care, not conducting contact tracing for unvaccinated residents/staff with exposure to COVID-19 positive staff and insufficient monitoring of the staff/visitor COVID-19 screenings for COVID-19 upon entrance into the building. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following correction actions: On [DATE] Regional Quality Assurance (RQA) #149/Designee initiated an audit for all staff currently at the facility for symptoms of COVID-19. On [DATE] all residents were rapid tested for COVID-19 and infection control procedures were implemented for the one additional positive resident (Resident #21). Testing was completed by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #103. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] Resident #9 and Resident #22 who were unvaccinated and not positive for COVID-19 were placed on quarantine per CDC recommendations. On [DATE] RQA #149 educated the Administrator, DON and ADON #103 on the policies for screening staff, not permitting staff to work with symptoms consistent with COVID- 19 and the requirements for quarantining unvaccinated residents who had close contact with positive staff or residents. On [DATE] a Quality Assessment Performance Improvement (QAPI) meeting was held with the Administrator, RQA #149 and the Medical Director via phone regarding the following: Review of the policies for screening staff and visitors. Review of the requirement of not permitting staff to work if symptomatic for signs and symptoms of COVID-19. The requirement to quarantine unvaccinated residents who had close contact with COVID-19 positive staff or residents. On [DATE] the facility department heads (ADON #103, Human Resource (HR) #127, Director of Housekeeping (DOH) #152, Administrator and the DON) initiated education for all facility staff which included but was not limited to screening of staff and not permitting staff members to work who were symptomatic and that both visitor and employee screening logs were to be completed in their entirety and to notify the administration if any staff were experiencing any COVID-19 symptoms. A plan for any staff not contacted prior to midnight on this date for education would not be permitted to work until receiving education. On [DATE] the transmission-based policy was reviewed and revised by RQA #149 and/or Director of Clinical Service (DOCS) #153 to include unvaccinated residents should generally be restricted to their rooms, even if testing was negative and cared for by health care personnel (HCP) using N95 or higher-level respirator (masks), eye protection, gloves and gown. These residents should not participate in group activities. On [DATE] the Administrator, DON and ADON #103 were educated by RDOP #151 on following the local health departments guidance and not permitting employees to not return to work until deemed appropriate (cleared) by the local health department. On [DATE] a plan for ongoing audits to be completed by the supervisor or designee on duty for each shift to monitor proper screening procedures to prevent symptomatic staff/visitors from entering facility and track for any trends for four weeks and then randomly thereafter was implemented. The audit will include: Screening log filled out in its entirety and that staff who were symptomatic were not permitted to work if they were symptomatic or positive for COVID-19. On [DATE] at plan for ongoing audits to be completed by the Administrator or designee by selecting five employees three times a week and asking staff if they know the signs and symptoms of Covid, who to report symptoms to and if they know not to work with symptoms, for four weeks, then randomly thereafter was implemented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] all current staff in the facility were re-screened by the DON for COVID-19 symptoms. At the time of re-screening there were no staff members identified to have signs or symptoms of COVID-19. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of the Centers for Medicare and Medicaid (CMS) QSO-,d+[DATE]-NH memo, revised [DATE] revealed Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality. The vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting have required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes. Review of the county community COVID-19 positivity rate, dated [DATE] revealed the community transmission rate was high (red) and the facility was in a county with a positivity rate of 25%. 1. Review of the undated staff vaccination log, revealed TNA #144 received a COVID-19 vaccination on [DATE]. Review of the staff screening logs for COVID-19 dated [DATE], [DATE] and [DATE] revealed documentation the TNA had no signs or symptoms of COVID-19 nor had the employee been in close contact with anyone with COVID-19. Review of TNA #144's time sheets, revealed TNA #144 worked [DATE] from 6:58 A.M. to 7:15 P.M., [DATE] from 6:58 A.M. to 7:13 P.M. and [DATE] from 7:03 A.M. to 8:00 A.M. Review of TNA #144 COVID-19 rapid test results, dated [DATE] revealed TNA #144 tested positive for COVID-19 on this date. There was no additional information related to symptoms the TNA was experiencing at that time. Review of a letter from the local health department (dated [DATE]) revealed TNA #144 was in isolation for COVID-19 from [DATE] to [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:13 A.M. and 12:41 P.M. interview with the DON revealed the facility was not aware TNA #144 had started exhibiting COVID-19 symptoms on [DATE]. The DON confirmed TNA #144 had worked a 12 hour shift on [DATE] and [DATE] and worked one hour on [DATE]. The DON confirmed during the dates worked, when the TNA was symptomatic of COVID-19, she had possibly provided direct care to all of the residents residing in the facility. The DON revealed she did not document TNA #144's symptoms; however, she could remember the TNA reporting she had a sore throat. TNA #144 was rapid tested by the facility on [DATE] after she verbally reported she was having symptoms. The TNA tested positive and was sent to urgent care for confirmation. The urgent care confirmed the TNA was positive for COVID-19 and the TNA had reported to the physician her symptoms had started on [DATE]. The DON confirmed the local health department had provided a letter indicating TNA #144's isolation period was from [DATE] to [DATE] due the TNA first exhibiting symptoms of COVID-19 on [DATE]. On [DATE] at 1:21 P.M. interview with TNA #144 revealed she started with a head cold on either [DATE] or [DATE]. She verified she had worked 12 hours shifts in the facility on [DATE] and [DATE] providing direct care to residents on all three hallways. TNA #144 revealed her scratchy throat started on [DATE] and she thought she better report her symptoms to the nurse and be tested . The nurse rapid tested her on [DATE] and she tested positive for COVID and then went directly to the doctor for a second confirmation. TNA #114 reported she thought she had marked on the screening log she had symptoms but had only been working at the facility for a month and really didn't know what the facility policy and procedure was for working with symptoms. The facility failed to ensure TNA #144, who was symptomatic of COVID-19 was timely removed from providing resident care when she first exhibited symptoms, failed to ensure contact tracing was completed to identify any staff or residents at risk for COVID-19 due to exposure to TNA #144 and failed to ensure any residents/staff with possible exposure were placed in quarantine to prevent the spread of COVID-19 in the facility. On [DATE] at 10:05 A.M. interview with Local Health Department Nurse (LHDN) #150 revealed TNA #144 reported to the local health department (LHD) she had symptoms of COVID-19 including coughing, shortness of breath, nausea/vomiting, headache, fatigue, and diarrhea that had started on [DATE]. LHDN #150 revealed the employee was recommended to be placed in isolation from [DATE] to [DATE]. On [DATE] at 7:59 A.M. interview with the DON revealed from [DATE] until [DATE] facility staff were wearing only surgical masks and eye protection during this time period. 2. Review of the staff screening logs, dated [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] revealed no written documentation HK #114 reported she was exhibiting any signs or symptoms of COVID-19. Further review of the staff screening logs dated [DATE], [DATE], [DATE], and [DATE] revealed no evidence HK #114 was screened prior to working. Review of HK #114's time sheet documentation revealed HK #114 worked [DATE] from 6:57 A.M. until 3:08 P.M., [DATE] from 6:55 A.M. until 2:56 P.M., [DATE] from 6:55 A.M. until 2:58 P.M., [DATE] from 6:55 A.M. until 2:25 P.M., [DATE] from 6:55 A.M. until 3:05 P.M., [DATE] from 6:55 P.M. until 12:00 P.M., and [DATE], [DATE] and [DATE] from 7:00 A.M. until 2:00 P.M. HK #114 was working 7:00 A.M. to 3:00 P.M. on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of HK #114's COVID-19 rapid test results, dated [DATE] revealed HK #114 tested positive for COVID-19 on this date. Record review revealed no documentation of the symptoms exhibited by the HK at that time. A letter from the LHD, faxed [DATE] and dated [DATE] revealed a recommendation for HK #114 to be in isolation for COVID-19 from [DATE] to [DATE]. Review of the housekeeping schedule, dated ,d+[DATE] revealed there were six staff members not including HK #114 to provide housekeeping services for 30 residents. The facilities bed capacity was 50. On [DATE] at 10:13 A.M., 12:40 P.M., and 2:00 P.M. interview with the DON revealed HK #114 had worked on [DATE] and [DATE] (the time period when TNA #144 tested positive for COVID-19). The DON revealed she thought HK #114 was asymptomatic but tested positive for COVID-19 on [DATE] as part of the facility outbreak testing. The facility asked HK #114 to return to work on [DATE] to work as a housekeeper on the COVID unit because they thought she was asymptomatic. The DON revealed the facility was not aware HK #114 had been symptomatic of COVID-19 since [DATE] and still currently had symptoms. On [DATE] at 1:41 P.M. interview with HK #114 revealed she was rapid tested for COVID-19 on [DATE] as part of the outbreak testing and tested negative for COVID-19. HK #114 reported she had a stuffy nose on [DATE] and continued to work with the stuffy nose, working throughout the entire facility on all three units on this date and over the weekend [DATE] and [DATE]. HK #114 revealed she had been in every resident room throughout these dates. HK #114 reported she still had a stuffy nose, but the facility had asked her to return to work to help in the COVID unit on [DATE] before her isolation was completed. HK #114 confirmed she did not report her stuffy head on the screening log because a stuffy head was not one of the questions on the screening form. HK #114 confirmed congestion was an option on the log, however, she stated she never thought about that as a symptom or consistent with a stuffy head. The facility failed to ensure HK #114, who was symptomatic of COVID-19 was timely removed from working in resident care areas when she first exhibited symptoms, failed to ensure contact tracing was completed to identify any staff or residents at risk for COVID-19 due to exposure to HK #114 and failed to ensure any residents/staff with possible exposure were placed in quarantine to prevent the spread of COVID-19 in the facility. On [DATE] at 3:00 P.M. observation of the COVID-19 unit revealed the only staff member on the unit was HK #114. HK #114 revealed the nurse had left the unit and it was only her and the nurse working the unit on this date. The nursing assistant staff from the other units (non COVID) would come over to help the nurse if needed. The COVID unit had a keypad lock on the entrance and exit doors. On [DATE] at 7:59 A.M. interview with the DON revealed the facility was not able to provide information/evidence the facility was in staffing crisis mode to justify HK #114 working in the facility with symptoms of COVID-19. In addition, during the interview, the DON revealed HK #114 did not report signs and symptoms of COVID-19 on the screening logs for [DATE] to [DATE] and she had not been screened for COVID-19 from [DATE] to [DATE]. The DON revealed the facility was not aware HK #114 was symptomatic or had symptoms. The DON then revealed HK #114 had reported she had a stuffy head yesterday. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 10:05 A.M. interview with LHDN #150 revealed HK #114 was ordered isolation from [DATE] to [DATE] due to the employee reporting symptoms of COVID-19 beginning on [DATE]. LHDN #150 revealed she had communicated to the facility on [DATE] that HK #114 should not have returned to work until [DATE]. LHDN #150 revealed the facility had not previously reported staffing issues or that they were in a staff crisis to allow for the consideration of HK #114 working during her isolation period. LHDN #150 reported the facility should not have allowed a symptomatic positive COVID-19 employee to work, even on the COVID-19 unit. 3. In addition to the above concerns related to TNA #144 and HK #114, review of the staff screening logs revealed the following additional concerns: a. The log dated [DATE] revealed LPN #129 had cough, congestion/runny nose, muscle pain, headache, and exposure to COVID positive person. There was no evidence the LPN was immediately removed from the facility at the beginning of the shift. Review of the COVID-19 testing log, dated [DATE] revealed LPN #129 tested positive for COVID-19 via a rapid test. Review of the nursing schedule dated ,d+[DATE] revealed LPN #129 was scheduled to work on [DATE] from 8:00 A.M. to 5:00 P.M. On [DATE] at 2:34 P.M., interview with the DON confirmed the screening log, dated [DATE] indicated LPN #129 had cough, congestion/runny nose, muscle pain, headache and exposure to COVID positive person. On [DATE] at 7:59 A.M. interview with the DON revealed the facility was not able to provide information/evidence the facility was in staffing crisis mode to justify LPN #129 working in the facility with symptoms of COVID-19. On [DATE] at 8:31 A.M. interview with the DON revealed LPN #129 worked on [DATE] from 8:00 A.M. to 5:00 P.M. while symptomatic of COVID-19. The DON revealed the LPN was scheduled on the COVID-19 unit and had possibly assisted with resident COVID testing as well. b. Review of the screening log dated [DATE] revealed State tested Nursing Assistant (STNA) #122 reported she had cough, congestion/runny nose, and sore throat on this date. There was no evidence the STNA was removed from the schedule based on the identification of COVID-19 symptoms at that time. Review of STNA #122's time sheet, dated [DATE] to [DATE] revealed the STNA worked on [DATE] from 6:59 A.M. until 7:17 P.M., on [DATE] from 1:53 P.M. until 7:24 P.M. and clocked in on [DATE] at 6:59 A.M. The STNA was scheduled to work on [DATE] until 7:00 P.M. c. Review of staff screening log dated [DATE] revealed Activities Assistant (AA) #137, who was unvaccinated reported she had fatigue, headache, loss of taste and smell, had contact with a positive COVID-19 person and did not have contact with a COVID-19 positive resident. There was no evidence the AA was removed from the schedule based on the identification of COVID-19 symptoms at that time. Review of AA #137's time sheet revealed AA #137 worked [DATE] from 9:13 A.M. until 5:16 P.M. and on [DATE] from 9:02 A.M. to 5:03 P.M. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] beginning at 9:27 A.M. AA #137 was observed going from residents' room to room providing residents with activities scheduled for the day. An interview with AA #137 at the time of the observation revealed she was providing activities to residents on Units B and C. On [DATE] at 7:59 A.M. interview with the DON confirmed AA #137 had been providing one on one activities with residents not in isolation for COVID-19 that may have been for over 15 minutes in a 24 hour period. The DON confirmed AA #137 had reported symptoms consistent with COVID-19, however, was permitted to work. On [DATE] at 10:05 A.M. interview with LHDN #150 revealed the expectation of the LHD would be for symptomatic staff to not work even if they had a rapid test that was negative for COVID-19. LHDN #150 revealed this guidance was especially important to follow since the facility currently had a COVID-19 outbreak. Review of the CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, dated [DATE] revealed health care personal (HCP) should not work while acutely ill, even if COVID-19 testing was negative, to minimize the risk of transmission of other infectious pathogens, including respiratory pathogens such as influenza. 4. Review of an unvaccinated resident vaccination status form, provided by the facility revealed the list contained eight unvaccinated residents, Resident #1, #4, #9, #15, #18, #21, #22 and #23 who were residing in the facility. a. On [DATE] at 8:08 A.M. and on [DATE] at 1:31 P.M. observation revealed no evidence Resident #9 and #22 had been placed in quarantine or encouraged to stay in their rooms related to possible exposure to COVID-19 positive staff in the facility. In addition, observations during these time periods revealed staff did not wear full personal protective equipment (PPE) when entering these residents' rooms. b. On [DATE] at 8:19 A.M. interview with LPN #147 revealed the LPN reported Resident #21 was on isolation for a wound infection and not related to COVID-19. A follow up interview on [DATE] at 12:05 P.M. with LPN #147 revealed the LPN had checked Resident #21's medical record and confirmed Resident #21 was on droplet precautions related to COVID-19 and not for a wound infection. c. On [DATE] at 12:03 P.M. observation with the DON present revealed TNA #144 entered Resident #23's room. Resident #23 was in quarantine for COVID-19 related to a new admission status and being unvaccinated and identified to have been possibly exposed to COVID-19 from a roommate (Resident #1) TNA #144 did not apply proper PPE, including a gown or gloves before entering the room. TNA #144 assisted the resident from a lying position to a sitting position on the side of the bed by pulling on the resident's arms. After providing care, TNA #144 exited the room and did not change her N95 mask or clean the eye protection she was wearing. Interview with TNA #144 at the time of the observation revealed she was told by a housekeeper that Resident #23's isolation was discontinued. The DON then responded no and reminded the TNA there was a sign to see nurse and a PPE cart sitting outside the resident's room. The DON confirmed the findings during the observation after the surveyor brought the observation to her attention and verified the resident was on droplet precautions for COVID-19. Resident #23 subsequently tested positive for COVID-19 on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	5. On [DATE] at 10:13 A.M. and 12:40 P.M., on [DATE] at 7:59 A.M. and on [DATE] at 9:30 A.M. interviews with the DON revealed the following: Resident #4 had tested positive for COVID-19 on [DATE], however she was a resident in the attached assisting living at the time she tested positive. Resident #4 was moved to the nursing home side of the facility on [DATE] when she started to decline and was placed in isolation. Resident #1 and #21 were placed on quarantine because they were both new admissions, however Resident #1 contracted COVID-19 on [DATE] and Resident #21 on [DATE]. Resident #9, #15, #18, #22 and #23 were not placed on quarantine after potential close contact with TNA #144 or HK #114. The staff did not wear appropriate PPE while providing care or encourage the residents to stay in their rooms after the exposure as well. Unvaccinated residents, Resident #1, #15, #18, #21, and #23, who were not placed in quarantine, later tested positive for COVID-19 after potential exposure to the positive staff members. Unvaccinated residents, Resident #9 and #22, who were not placed on quarantine, had not tested positive for COVID-19 as of this time. During the interviews, the DON confirmed it was possible TNA #144 and HK #114 could have had close contact with all unvaccinated residents because there were not dedicated staff for each unit. The staff members were also responsible for assisting on the COVID-19 unit and then returning to the non-COVID units to provide direct care. The facility had not completed contact tracing or an investigation to determine how the COVID-19 outbreak occurred. The DON reported she thought it was the LHD's responsibility to complete the contact tracing. On [DATE] at 10:05 A.M., interview with LHDN #150 revealed the facility should have immediately placed all non-vaccinated residents on quarantine after potential exposure to the positive staff members. LHDN #150 reported the facility was small and contact tracing should have been completed or the facility should have reached out to her or the LHD for assistance with contact tracing if they needed assistance. LHDN #150 revealed the LHD was responsible for contact tracing outside the facility, however it was the facility's responsibility to perform contact tracing within the building. During the interview, LHDN #150 voiced concerns of the facility not performing contact tracing, not encouraging staff to stay home when symptomatic of COVID-19 and not utilizing dedicated staff on the COVID-19 unit. LHDN #150 revealed these concerns had been previously voiced to the health department medical director and the regional epidemiologist. 6. During the complaint investigation, the following infection control concerns and COVID-19 timeline were reviewed which included but was not limited to: a. On [DATE] at 8:08 A.M. an initial tour of the facility and interview with LPN #147 revealed outside the COVID-19 unit there was one room (A hall / room number provided) with two residents who were positive for COVID-19 and one room (C hall / room number provided) for a resident in isolation for a wound infection. There was no evidence of any other rooms for resident's in quarantine/isolation. Resident #28 tested positive for COVID-19 on [DATE]. At the time Resident #28 tested positive, her roommate, Resident #5 was not placed in quarantine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366130	A. Building B. Wing	12/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Landing Nursing and Rehabilitation	856 South Riverside Drive McConnelsville, OH 43756

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] at 9:30 A.M. interview with the DON revealed Resident #5 had a physician's order for quarantine, however no PPE equipment or signs were placed by the resident's room. On [DATE] at 1:31 P.M. observation revealed no evidence Resident #5 was in quarantine. There was no signage on the resident's door or PPE cart outside the room. At this time, Resident #5 was observed in the common area of the facility sitting less than six feet from Resident #19, without a mask. There was no evidence staff had encouraged resident to stay in their room or wear a mask. b. Record review revealed Resident #31 tested positive for COVID-19 on [DATE] after exhibiting symptoms (headache and nasal congestion). On [DATE] the resident was assessed to have an audible gurgle/rattle with exhalation breathing. The resident's skin was cool/clammy to touch and the resident was pale in color. The resident's oxygen level was 83% on three liters of oxygen via mask. The resident's temperature was 104. 6 degrees. The physician was notified and new orders were received to send the resident to the emergency room . However, the resident expired seven minutes later. Resident #31 contracted COVID-19 while residing in the facility. The resident had not left the facility or had any visitors recently. c. Unvaccinated Resident #18 and vaccinated Resident #6 shared a room and both tested positive for COVID-19. Resident #18 on [DATE] and Resident #6 on [DATE] after exhibiting symptoms (non-productive cough and hoarse voice). Resident #18 was moved to the COVID-19 unit and Resident #6 was placed in a quarantine room with unvaccinated Resident #23 who tested positive on [DATE], however was exhibiting symptoms (temperature 100.1) on [DATE] and was ordered Tylenol for temperature. Resident #23 became lethargic and had poor appetite on [DATE] when she tested positive for COVID-19. Resident #23's roommate prior to quarantine was Resident #14 who tested positive for COVID-19 on [DATE]. d. Resident #3 and Resident #16 shared a room. Resident #3 tested positive for COVID-19 on [DATE] and was exhibiting symptoms (fever, weakness, and wheezes) and Resident #16 on [DATE]. Resident #20 and #27 shared a room and both tested positive for COVID-19 on [DATE]. On [DATE] Resident #27 was treated with Tylenol for a temperature of 99.2 and sore throat, however there was no evidence she was tested for COVID-19 at that time. Resident #20 started exhibiting symptoms of weakness and hoarse voice on [DATE] so the facility tested both residents. Unvaccinated Resident #15 and roommate Resident #25 shared a room. Resident #15 was exhibiting symptoms (lethargic) of COVID-19 and tested positive on [DATE]. Resident #25 was moved to a quarantine unit, started exhibiting symptoms (weakness, hoarseness, non-productive cough) of COVID-19 and subsequently tested positive on [DATE]. Resident #12 and #13 shared a room. Resident #12 started to exhibit symptoms (lethargic, febrile, and poor appetite) of COVID-19 and tested po [TRUNCATED]