STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495193	A. Building B. Wing	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on interview, record review, and policy review, the facility failed to ensure that each resident or the financial representative received a quarterly accounting of the personal funds for one of 27 sampled residents (Resident (R) 57). Findings include: Review of R57's undated Admission Record, located in R57's electronic medical record (EMR) under the Profile tab, revealed a facility re-admitted [DATE] with multiple medical diagnoses. Review of R57's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/21 revealed the facility assessed R57 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R57 was cognitively intact. On 09/08/21 at 3:11 PM an interview with R57 was conducted. R57 stated, I have not received any statements about my funds account. On 09/10/21 at 2:40 PM an interview with the Business Office Manager (BOM) was conducted. The BOM stated R57 has a resident fund account with $16.00 in it. There was a $20.00 deposit made on 06/11/21. Statements were sent out in July, there is no address listed on the statement, I do not know where it was sent. On 09/10/21 at 2:50 PM an interview with the BOM was conducted. The BOM stated, the corporate office stated the statements for the accounts are sent out by a third party. I'm not sure where it was sent, if it was sent. Review of the facility policy Patient Trust Funds Accounts, dated 02/01/19, failed to reveal any process related to the processing of resident statements for the trust funds accounts.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. 41449 Based on Resident interview, staff interview and facility documentation review, the facility staff failed uphold Resident Rights with regards to receiving mail unopened for 1 Resident (Resident #805) in a survey sample of 12 Residents. The findings included: On 10/26/21 at 2:00 PM, an interview was conducted with Resident #805. During this interview, Resident #805 stated that her wedding ring had been stolen. When asked if it was replaced, Resident #805 said No ma'am, I never got a penny for it. It was stolen in April when [previous facility Administrator name redacted] was here and I never got a cent. On 10/27/21 at 10:05 AM, during a follow-up interview with Resident #805, she reported she they lost the ring in April, I reported it to several nurses and said they had it locked in the med cart. The administrator said corporate was going to cut a check and send it, I never received anything. Then these people took over [referring to the change in facility ownership] and [the current Administrator name redacted] said the same thing, they were going to cut a check. That's all they ever tell me. On 10/27/21, a review of the Facility Reported Incidents (FRI's) was conducted. This review revealed that the facility staff did complete a FRI report on 5/31/21. This report had a statement attached that indicated Resident #805 had removed her wedding rings due to her finger being swollen on 5/21/21. Then on 5/30/21, when the Resident requested the ring it was not able to be located/recovered. The facility conducted an investigation and on 6/4/21, filed a follow-up FRI report which indicated, We concluded that a misappropriation of patient property had occurred.The facility has agreed to reimburse [Resident #805's name redacted] for the missing ring. On 10/27/21, Surveyor C asked the facility Administrator to provide evidence of Resident #805 being reimbursed for the ring. During investigation of this, it was noted that the reimbursement check got applied to the Resident's account/bill at the facility and was not given to the Resident. The check was made payable to Resident #805. Upon Surveyor B questioning how this happened, it was determined that the facility receptionist opened the Resident mail, then wrote out a receipt for the payment. On 10/27/21 at 2:28 PM, an interview was conducted with Employee K the receptionist. She was asked about the process when mail is received. Employee K said, I meet him (mail man) in the vestibule and give him going out mail. Resident mail goes into activity mail box and they distribute it. Payments, I open and write in the receipt book and mail them [the sender] a receipt. She was shown a copy of the reimbursement check dated 7/30/21, and asked if she would open mail addressed like this, Employee K said, I would open it and write a receipt for it. She was asked, even though it is in the Resident's name? Employee K said, All payments are opened and written in the receipt book. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Business Contract/Admissions Agreement for Resident #805 revealed a copy of Resident Rights which noted 15. To have immediate access and visitation rights and to communicate privately with persons of his/her choice, and send and receive his/her personal mail unopened . Resident #805 signed the agreement along with a facility representative/Employee M on 12/12/20. Review of the 6 pages of General Acknowledgements within this same Contract, revealed no authorization for the facility staff to open Resident #805's mail. On 10/27/21, in the afternoon, a follow-up conversation was held with Resident #805. Resident #805 was unaware that she had ever been mailed a reimbursement check and that the facility staff had opened her mail and applied this reimbursement check to her bill/account at the facility which created a credit on her account. Resident #805 said she had not given authorization for the facility to do this. On 10/28/21, during an end of day meeting the facility Administrator was made aware that the facility had opened Resident #805's mail without authorization. No further information was received.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 41449 Based on Resident interview, staff interview and facility documentation review, the facility staff misappropriated a refund check for 1 Resident (Resident #805) in a survey sample of 12 Residents. The findings included: On 10/26/21 at 2:00 PM, an interview was conducted with Resident #805. During this interview, Resident #805 stated that her wedding ring had been stolen. When asked if it was replaced, Resident #805 said No ma'am, I never got a penny for it. It was stolen in April when [previous facility Administrator name redacted] was here and I never got a cent. On 10/27/21 at 10:05 AM, during a follow-up interview with Resident #805, she reported she they lost the ring in April, I reported it to several nurses and said they had it locked in the med cart. The administrator said corporate was going to cut a check and send it, I never received anything. Then these people took over [referring to the change in facility ownership] and the [current Administrator name redacted] said the same thing, they were going to cut a check. That's all they ever tell me. On 10/27/21, a review of the Facility Reported Incidents (FRI's) was conducted. This review revealed that the facility staff did complete a FRI report on 5/31/21. This report had a statement attached that indicated Resident #805 had removed her wedding rings due to her finger being swollen on 5/21/21. Then on 5/30/21, when the Resident requested the ring it was not able to be located/recovered. The facility conducted an investigation and on 6/4/21, filed a follow-up FRI report which indicated, We concluded that a misappropriation of patient property had occurred.The facility has agreed to reimburse [Resident #805's name redacted] for the missing ring. On 10/27/21, Surveyor C asked the facility Administrator to provide evidence of Resident #805 being reimbursed for the ring. During Surveyor C's investigation/questioning of this, the facility staff identified that the reimbursement check got applied to the Resident's account/bill at the facility, which created a credit balance. Resident #805 did not receive the reimbursement from the previously misappropriation of her wedding ring. The check was made payable to Resident #805. Upon Surveyor B questioning how this happened, it was determined that the facility receptionist opened the Resident mail, then wrote out a receipt for the payment. The business office manager/Employee O then indicated in writing for the corporate staff to apply the payment towards her patient liability. Review of the facility policy titled, Manual Section: Abuse/Neglect/Misappropriation/Crime, Policy Name: Administrative Reference Guide, it read, . Misappropriation of Personal Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent. On 10/27/21, in the afternoon, a follow-up conversation was held with Resident #805. Resident #805 was unaware that she had ever been mailed a reimbursement check and that the facility staff had opened her mail and applied this reimbursement check to her bill/account at the facility which created a credit on her account. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/21, during an end of day meeting the facility Administrator was made aware that the facility had misappropriated Resident #805's reimbursement check. On 10/28/21, the corporate clinical director provided Surveyor C with a copy of a second reimbursement check that the company's corporate office had written and was sending overnight to Resident #805. No further information was received.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interview, and review of the facility policy, the facility failed to issue a written transfer notice to a resident and/or legal representative and to the state Ombudsman for one of two residents (Resident (R) 5) reviewed for hospitalization s. Findings include: Review of the facility policy titled, Notice of Discharge /Transfer, dated 01/06/20, revealed When the Center initiates a notice of transfer/discharge to a patient and/or responsible party, discharge planning will pursue timely and appropriate transfer/discharge notifications as well as discharge planning initiatives to ensure a safe and orderly discharge from the Center . Provide designated copies of the completed MFA Notice of Transfer/Discharge form to each of those specified on the form, which includes the Ombudsman . Scan a copy of the Notice of Transfer/Discharge into the patient's medical record in PCC [Point Click Care-electronic medical record] under the Misc. [Miscellaneous] tab. Once the document has been scanned into PCC, complete a Discharge Planning Progress note confirming the following: Date Patient and/or RP were given the notice and the method in which they received the notice. Date the notice was sent to the ombudsman and the method by which it was sent (The Ombudsman should be notified as close as possible to the actual time of a facility-initiated transfer or discharge) . Review of R5's Face Sheet, found in the electronic medical record (EMR) under the Profile tab, revealed that R5 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of R5's EMR Misc. [Miscellaneous] tab revealed a Nursing Note, dated 02/21/21, which indicated that R5 was sent to an acute care hospital and subsequently admitted . Review of R5's EMR lacked evidence to support that a written notice of transfer was given to the resident and/or resident representative and the Ombudsman. During an interview on 09/03/21 at 11:30 AM, Discharge Planning Director (DPD) verified that there was no evidence that a written transfer notice was provided to the resident and/or resident representative or Ombudsman. During a telephone interview on 09/10/21 at 8:45 PM, the Director of Nursing (DON) verified that the facility is required to provide a written transfer notice to the resident and/or resident representative and to the Ombudsman. During an interview on 09/03/21 at approximately 1:05 PM, the Administrator verified that the facility is required to provide a written transfer notice to include appeal rights to the resident and or representative and the Ombudsman.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review and interviews, the facility failed to provide the resident and/or the resident representative a written notice of the bed hold policy in one of two residents (Resident (R) 5) reviewed for hospitalization s. Findings include: The facility was unable to provide the requested bed hold policy by the end of the survey on 09/10/21. Review of R5's Face Sheet, found in the electronic medical record (EMR) under the Profile tab, revealed that R5 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). Review of R5's EMR Misc. [Miscellaneous] tab revealed a Nursing Note, dated 02/21/21, which indicated that R5 was sent to an acute care hospital and subsequently admitted . Review of R5's EMR lacked evidence to support that a written notice of bed hold was given to the resident and/or resident representative. During an interview on 09/03/21 at 11:30 AM, Discharge Planning Director (DPD) verified that there was no evidence that a written notice of bed hold was provided to the resident and/or resident representative. During a telephone interview on 09/10/21 at 7:45 PM, the Director of Nursing (DON) verified that the facility is required to provide a written bed hold notice to the resident and/or resident representative. During an interview on 09/03/21 at approximately 1:05 PM, the Administrator verified that the facility must provide a written bed hold notice to include cost of care to the resident and or representative.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on Resident interview, staff interview, facility documentation review and clinical record review the facility staff failed to administer medications in accordance with physician orders and professional standards of practice for one Resident (Resident #806) in a survey sample of 12 Residents. The findings included: On 10/26/21 at 2:04 PM, an interview was conducted with Resident #806. During the interview RN B responded to Resident #806's call light. Resident #806 reported tightness in his chest and said they didn't give me my medicine last night, I think that may be the problem. I didn't get my gabapentin last night. I missed it once before and I got sick. On 10/26/21 at 2:14 PM, Surveyor C approached RN C at the nursing station. RN C and Surveyor C conducted a narcotic count of Resident #806's gabapentin and the count matched the quantity of pills present. A copy of the narcotic count sheet was obtained. On 10/26/21, a review of the electronic health record for Resident #806 was conducted. This review revealed physician orders dated 4/6/21, for Gabapentin that read, Gabapentin Capsule 300 MG Give 1 capsule by mouth two times a day for Neuropathy and another order dated 4/6/21, that read, Gabapentin Capsule 300 MG Give 2 capsule by mouth at bedtime for neuropathic pain. Review of the narcotic count sheet revealed that only 1 Gabapentin had been signed off as being provided on 10/25/21. On 10/27/21 at 12:04 PM, a meeting was held with the DON (Director of Nursing) and facility administrator. The DON said following the surveyor's request for records and asking if any medication errors had been identified she said, I do now have a medication error I've had to complete on his gabapentin. The DON said, It is an order entry error, the NP (nurse practitioner) put two separate orders under one entry, it repeats that one, at 9pm he should have been given 2 tablets and he was only given one. When asked what systems are in place to prevent such errors from occuring, the DON said, Doing those chart checks but that would have required someone to definitely know when you see those orders that say give this tab and that that is typically where 2 orders have been put in under one entry. Also, they now the 6 rights of medication pass, if she had read that order she would have saw where it says 2 tabs at bedtime. The DON stated their professional standards of practice they follow is: [NAME]. According to [NAME] Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to . follow physician orders . Additional Guidance from [NAME]'s Nursing Center.com (www.nursingcenter.com) Rights of Medication Administration .2. Right medication: Check the medication label. Check the order. 3. Right dose: Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well .5. Right time: check the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Right documentation: Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug . Reference: Nursing2012 Drug Handbook. (2012). [NAME] & [NAME]: Philadelphia, Pennsylvania. Accessed online at: www.nursingcenter.com. No further information was provided prior to the end of survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 30347 Based on observations, interview, and review of facility policies, the facility failed to store, prepare, and serve food under sanitary conditions. Specifically, air vents, portions of the ceiling, and electrical cords above food preparation tables and the steam table were found to be covered with dirt and dust. These failures had the potential to affect 78 of 82 residents living at the facility, who received food from the kitchen; there were four residents requiring tube feedings. Findings include: On 09/07/21 at 9:30 AM, an initial tour of the kitchen was conducted with the Dietary Manager (DM). Observations of the food preparation area in the kitchen revealed six electrical cords, hanging from the ceiling over the steam table and food preparation area, were noted to be covered with dirt and dust. The air conditioner vent and ceiling located over the reach in refrigerator were noted to be covered in dirt and dust. On 09/07/21 at 09:40 AM observations conducted in the walk-in refrigerator of the facility kitchen revealed the ceiling and all four walls to be covered in dust. On 09/07/21 at 9:30 AM an interview with the DM was conducted. The DM confirmed the ceiling, electrical cords and air conditioning vents were covered in dirt and dust. They are all dirty and need to be cleaned. On 09/07/21 at 9:40 AM an interview with the DM was conducted. The DM confirmed the ceiling, and walls in the walk-in refrigerator were covered in dirt and dust. They are dirty and need to be cleaned, staff will clean them today. Review of the facility cleaning schedule for the walk-in refrigerator dated for the week of 08/27/21 through 08/31/21 revealed, the floors, walls, food racks, labeling, and utility carts had all been cleaned.

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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** 42531 Based on interviews, record review, review of facility policy, and review of Center for Disease Control and Prevention (CDC) guidelines, the facility failed to initiate appropriate Personal Protective Equipment (PPE) to include N95 and eye protection for all staff, failed to initiate quarantine of residents during an outbreak, and failed to ensure all staff, visitors, and vendors were screened for COVID-19 signs and symptoms prior to entrance into the facility. These failures had the likelihood of increasing the risk of transmission of COVID-19 to all residents. Based on interviews, observations, and review of facility policy, the facility failed to ensure staff performed hand hygiene during meal delivery. On 09/08/21 at 7:39 PM, the Administrator was notified that the failure to ensure all staff were wearing appropriate PPE for outbreak status after the facility was notified on 09/03/21 that a staff member tested positive for COVID-19, failure to initiate quarantine of residents during an outbreak, and failure to screen all staff, visitors, and vendors constituted immediate jeopardy at F880-L: Infection Control. The facility provided an acceptable plan for removal of the immediate jeopardy for F880-L on 09/10/21 that included staff education regarding the appropriate PPE to wear during outbreak status to include an N95 mask and eye protection in the entire building, the entire North Wing Unit was placed on droplet precautions, and staff education on screening. The survey team conducted the following to verify implementation of the removal plan for F880-L: 1.The survey team conducted observations of staff on wearing the required PPE for Transmission Based Precautions (TBP) during an outbreak. 2. The survey team conducted interviews with staff on education concerning the required PPE and TBP during an outbreak. 3.The survey team observed signage indicating the facility was in an outbreak status. 4.The survey team observed signage and PPE indicating residents on the North Wing Unit were under quarantine. 5.The survey team reviewed inservice information on screening and PPE usage. 6. The survey team conducted interviews with staff to validate their understanding on screening requirements. The immediate jeopardy was removed on 09/10/21 at 3:50 PM. The deficient practice remained at an F (potential for more than minimal harm) scope and severity following the removal of the immediate jeopardy. Findings include: (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 CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, dated 02/23/21 states, New Infection in Healthcare Personnel or Resident . Because of the high risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a Nursing Home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak . HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e. , goggles or a face shield that covers the front and sides of the face), gloves, and gown . Residents should generally be restricted to their rooms and serial SARS-CoV2 testing performed . Establish a Process to identify and Manage Individuals with Suspected of Confirmed SARS-CoV-2 Infection. Ensure everyone is aware of recommended IPC practices in the facility. Post visual alert (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) with instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene). Review of facility policy titled COVID-19, effective date 06/30/21, revealed, Surveillance -Employees. Screen Center employees prior to beginning shift to include Positive travel history to locations with sustained community transmission of COVID-19 withing the past 14 days. Signs or symptoms of COVID-19 (temperature greater than 99.5 degrees F or 37.5 degrees C), chills, sore throat, cough, nasal congestion, congestion, runny nose, fatigue, myalgia, body aches, shortness of breath, difficulty breathing, headache, nausea, vomiting, diarrhea, or new loss of tase or smell). Review of the facility policy titled, COVID-19 Plan undated revealed: Employee screening: 100% screening of all staff entering the center at the beginning of each shift . During the entrance conference on 09/07/21 at 09:00 AM, the Administrator indicated that the facility currently had one staff member out of work that tested positive for COVID-19 during a weekly COVID-19 test on 09/03/21. Upon entry to the facility on [DATE] at 09:00 AM, no signs were observed on the facility entrance indicating that the facility was in outbreak status. During an interview with the Director of Nursing (DON) and Administrator on 09/08/21 at 9:45 AM, both the DON and Administrator were observed wearing surgical masks and not the required N95 mask and eye protection as required per CDC guidelines during an outbreak status. At this time the DON was unable to indicate what precautions should be put into place after a staff member and/or a resident tests positive for COVID-19.Per the CDC guidance during outbreak status facility is to implement N95 masks and eye protection for all staff, staff is to wear all PPE (N95, eye protection, gowns, and gloves) when caring for residents who have been exposed, residents are to remain in their rooms unless wearing a face mask and practicing social distancing in common areas, and to post signs indicating outbreak status with required PPE. During an interview on 09/08/21 at 10:00 AM, the Infection Preventionist (IP) indicated that she was in the building working on 09/03/21 and was not notified of a staff member that tested positive for COVID-19, and had she been notified she would have begun CDC recommendations for outbreak status to include, posting signs of the outbreak on the front door, initiating appropriate PPE to include N95 and eye protection, initiating droplet precautions for the unit the staff member was on, and interviewing the NWM as to where she came in, what her symptoms were, and who she came into contact with. (continued on next page)

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Henrico Health & Rehabilitation Center	561 North Airport Drive Highland Springs, VA 23075

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observations from 09/08/21 at 9:45 AM through 09/09/21 at 10:00 AM revealed staff on the North Wing wearing surgical masks, not N95 face masks, and no eye protection despite the facility being in an outbreak. It took surveyor intervention on 09/09/21 at approximately 10:00 AM for the facility to implement the CDC guidelines during an outbreak. During an interview on 09/10/21 at 11:07 AM, Registered Nurse (RN)1 indicated she was in serviced that morning [09/10/21] about what PPE is required during an outbreak this morning. During an interview on 09/10/21 at 11:39 AM, CNA 3 indicated she was at approximately 10:00 AM as to the appropriate PPE to wear during an outbreak status to include N95 mask, eye protection and using droplet precautions when in residents' rooms. During a telephone interview on 09/10/21 at 5:00 PM, the North Wing Unit Manger (NWM) stated that at approximately 10:00 AM on 09/03/21 there was an announcement for the weekly COVID-19 testing in the dining room. NWM stated she tested positive during the rapid antigen test and the DON then did a PCR test and immediately sent her home. The NWM further stated that she does not screen herself at the entrance and she thought the screening Kiosk was for visitors. She stated she used it the day of her interview and thought that after she was hired, she was not a visitor anymore. VWM further indicated that no one instructed her to screen before entering the facility. VWM stated she was not instructed on the screening process. During an interview on 09/09/21 at 4:41 PM, the Administrator indicated that she was unable to find any evidence that NWM screened for signs of COVID-19 prior to working a shift since July 2021. The Administrator was asked to provide to the survey team all screening logs for the facility for the months of July, August, and September 2021. By the end of survey on 09/10/21 at 10:00 PM the Administrator was unable to provide screening logs. During an interview on 09/09/21 at approximately 5:45 PM, the DON stated that staff are educated upon hire that they are supposed to screen themselves before entering the building, either by using the electronic Kiosk in the front of the building, or the paper form in the back of the building. The DON stated there was no written staff screening policy and procedure, and that it's done verbally, with no paper documentation to indicate staff screening was done. 30347 2. The facility failed to ensure staff performed hand hygiene during meal delivery. On 09/07/21 at 12:20 PM multiple observations of Certified Nursing Assistant (CNA) 3 were conducted. CNA3 was observed delivering lunch to Resident (R) 74, R24, R50, R67, R44, R62, and R23. CNA3 was observed pushing the food cart, opening the doors of the food cart, handling multiple trays for other residents, and touching his clothes. CNA3 failed to perform hand hygiene of any kind (ABHR, hand washing) between the handling of the residents' food trays. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/07/21 at 12:20 PM multiple observations of CNA5 were conducted. CNA5 was observed delivering lunch to R16, R59, R2, R22. CNA5 was observed pushing the food cart, opening the doors of the food cart, handling multiple trays for other residents, and touching her clothes. CNA5 failed to perform hand hygiene of any kind (ABHR, hand washing) between the handling of the residents' food trays. On 09/07/21 at 12:20 PM multiple observations of CNA1 were conducted. CNA1 was observed delivering lunch to R3, R71, R6, R52 and R79. CNA1 was observed pushing the food cart, opening the doors of the food cart, handling multiple trays for other residents, and touching her clothes. CNA1 failed to perform hand hygiene of any kind (ABHR, hand washing) between the handling of the residents' food trays. On 09/07/21 at 12:35 PM an interview with CNA1 was conducted. CNA1 stated, I was not taught to sanitize between trays. On 09/07/21 at 12:37 PM an interview with CNA5 was conducted. CNA5 stated, I was not taught to sanitize between trays. On 09/07/21 at 12:45 PM an interview with CNA3 was conducted. CNA3 stated, I'm supposed to wash hands in between trays, but I don't touch anything (doors, tables, etc.) I only handle the trays, so I don't need to wash. 30260 Observation on 09/07/21 at 12:05 PM, revealed Certified Nursing Assistant (CNA) 4 removing a food tray from a food cart stationed in the hallway, entering room [ROOM NUMBER], and delivering a food tray to the resident in bed B. CNA4 failed to perform hand hygiene before entering room [ROOM NUMBER]. CNA4 was further observed leaving room [ROOM NUMBER] and obtaining another food tray from the food tray cart in the hallway. CNA4 delivered the food tray to the resident in bed A room [ROOM NUMBER]. CNA4 failed to perform hand hygiene after delivery the tray to the resident in bed A. CNA4 was observed to exit room [ROOM NUMBER] and obtain a food tray for the resident in room [ROOM NUMBER] bed B. CNA4 failed to perform handwashing before and after the delivery of two food trays to the two residents in the room [ROOM NUMBER]. Continued observation revealed CNA4 leaving room [ROOM NUMBER], proceeding to the food cart, and retrieving a food tray for room [ROOM NUMBER]. No hand hygiene was performed. CNA4 entered room [ROOM NUMBER] and donned (put on) gloves. CNA4 failed to perform hand hygiene before entering resident's room [ROOM NUMBER] and before donning gloves. After donning gloves, CNA4 set up the food tray for the resident in room [ROOM NUMBER] bed A. When set-up was completed, CNA4 doffed (removed) the gloves and left the room without performing any handwashing. CNA4 retrieved a food tray from the food cart, returned to room [ROOM NUMBER], and delivered the food tray to the resident in B bed. No hand hygiene was performed. CNA4 was then observed retrieving the food tray from the resident in the B bed in room [ROOM NUMBER] and returning the tray to the food cart. When asked why, CNA4 stated that the resident in 57B had her own food and had declined the food tray. No handwashing was performed throughout the preceding observations. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	CNA4 proceeded to retrieve a food tray for the resident B bed in room [ROOM NUMBER]. CNA4 donned gloves to assist the resident in 58B with the tray. CNA4 discarded gloves, left room [ROOM NUMBER], entered room [ROOM NUMBER], and failed to perform hand hygiene in between assisting the residents in room [ROOM NUMBER] and 59. Next, CNA4 entered room [ROOM NUMBER] (only one resident in the room) with a food tray, donned gloves, and began to feed the resident in the A bed. No hand hygiene was performed before entering the room, donning gloves, and feeding the resident. CNA4 doffed the gloves and left room [ROOM NUMBER] for the pantry to pick up a can of soda for the resident in bed A in room [ROOM NUMBER]. No hand hygiene was performed. CNA4 reentered room [ROOM NUMBER]A and gave the soda to the resident in room [ROOM NUMBER]. CNA4 donned gloves without performing hand hygiene and continued to feed the resident in bed A room [ROOM NUMBER]. CNA4 doffed gloves and left the room for the nurse's station to get a telephone. Upon returning to the room, CNA4 donned gloves and assisted the resident to make a phone call. With the same gloves still on, CNA4 wet a washcloth and cleaned the resident's face. After cleaning the resident's face, CNA4 discarded the gloves and was observed washing her hands at the sink in room [ROOM NUMBER]. In an interview with CNA4 on 09/07/21 at 12:45 PM, CNA4 stated that she was a TNA (Nursing Assistant in training) and had been a TNA with the facility for about 6 months, training to get her certification as a CNA. CNA4 was told that during observations for the prior 45 minutes that she had been observed going in and out of residents' rooms without performing hand hygiene and only performed hand hygiene one time at 12:45 PM in room [ROOM NUMBER]. CNA4 stated that she only just came on duty and that she had used sanitizer. When CNA4 was told that she had not been observed using hand sanitizer, she gave no further responses. A review of the facility's policy titled Infection Prevention & Control Policies & Procedures-Handwashing Requirements, Policy Number 401, Effective Date 02/06/20, revealed that: All staff are trained in proper technique upon hire, annually, and PRN, and are monitored for proper handwashing practices. Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections . Hand hygiene can consist of handwashing with soap and water or use of an alcohol-based hand rub (ABHR). A. Hand Hygiene l. The following is a list of some situations that require hand hygiene: a. When coming on duty. b. When hands are visibly soiled (handwashing with soap and water); before and after direct patient contact (for which hand hygiene is indicated by acceptable professional practice) e. Before and after eating or handling food (handwashing with soap and water) f. Before and after assisting a patient with meals (handwashing with soap and water) g. Before and after assisting a patient with personal care (e.g., oral care. bathing) (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	r. After removing gloves or aprons s. After completing duty

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Report COVID19 data to residents and families. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on record review, interviews, review of facility documents, and review of Centers for Medicare and Medicaid Services (CMS) memo QSO-20-29-NH, the facility failed to notify in a timely manner residents and resident representatives when a staff member tested positive for COVID-19. This failure had the potential to affect all 85 residents in the facility. Findings include: Review of the CMS Ref: QSO-20-29-NH Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes, dated May 6, 2020, revealed The facility must inform residents, their representatives, and families of those residing in facilities by 5:00 PM the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. During an entrance conference on 09/07/21 at 9:10 AM, the Administrator indicated that during a routine weekly testing, an asymptomatic staff member tested positive for COVID-19, as indicated by a rapid antigen test. A polymerase chain reaction (PCR) test was immediately done and sent out and the staff member was immediately sent home. Positive PCR results were obtained on 09/03/21. The Administrator stated that after the positive result all staff and residents were tested on [DATE] with negative results. The Administrator stated that all staff, residents and/or their resident representatives were notified that there was positive COVID-19 in the facility immediately after positive results were obtained. During an interview with Resident (R) 67 on 09/08/21 at 10:45 AM, R67 indicated he had not been notified of a staff member who tested positive for COVID-19 on 09/03/21. Review of R67's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/10/21 revealed a Brief Interview for Mental Status (BIMS) of 15 out of 15 indicating intact cognition. During an interview with R5 on 09/08/21 at 10:49 AM, R5 indicated that he had not been notified of a staff member who tested positive for COVID-19 by 09/04/21. Review of R5's MDS with ARD of 06/09/21 revealed a BIMS of 15 out of 15 indicating intact cognition. During an interview on 09/08/21 at 9:45 AM with the Director of Nursing (DON) and Administrator, the DON indicated when a resident or staff member test positive for COVID-19 the receptionist is responsible to ensure that all the families are notified of a positive case of COVID-19 in the building. Staff are notified by a notice on the time clock and verbally. The DON was unable to provide evidence that this was done. (continued on next page)

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview on 09/08/21 at 10:14 AM, the Administrator confirmed residents and/or family representative were not notified of a staff member that tested positive for COVID-19 by 5:00 PM on 09/04/21. During an interview on 09/08/21 at 10:43 AM, the Infection Preventionist (IP) stated that she was present in the building on 09/04/21 and was not aware that a staff member tested positive for COVID-19. The IP stated that if she had been made aware she would have printed out a resident census and given it to the receptionist to notify family members and would have ensured that staff and residents were notified. During an interview on 09/08/21 at 11:39 AM, Certified Nursing Assistant (CNA) 5 stated that she was notified by one of her co-workers that there was a positive staff member mid-morning on 09/04/21 after she had already begun her shift. CNA5 verified that she was not notified by the facility management. During an interview on 09/08/21 at 11:42 AM, Licensed Practical Nurse (LPN)1 indicated that she was given a facemask and face shield upon entrance but was not informed that the facility was in outbreak status. During an interview on 09/09/21 at approximately 11:06 AM, the Receptionist (RS) indicated that they used to get a facility census during an outbreak, and they would document on the census when they contacted family members to notify them of the outbreak, but she has not seen the book since the old Administration left. The RS could not remember if a census list was provided on 09/03/21 and indicated that it would have been given back to the Administrator. During an interview on 09/09/21 at 1:21 PM, the Nurse Consultant confirmed that the facility COVID-19 policy did not include, when and how to notify residents and/or resident representatives of a positive case of COVID-19 in the facility.

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42531 Based on interview, record review, review of policies and procedures, and review of the Centers for Medicare and Medicaid Services (CMS) QSO 20-38-NH Revised memo, the facility failed to implement outbreak testing of staff and residents to prevent the spread of COVID-19 upon identification that a North Wing Unit Manager (NWM) tested positive for COVID-19 on 09/03/21. This failure increased the likelihood of COVID-19 transmission to the 82 residents living at the facility. As of 09/08/21 at 7:01 PM, the facility had not begun outbreak testing per CMS guidance. On 09/08/21 at 7:39 PM, the Administrator was notified that the failure to ensure that all residents and staff were tested for COVID-19, regardless of vaccination status, after the facility was notified on 09/03/21 that the NWM tested positive for COVID-19, constituted immediate jeopardy at F886-L: COVID 19 Testing Residents and Staff. The facility provided an acceptable removal plan for the immediate jeopardy at F886-L on 09/10/21. The removal plan for F886-L included: 1. testing of all residents and staff, regardless of vaccination status, completed on 09/09/21; 2. continued testing of all COVID negative staff and residents, regardless of vaccination status every 3-7 days until testing identified no new cases of COVID 10 infections among residents for staff for a period of at least 14 days since the most recent positive case of 09/03/21; 3. staff to be notified of testing dates by a memo at the front entrance and time clock; 4. the Director of Nursing (DON) or designee to document test results of staff and residents on a line list log, the line list will be reviewed by the DON or designee for positive results, and any positive staff or residents will restart the outbreak testing guidelines; and 5.the Infection Preventionist, the DON and the Administrator were educated by the Nurse Consultant on COVID testing requirements and appropriate documentation of the testing results on 09/09/21. The survey team conducted the following to verify implementation of the removal plan for F886-L: 1.The survey team reviewed the testing logs for all the residents and staff completed on 09/09/21. 2.There were no positive results for the residents and/or staff from the 09/09/21 testing to reset the duration of the outbreak testing at the time of the survey. 3.The survey team observed the posting for staff testing dates. 4.The survey team reviewed the testing/results line list log from 09/09/21. 5. The survey team reviewed the education provided by the Nurse Consultant on COVID testing and documentation. The immediate jeopardy was removed on 09/10/21 at 3:50 PM. The deficient practice remained at an F scope and severity (potential for more than minimal harm) following the removal of the immediate jeopardy. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Findings include: Review of facility policy titled, COVID-19 Testing, dated 05/04/21, revealed COVID-19 testing will be performed by trained personnel following CMS recommendations for testing . Outbreak testing for employees and patients: a. An outbreak is defined as a new COVID-19 infection. Upon identification of a single new case of COVID-19 infection in any employee or patient, testing is indicated. b. Outbreak testing of all employees and patients will occur as soon as possible when a new case is identified, regardless of vaccination status. Retesting of negative individuals will occur every 7 days until testing identifies no new cases of COVID-19 infection among employees or patients for a period of at least 14 days since the most recent positive result. Review of Centers for Medicare & Medicaid Services (CMS), Ref: QSO-20-38-NH, dated 04/27/21, revealed . For outbreak testing, all staff and residents should be tested , regardless of vaccination status, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result . Documentation of testing: Symptomatic patients and employees- document the date(s) and times(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the Center took based on the results. Identification of a new COVID-19 case in the Center-document the date the case was identified, date that all other patients and employees were tested , and the dates that all negative patients and employees were retested .For routine unvaccinated employee testing, document the centers county positive rate, corresponding testing frequency, and the date each positivity rate was collected, as well as date(s) that testing is performed . During the entrance conference on 09/08/21 at 09:00 AM, the Administrator indicated that the facility currently had one staff member out of work that tested positive for COVID-19 during a weekly COVID-19 test on 09/03/21. The Administrator further indicated the entire staff and residents were tested on [DATE] and all results were negative. The facility was unable to provide evidence that the residents and staff were tested for COVID-19 on 09/03/21. During an interview on 09/08/21 at 10:43 AM, the Infection Preventionist (IP) stated that the facility did not perform any COVID testing on 09/03/21. The IP stated that she is required to report the test results to the Department of Health (DOH). Upon asking the DOH for evidence of facility testing, the IP received an email indicating that the DOH was unable to provide any specific information about submitted results. On 09/08/21 at 11:35 AM an interview with Certified Nursing Assistant (CNA) 2 was conducted. CNA2 stated I have not been tested in the last two weeks. During an interview on 09/08/21 at 11:39 AM, with two residents (Resident (R) 6 and R52) was conducted. Both stated they were tested last week but neither could remember the exact day. Review of a R6's electronic medical record (EMR) significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/05/21 revealed a Brief Interview for Mental Status (BIMS) of 14 out of 15 indicating intact cognition. Review of R52's EMR quarterly MDS with an ARD of 08/10/21 revealed a BIMS of 14 out of 15 indicating intact cognition. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Interview with North wing Licensed Practical Nurse (LPN)1 on 09/08/21 at 11:42 AM indicated that she was given a facemask and face shield upon entrance to the facility but was not informed that the facility was in outbreak status. During an interview with the Director of Nursing (DON) and Administrator on 09/08/21 at 10:14 AM, the DON confirmed that the facility could not provide evidence that the residents and staff members were tested for COVID-19 after a staff member tested positive on 09/03/21. The DON indicated that it was the IP who kept the testing logs of both staff and residents. The facility was unable to provide any line listings of staff and/or resident testing prior to the survey team leaving the facility on 09/09/21 at 10:00 PM.

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41450 Based on staff interview and facility documentation review, the facility staff failed to document the COVID-19 vaccination status for 27 out of 85 staff members. The findings included: The facility staff failed to obtain and document the COVID-19 vaccination status for 27 out of 85 staff members. On 10/27/21, a copy of the facility's documentation for the COVID-19 Immunization status staff members was requested and received from the Facility Administrator. Review of the document revealed that from a list of 85 staff members, the COVID-19 immunization status was unknown for 23 staff members as noted with blank spots in both the 1st vaccine and 2nd vaccine columns and 4 additional staff members that only had a first dose date recorded with a blank spot noted under 2nd vaccine column. On 10/27/21, an interview was conducted with the facility's Infection Preventionist who verified the list for staff members COVID-19 vaccine status was current and the immunization status was unknown for 23 staff members listed and incomplete for 4 members listed. The Infection Preventionist further stated, I do not have a vaccination status list for agency staff as well as dietary and housekeeping staff, I am unaware of their [COVID-19 immunization] status there is no written [COVID-19] vaccination policy that I'm aware of. On 10/28/21 at approximately 10:30 AM, a group interview was conducted with the Infection Preventionist and the facility Staff Development Coordinator, both whom verified there were no additional updates made to the COVID-19 vaccine status list for staff members previously submitted the day before. On 10/28/21 at approximately 2:00 PM, a group interview was conducted with the Facility Administrator, Director of Nursing, and Corporate Clinical Consultant and updated on the findings. The Corporate Clinical Consultant verified she was aware of the current regulations for COVID-19 Immunizations that were updated by CMS (Centers for Medicare & Medicaid Services) on 5/11/21. The CMS (Centers for Medicare & Medicaid Services) recommendations found in Ref: QSO-21-19-NH, revised on 5/11/21, page 5, read, The facility must document the vaccination status of each staff member (i.e. , immunized or not), including whether fully immunized (i.e., completed the series of multi-dose vaccines).