STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435125	A. BUILDING ______ B. WING ______	12/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRAND-KJORSVIG COMMUNITY REST HOME	**801 S MAIN POST OFFICE BOX 195** **ROSLYN, SD 57261**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 42477 A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office ending on 12/14/20. Strand-Kjorsvig Community Rest Home was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6). The facility was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulation(s): F550, F562, F563, F583, F882, and F885. The facility was found not in compliance with 42 CFR Part 483.80 infection control regulations, and had not implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. Three deficiencies were found: F835, F880, and F886. On 12/9/20 at 5:45 p.m. an Immediate Jeopardy was identified when the facility failed to ensure: *Staff and visitors were screened for signs and symptoms of COVID-19. *A dietary aide that had COVID-19 and was symptomatic did not serve meals in the main dining room to residents that had not tested positive (widespread). *A face mask worn into a COVID-19 positive room was not worn into a non-COVID-19 room (widespread). *A COVID-19 positive resident remained in isolation for 10 days, and was not walking around the facility without a mask on (widespread). *Residents were screened and assessed for all signs and symptoms related to COVID-19	F 000	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. This plan of correction is prepared for these defienceis was executed solely because it is required by provisions of State anf Federal Law. Without waiving the foregoing statement, the faiclity states that with respect to:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chad Stroschein	Administrator	12/30/2020

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.

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F 000	Continued From page 1 (widespread). An onsite visit was completed on 12/11/20 at 11:15 a.m. to verify the immediate jeopardy removal plan. Immediate jeopardy was not removed due to the following: *All staff were not immediately educated as stated in their removal plan. *A physical therapy assistant was observed exiting a positive COVID-19 resident's room, did not change or remove her N95 mask. -She did not receive the education outlined in the immediate jeopardy plan. *A positive staff working stated she used the community break room and the staff restroom. *She was unable to name all of the four negative residents that she should not be working with. *They were not going to start their monitoring plan until the following week. *They had not implemented the increased screenings for residents for all the signs and symptoms of COVID-19. Immediate Jeopardy was removed on 12/14/20 at 12:48 p.m. after the removal plan implementation was verified during an onsite visit by the surveyor. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F". The resident census was 26.	F 000		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 835	Provider will update the infection control policy to reflect that all visitors will be screened by staff upon entering the building Staff will be educated on the updated policy. Director of Nursing or designee will audit staff compliance to this updated policy 3 times per week for one week then once per week for three more weeks and monthly for two more months.	1/1/2021

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F 835	Continued From page 2 well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and policy review, the provider failed to ensure during a world wide pandemic the facility was administered and operated in a manner to ensure the safety and overall wellbeing for all twenty-six residents in the facility. Findings include. 1. Interviews, observations, record reviews, and policy reviews throughout the course of the survey revealed the administrator and the director of nursing (DON) had not ensured the safe management and overall well-being of all residents in the outbreak of a pandemic (COVID-19). 2. On 12/9/20 at 5:45 p.m. an Immediate Jeopardy was identified when the facility failed to ensure: *Staff and visitors were screened for signs and symptoms of COVID-19. *A dietary aide that had COVID-19 and was symptomatic did not serve meals in the main dining room to residents that had not tested positive (widespread). *A face mask worn into a COVID-19 positive room was not worn into a non-COVID-19 room (widespread). *A COVID-19 positive resident remained in isolation for 10 days, and was not walking around the facility without a mask on (widespread). *Residents were screened and assessed for all signs and symptoms related to COVID-19 (widespread). On 12/9/20 at 5:45 p.m. the immediate jeopardy	F 835	Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendation. Provider will have positive COVID staff work only with positive COVID residents based on staff availability and logistically assigning staff to the area of the building with the most positive COVID residents through the work schedule. Infection control policy will be updated to reflect these changes. All staff will be educated on the updated policy. Dining assistant and all other staff will be re-educated on the updated policy regarding positive COVID staff not working with negative COVID residents. All negative COVID residents will be audited to ensure that positive COVID staff are not working with them. Director of Nursing or designee will audit staff compliance to this updated policy for three times per week for one week then once per week for three more weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAPI meeting for review and recommedation. Provider will update the infection control policy regarding use of face shields and N95 masks and removal of the face shiled by staff when leaving a positive COVID resident room. All staff will be re-educated on the removal of face shields after leaving a positive COVID resident room. Director of Nursing or designee will audit staff usage of N95 masks and face shields three times per week for one week then once per week for three more weeks and monthly for two more months. Diretor of Nursing will report audit findings at the monthly QAPI meeting for review and recommendation.	

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F 835	Continued From page 3 findings were discussed with DON B, Administrator A, and assistant administrator for the South Dakota Department of health via telephone conference. Administrator A revealed they would began working on their plan of correction immediately. Refer to F880, findings 1, 2, 3, 4, 5, 6, and 7. 3. Interview on 12/9/20 at 1:19 p.m. with DON B revealed: *Since having a resident test positive on 11/13/20, they had not been testing residents every three to seven days. *They tested residents only when they showed symptoms related to COVID-19. *Staff did not have set days or times to be tested. *Staff were good about letting her know if they needed to be tested. *DON B was not sure if all staff had been routinely tested every three to seven days. Refer to F886, findings 1, 2, and 3.	F 835	Provider will update the infection control policy regarding the isolation of positive COVID residents to include the 10 days of isolation needed for positive COVID residents. Resident 2 and all other positive COVID residents will be audited to esnure they are staying in isolation for 10 days after testing positive for COVID. Staff will be educated on the updated policy. Director of Nursing of designee will audit staff compliance to this updated policy three times per week for one week then once per week for three more weeks and monthly for two more months. Director of Nursing will report audit findings at the monthly QAPI meetings for review and recommendation. Provider will update the infection control policy to reflect the need to test COVID negative residents every 3 to 7 days for COVID when a resident test positive. Staff will educated on the updated policy. Director of Nursing or designee will audit testing compliance once per week for four weeks and monthly for two more months. Director of Nursing will present the audit findings at the monthly QAPI meetings for review and recommednation.	
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880	F835 continued: Provider will set days for the staff to be tested for COVID and the infection control policy will be updated to reflect these changes. Staff will be eduacted on the updated policy. Director of Nursing or designee will audit testing compliance once per week for four weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendation.	

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F 880	Continued From page 4 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	F880: Provider will update the infection control policy to reflect that all visitors will be screened by staff upon entering the building. staff will be educated on the udpated policy. Director of Nursing or designee will audit staff compliance to this updated policy three times per week for one week then once per week for three weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendation. Provider will update the infection control policy to reflect the need to test COVID negative staff and residents every 3 to 7 days for COVID when the facility is in outbreak status. Staff will be educated on the updated policy. Director of Nursing or designee will audit staff compliance once per week for four weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendation. Provider will update the infection control policy regarding the use of face and N95 masks and removal of face shields by staff when keaving a positive COVID resident room. Staff H, K, L and all other staff will be re-educated on the removal of face shields after leaving a COVID resident room. Director of Nursing or designee will audit staff usage of N95 masks and face shields 3 times for one week and then once per week for three weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendation.	1/1/2021

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F 880	Continued From page 5 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, policy review, and reference source review, the provider failed to implement proper infection control practices for the coronavirus (COVID-19) pandemic with the potential for exposing residents and staff to serious harm including death, by failing to: *Screen staff and visitors for all signs and symptoms related to COVID-19. *All staff and residents were tested three to seven days due to their outbreak status. *Ensure three of three nursing aides (H, K, and L) and one physical therapy staff (K) disposed of face masks or stored them safely after assisting residents that were positive for COVID-19 (2, 3, 4, 5, and 6). *Ensure residents negative for COVID-19 were not exposed to a staff that had COVID-19 and was symptomatic. *Ensure the health and safety of all staff and residents. *Ensure staff who had tested positive were not: -Working while symptomatic for one of one dietary aides (D).	F 880	Provider will have positive COVID staff work only with positive COVID residents based on staff availability and logistically assigning staff to the area of the building with the most COVID positive residents through the work schedule. The infection control policy will be updated to reflect these changes. All staff will be educated on the updated policy. Dietary assistant D and all other staff will be re-educated on the updated infection control policy regarding positive COVID staff not workgin with negative COVID residents. All negative COVID residnets will will be audited to ensure that positive COVID staff are not working with them. Director of Nursing or designee will audit staff compliance to this updated policy 3 times per week for one week then once per week for three more weeks and monthly for two more months. Director of Nursing will report aduit findings at the monthly QAPI meetings for review and recommendation.	

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F 880	Continued From page 6 -Working only with positive staff and positive residents. -Working in the dining room that contained residents from both memory lane and morning glory hallways. -Utilizing the same breakroom and restroom as other staff members (widespread). *Residents were screened and assessed per Centers for Disease Control and Prevention (CDC)'s recommendations (widespread). *Ensure residents remained on isolation for ten days for one of five residents (2). These failures had the potential to expose all residents, staff, and visiting essential personnel to COVID-19, a viral infection that could lead to serious harm or death. NOTICE: On 12/9/20 at 5:45 p.m. an Immediate Jeopardy was identified when the facility failed to ensure: *Staff and visitors were screened for signs and symptoms of COVID-19. *A dietary aide that had COVID-19 and was symptomatic did not serve meals in the main dining room to residents that had not tested positive (widespread). *A face mask worn into a COVID-19 positive room was not worn into a non-COVID-19 room (widespread). *A COVID-19 positive resident remained in isolation for 10 days, and was not walking around the facility without a mask on (widespread). *Residents were screened and assessed for all signs and symptoms related to COVID-19 (widespread). At the above time the administrator and director of nursing (DON) B were asked for an immediate	F 880	Provider will updated infection control policy regarding the isolation of positive COVID residents to include 10 days of isolation needed for positive COVID residents. Resident 2 and all other COIVD positive residents will be audited to esnure the residents are staying in isolation for 10 days after testing positive for COVID. Staff will be educated on the updated policy. Director of Nursing or designee will audit staff compliance to this updated policy 3 times per week for one week then once per week for 3 more weeks and monthly for two more months. Director of Nursing will report audit findings at the monthly QAPI meetings for review and recommedation.	

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F 880	Continued From page 7 plan of correction (POC) to ensure all staff working in the facility received education and monitoring for nationally recognized infection control procedures. PLAN: On 12/10/20 at 4:40 p.m. the DON B and administrator provided the surveyor with an email that included the final written removal plan. The written removal plan was approved by the assistant administrator for the department of health on 12/10/20 at 5:53 p.m. The facility provided the following acceptable removal plan on 12/10/20: "Positive COVID Staff working with Negative Residents: Provider will have positive COVID staff work only with positive COVID residents based on staff availability and logistically assigning staff to the area of the building with the most positive COVID residents through the work schedule. Infection control policy will be updated to reflect these changes. All staff will be immediately educated on the updated policy through staff meeting held on 12/10/20 as well as through communication book located at the nurses' station. Dining assistant and all other staff will be immediately re-educated on updated infection control policy regarding positive COVID staff not working with negative residents through staff meeting held on 12/10/20 as well as through communication book located at nurse's station. And all other negative COVID residents will be	F 880		

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F 880	Continued From page 8 audited to ensure that positive COVID staff are not working with them. Director of nursing or designee will audit staff compliance to this updated policy 3 times for one week then once per week for three more weeks and once per month for 2 more months. Director of nursing will present findings at the monthly QAPI meetings for review and recommendations." "N95 masks worn by staff not changed when coming out of a positive COVID19 resident room: Provider will update infection control policy regarding n95 masks removed by staff and disposed of when leaving a positive COVID-19 resident room. All staff will be immediately re-educated on the removal and disposal on N95 masks after leaving a positive COVID resident room. Staff will DON a face shield when entering a COVID positive room and DOFF when leaving. Will be given assigned face shields. Must be cleaned with Sani wipes after each use and stored in brown bag. N95 will be stored in brown bags between use and discarded after 3/12 hour shifts or 5/8 hour shifts. Education of staff of the updated policy through staff meeting held on 12/10/20 as well as through communication book located at the nurse's station. Director of Nursing or designee will audit staff usage of N95 masks 3 times per week for one week then once per week for three more weeks and monthly for two more months.	F 880		

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F 880	Continued From page 9	F 880		

Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendations."

"Positive COVID Residents in isolation for 10 days after testing positive for COVID 19:

Provider will update infection control policy regarding the isolation of positive COVID residents to include the 10 days of isolation needed for positive COVID residents.

All other positive COVID residents will be audited to ensure they are staying in isolation for 10 days after being positive.

All staff will be immediately educated on the updated policy through staff meeting held on 12/10/20 as well as through communication book located at nurse's station.

Director of nursing or designee will audit staff compliance to this updated policy 3 times for one week then once per week for three more weeks and once per month for 2 more months.

Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendations[.]

Positive staff who are asymptomatic and able to work may work with positive and/or recovered residents. Facility will create a positive staffing schedule to assign positive staff with positive residents. Positive staff will use an open available room with private bathroom to have a break in facility. When not able to assign designated staff to non covid residents facility will provide PPE to

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F 880	Continued From page 10	F 880		

prevent further spread of COVID."

"Doors closed for residents that tested positive for COVID 19:

Provider will update the infection control policy to reflect that doors are to remain closed or use of another acceptable barrier in place of door being closed for positive COVID residents.

Resident 2 and all other positive COVID residents will be audited to ensure they are staying in isolation for 10 days after being tested positive.

Staff will be immediately educated on the updated policy through staff meeting held on 12/10/20 as well as through communication book located at the nurse's station.

Director of nursing or designee will audit staff compliance to this updated policy 3 times for one week then once per week for three more weeks and once per month for 2 more months.

Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendations[.]"

"Visitors Screened upon entering the building:

Provider will update the infection control policy to reflect that all visitors will be screened by staff upon entering the building. Screening will be moved to the front door.

Staff will be immediately educated on the updated policy through staff meeting held on 12/10/20 as well as through communication located at nurse's station.

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F 880	Continued From page 11	F 880		

Director of nursing or designee will audit staff compliance to this updated policy 3 times for one week then once per week for three more weeks and once per month for 2 more months.

Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendations[.]"

"Failed to ensure that residents were screened Three times a day per CDC recommendations:

Provider will update the infection control policy to reflect that residents are screened 3 times per day for signs and symptoms of COVID 19 by Charge Nurse or designee when the facility has an active positive COVID resident. COVID positive residents will be assessed/screened by the charge nurse.

All staff will be immediately educated on the updated policy through staff meeting held on 12/10/20 as well as through communication located at nurse's station.

Director of nursing or designee will audit staff compliance to this updated policy 3 times for one week then once per week for three more weeks and once per month for 2 more months.

Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendations[.]"

An onsite visit was completed on 12/11/20 at 11:15 a.m. to verify the immediate jeopardy removal plan. Immediate jeopardy was not removed due to the following:

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F 880	Continued From page 12 *All staff were not immediately educated as stated in their removal plan. *A physical therapy assistant was observed exiting a positive COVID-19 resident's room, did not change or remove her N95 mask. -She did not receive the education outlined in the immediate jeopardy plan. *A positive staff working stated she used the community break room and the staff restroom. *She was unable to name all of the four negative residents that she should not be working with. *They were not going to start their monitoring plan until the following week. *They hadn't implemented the increased screenings for residents for all the signs and symptoms of COVID-19. This surveyor entered the facility on 12/11/20 at 11:15 a.m. and was appropriately screened by registered nurse (RN) E. Interview with the director of nursing (DON) B on 12/11/20 at 11:30 a.m. revealed: *Dietary aide D was not working that day. *Staff had been educated on the items on their immediate jeopardy removal plan. *They had one positive staff working in the facility, certified nursing assistant (CNA) L. -She was to take breaks in an empty resident room and use the bathroom in that room. *They provided all staff education on 12/10/20, regarding all topics. *They would start their audits/monitoring next week. *N95 masks would be stored in each staff members locker, located in the community break room. *Screening would be done by any available nurse. *COVID-19 positive residents will be screened	F 880		

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and assessed by an registered nurse three times per day.

Observation and interview on 12/11/20 at 11:40 a.m. with DON B while touring the facility revealed:
*The door was open to resident 5's room.
-Resident 5 was positive for COVID-19.
*Physical therapy assistant (PTA) K came out of resident 5's open doorway.
*PTA K came out of resident 5's room wearing an N95 mask.
*She did not perform hand hygiene and walked back to the therapy room.
*Asked DON B if PTA K was wearing all of her PPE in resident 5's room.
-DON B stated PTA K removed it before she left the room.

Further interview on 12/11/20 at 11:45 a.m. with DON B and PTA K revealed:
*PTA K stated she had "peeked" in resident 5's room to ask the resident assessment questions.
-This was to determine how much assistance was needed by therapy for various daily activities by resident 5.
*PTA K said she just "peeked" in positive resident's room.
*When asked what she wore to "peek" into resident 5's room, she:
-Only wore her N95 mask.
-Had not worn a gown, face shield, or gloves.
-She was still wearing the same N95 mask that she had worn into resident 5's room.
-Normally she wore full PPE into a positive COVID-19 resident's room but she was just "peeking in."
-Changed her N95 after working three 12-hour shifts or five 8-hour shifts.

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-Had not received education on 12/10/20.
-Was not aware she should remove or store her N95 mask upon leaving the room of a resident that was positive for COVID-19.

Observation and interview on 12/11/20 at 12:24 p.m. with DON B and CNA L revealed:
*DON B revealed CNA L was currently positive with COVID-19.
*CNA L came out of resident 5's room.
*DON B informed CNA L that she would get her a wipe so she could clean off her face shield.
*DON B walked two doors down to a three-drawer container.
-Removed a couple of packets of sani-cloth wipes, walked back, and handed one to CNA L.
-She then put the remaining packets of wipes in the three drawer container outside of resident 5's room.
--There were not any wipes in the three-drawer container outside of resident 5's room.
*CNA L wiped off her face shield and put it back on her head.
*This surveyor asked CNA L where she took breaks and she replied, "the break room."
*This surveyor asked CNA L what bathroom she used and she replied, "the staff restroom."
*She said she had received education on 12/10/20.
-She said the education was to clean off her faceshield.
*This surveyor inquired if because she had COVID-19 there were residents she should not work with. She indicated residents that were negative.
-CNA L was aware of three of the four residents that were negative.

Further interview on 12/11/20 at 12:33 p.m. with

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DON B about the immediate jeopardy implementation plan revealed:
*They had not initiated the increased screening of those residents who were COVID-19 positive.
*Not all staff had received the education on 12/10/20.
-She had planned to send out a mass text to alert the other staff of the education.

On 12/11/20 at 12:55 p.m. the assistant administrator with the South Dakota department of health and this surveyor interviewed DON B and administrator A. The assistant administrator with the South Dakota department of health and administrator A attended by phone. This interview revealed:
*DON B felt that staff "peeking" in an isolation room should not have to remove their N95 mask.
-This surveyor stated that she was standing inside the doorway when we saw her and she had the door open.
*CNA L received the education but still had not understood what she needed to do.
-This surveyor clarified PTA K was standing inside the room with the door open when they had observed her on 12/11/20 at 11:40 a.m.

Immediate Jeopardy was removed on 12/14/20 at 12:48 p.m. after the removal plan implementation was verified during an onsite visit by the surveyor. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F".

Findings include:
1a. Observation on 12/9/20 at 10:35 a.m. upon entering the facility lobby revealed:
*This surveyor was let into the building by activity assistant (M) and was brought to the nurse's station which was located in the center of the

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F 880	Continued From page 16 main hallway of the facility. *While waiting for DON B, this surveyor was greeted by activity assistant M , registered nurse (RN)/charge nurse C, certified nursing assistant (CNA) I, and business office manager N. -This surveyor was not screened for signs or symptoms of COVID-19 or possible exposure to COVID-19. b. Interview on 12/9/20 at 11:19 a.m. with DON B revealed: *Their current outbreak in the facility started around 11/13/20 when a resident (8) started showing symptoms of COVID-19. -They tested resident 8 and he was positive. *They had four residents (3, 4, 5, and 6) in their facility that were positive with COVID-19 at the time of survey. -They have had nine residents pass away from COVID-19 since 11/13/20. *They are testing all staff twice per week. -Did not have set days to test staff, they just know to come in. *They were only testing residents that had symptoms. *She was not aware that all residents that were negative were to be testing every three to seven days during an outbreak. *They were screening all residents for temperature (temp) and oxygen (O2) saturation (sat) once per day. *Residents that were positive for COVID-19 did not have increased screenings. -Screenings were done by the CNAs. *The nurses did an assessment when they did their medication pass. *There were COVID-19 positive staff working with residents. *They had symptoms but were able to work as	F 880		

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F 880	Continued From page 17 long as they "felt well enough to work." *They had two positive staff working in the facility. *The positive staff wore an N95 mask and faceshield when working. *Dietary aide D and CNA L were positive for COVID-19 and were working at the time of the survey. *Dietary aide D was a waitress, and runner for food, she tested positive on 12/7/20. *DON was surprised to see dietary aide D scheduled, thought she was off for a couple of days. *RN C tested positive on 11/29/20 and was working at the time of survey. *From 11/30/20 to 12/4/20 they had 5 residents (2, 3, 4, 5, and 6) who tested positive. -Resident 2, was no longer on isolation on 12/9//20. *They did not count day 10 as a day of isolation. *They had four remaining negative residents (1, 7, 9, and 10). *There was not a designated COVID-19 unit. *There were two hallways: morning glory and memory lane that had resident rooms. *Morning glory had two residents positive for COVID-19 (4 and 3) and two who were negative for COVID-19 (7 and 10). *Memory lane had three residents positive for COVID-19 (2, 5, and 6) and two who were negative for COVID-19 (1 and 9). c. Observation on 12/9/20 at 12:00 p.m. of the facility's dining room and nurses station revealed: *RN C was behind the desk wearing a surgical mask, she was the charge nurse on duty. *RN C said she was suffering from "brain fog" from COVID-19. -She was on day eleven after testing positive for COVID-19.	F 880		

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*There were 10 residents in their dining room eating lunch, including resident 1, 2, and 7).
*They were being served their meals and drinks by dietary aide D.
*She was wearing a face shield, gloves, and a surgical mask.
*She was coughing under her mask, while working.
*The dining room was shared by residents from both memory lane and morning glory.

d. Observation on 12/9/20 at 12:15 p.m. of memory lane revealed:
*Resident 2 was walking back to his room.
-He was coughing, he did not have a mask on.
*His room door was open, he had precaution signs still on his door.
*A blue isolation gown was hanging inside the doorway.
*A three-drawer container was in the hallway beside the door.

e. Observation on 12/9/20 at 12:18 p.m. of dietary aide D revealed:
*She was coming out of the staff break room.
-There were other staff members currently in the break room.
*The breakroom was located in the main hallway across from the dining room.

f. Interview on 12/9/20 at 12:24 p.m. with dietary aide D revealed she:
*Had tested positive for COVID-19 two days ago.
*Was not feeling well and had a cough and a lot of sinus congestion.
-Was coughing while serving residents.
*Was surprised she was told she could come in to work today.
*Served all residents in the facility.

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*Was to wear a surgical mask and face shield while working.
*Used the same break room and restroom as the other staff members.
*They tried to socially distance while in the break room.
*Had a locker in the break room. This is where all the staff lockers were located.

g. Observation and interview on 12/9/20 at 12:25 p.m. with nursing aide H on memory lane revealed, he:
*Was currently coming out of resident 6's room.
*Only changed his N95 mask after three 12-hour shifts or five 8-hour shifts.
*Wore the same N95 mask to care for all residents, regardless of COVID-19 status.
*Took care of residents on morning glory and memory lane.
*Went to the nurses station to disinfect his goggles.

h. Interview on 12/9/20 at 1:20 p.m. with dietary manager F revealed:
*She had worked at the facility for many years.
*She is also in charge of activities, dietary, and was also a CNA.
*They had been "ok" with staffing levels.
*As long as staff feel "ok", then positive COVID-19 staff come into work.
*Dietary aide D was not wearing an N95 because she is not fit tested.
*She stated positive staff do not take care of negative residents.
-Surveyor mentioned resident 1 was in the dining room, dietary manager F stated, "well you can't keep her in her room."
*When she was asked about dietary aide D working with COVID-19 and having symptoms

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she revealed:
-She still came to work when she had COVID-19. "No one told her that she did not have to work."
*They were not short on dietary staff.
*They usually had two dietary staff on duty. They had three dietary staff on duty during the survey, including dietary aide D and dietary manager F.
-Dietary manager F was in her office completing paperwork.

i. Further observation on 12/9/20 at 1:57 p.m. of nursing aides H and J revealed:
*They were distributing water to the residents on memory lane and morning glory.
*The water cups were on a cart that was being moved throughout the hallways.
*The only PPE they were wearing was an N95 mask.
*Nursing aide H went into resident 2's room, distributed water, without putting on additional PPE.
-He did not change his N95 mask.

j. Further interview on 12/9/20 at 4:07 p.m. with nursing aides H and J revealed:
*They wore the same N95 on for the whole shift.
*No one told them it should be changed after contact with a positive resident and before contact with a negative resident.

2. Review of provider's COVID-19 resident screening/assessment monitoring forms from 10/1/20 to 12/9/20 revealed:
*They screened residents once per day for temperature and O2 sat. The form also included a section for symptoms.
*The form had a list of residents on both memory lane and morning glory.
*There were 69 days when residents would have

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F 880	Continued From page 21 been screened. *Only 25 forms had completed documentation. *There were 24 days of missing forms. -The other 20 days were not completely filled out. *Only 4 of the 69 days had symptoms documented. -Those symptoms included; "+COVID", "positive in ISO [isolation]", or "ISO" 3. Further interview on 12/9/20 at 5:00 p.m. with DON B revealed: *CNAs completed the resident monitoring forms, and reported any symptoms to the charge nurse. *Screening was the same for both positive and negative residents. *Typically, the charge nurse looks over the resident screening forms. *Charge nurse made the determination as to when a resident came off of isolation. *Staff did not change their N95 mask after caring for positive residents. 4. Review of provider's 11/9/20, COVID-19 Prevention and Control Guidance Policy and Procedure revealed: *"Any resident showing symptoms will be quarantined and vitals taken each shift each day to assess for worsening condition." *Screening residents for signs and symptoms of COVID-19: -"1. Residents are to be screening daily." -"2. This will consist of Temperature and O2 sats. Will also monitor for new coughs and shortness of breath." *Assessing residents for worsening symptoms of COVID-19 that have tested positive: "1. Residents are to be assessed each shift daily that have tested positive for COVID-19 for 14 days or until no symptoms are present whichever	F 880		

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is longer."
"2. Assessments will consist of temperature, O2 sats, lung sounds, new cough, and/or new shortness of breath."

5. Review of the providers' 4/30/20 Coronavirus Surveillance policy revealed:
"2. Heightened surveillance activities will be implemented to limit the transmission of COVID-19 outbreak through CDC website, and will monitor for changes in prevention, treatment, isolation and other recommendations."
Screening for visitors and staff:
-"a. Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat or other symptoms of coronavirus (i.e. [for example].,) chills, muscle pain, headache, new loss of taste or smell)."
-"b. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, suspected to have COVID-19, or is ill with respiratory illness."
-"c. Travel within the last 14 days to geographic areas with sustained community transmission."
-"d. Residing in a community where community based spread of COVID-19 is occurring."
*"4. Visitors will be denied entry into the facility if they exhibit any of the criteria listed above ..."
*"5. Staff who has signs and symptoms of a respiratory infection shall not report to work. Any staff that develop signs and symptoms while on-the-job shall: a. Immediately stop work, put on a facemask, and self-isolate at home. b. Inform the Infection Preventionist, and include information on individuals, equipment, and locations the person came in contact with; and c. Contact and follow the local health department recommendations for next steps such as testing and locations for treatment."

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*"6. The facility will refer to current CDC guidance for exposures that might warrant restricting asymptomatic staff from reporting to work."
*"Residents will be monitored for signs and symptoms of coronavirus illness at least 1 time a day: fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, sore throat, or new loss of taste or smell. The physician will be notified immediately if evident. Staff shall follow established procedures when COVID-19 is suspected."

6. Review of provider's Infection control: COVID-19 Testing policy and Procedure revealed:
*"Outbreak: a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. A resident who is admitted to the facility with COVID-19 does not constitute a facility outbreak."
* "3. Testing of Staff and Residents in Response to an Outbreak[.] a. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission. b. Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents that may have been in close contact or who have symptoms should be tested, and all staff and residents that may have been in close contact or who have symptoms should be tested, and all staff and residents that tested negative should be retested every 3 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."

7. Review of
https://www.cdc.gov/niosh/topics/hcwcontrols/rec

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F 880	Continued From page 24 ommendedguidanceextuse.html, March 2020 Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Facepiece Respirators in Healthcare Settings, accessed on 12/13/20, regarding reusing N95 masks revealed: *Extended use: -Referred to the practice of wearing the same N95 for repeated close contact several patients without removing the respirator between patient encounters with patients of the same infectious pathogen. -Was used for patients who were placed together in cohorted (dedicated) units. -Was favored over reuse, because it was expected to involve less touching of the respirator and therefore less risk of contact transmission. -When practiced had required a maximum extended use period of eight to twelve hours. -"Should not be worn for multiple work shifts and should not be reworn after extensive use." *Reuse of N95 masks: -Referred to the practice of reusing the same N95 for multiple encounters with residents but removing after each encounter. -The N95 was stored in between encounters to be put on again prior to the next encounter. -Restrictions were to be in place to limit the number of times the same respirator could be reused. -The provider was to refer to the N95 manufacturer regarding the maximum number of donnings or uses they recommended. *N95 respirators were to be discarded: -Following close contact with, or exit from the care area of any patient co-infected with an infectious disease requiring contact precautions. -Following use during aerosol generating procedures. -Contaminated with blood, respiratory or nasal	F 880		

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F 880	Continued From page 25 secretions, or other bodily fluids from patients. *"Hang used respirators in a designated storage area or keep them in a clean, breathable container such as a paper bag between uses, where they do not touch each other and the bag is clearly identified." *"Use a pair of clean gloves when donning a used N95 and performing a user seal check." Review of https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html June 2020, CDC Strategies for Optimizing the Supply of N95 Respirators, accessed 12/13/20 revealed: *Assigning designated teams of healthcare personnel to provide care for all patients with suspected or confirmed COVID-19 could minimize respirator use when extended wear of respirators were implemented. *"Extended use refers to the practice of wearing the same N95 respirator for repeated close contact encounters with several different patients, without removing the respirator between patient encounters. Extended use is well suited to situations wherein multiple patients with the same infectious disease diagnosis, whose care requires use of a respirator, are cohorted." Review of https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, updated 11/20/20, CDC Responding to Coronavirus (COVID-19) (Covid) in Nursing Homes, accessed 12/13/20 revealed: -"For a resident with new-onset suspected or confirmed COVID-19: Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents."	F 880		

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F 880	Continued From page 26 -"If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission." -"If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to a designated COVID-19 care unit." -"Counsel all residents to restrict themselves to their room to the extent possible." -"Educated and train HCP [health care personnel], including facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility. Including consultants is important, since they commonly provide care in multiple facilities where they can be exposed to and serve as the source of COVID-19." -"Reinforce sick leave policies, and remind HCP not to work when ill. -"Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities." *Create a plan for testing residents and healthcare personal for SARS-CoV2[COVID-19]: -"Testing for SARS-CoV2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as viral testing or test) among residents and HCP in nursing homes. *Identify a space in the facility that could be dedicated to monitor and care for residents with COVID-19. -"Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the	F 880		

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F 880	Continued From page 27 end of the unit that will be used to cohort residents with COVID-19." -"Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use." *"Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space)." -"Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection. Consider increase monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms." Review of International Facility Guidance, June 2017, page 5, 1.4: Work Flows: "While the cleanliness of people, tools and supplies within the facility is vital to infection prevention and control, the spaces they enter and how they move between spaces is also critical. This means that spaces must be designed with certain activities separated from others to avoid the risk of infection and cross contamination. A carefully planned workflow is essential to minimizing risk of contamination."	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:	F 886	Provider will update the ingection control policy to reflect the need to test COVID negative residents every 3 to 7 days for COVID when a resident tests positive for COVID. Staff will be educated on the updated policy.	1/1/2021

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F 886	Continued From page 28 §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive	F 886	Director of Nursing or designee will audit testing compliance once per week for 4 weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendation. Provider will set days for the staff to be tested for COVID and the infection control policy will be updated. Staff will be educated on the updated policy. Director of Nursing or designee will audit testing compliance once per week for 4 weeks and monthly for two more months. Director of Nursing will present audit findings at the monthly QAPI meetings for review and recommendation.	

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F 886	Continued From page 29 for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, record review, and reference source review, the provider failed to follow outbreak testing procedures for staff and residents in their building. Findings include: 1. Interviews, observations, record reviews, and policy reviews, throughout the course of the survey revealed the facility was not testing all residents and staff every three to seven days since being in outbreak status starting on 11/13/20. 2. Interview on 12/9/20 at 1:19 p.m. with DON B revealed: *Since having a resident test positive on 11/13/20, they had not been testing residents every three to seven days. *They tested residents only when they showed symptoms related to COVID-19. *Staff did not have set days or times to be tested. *Staff were good about letting her know if they needed to be tested.	F 886		

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F 886	Continued From page 30 *DON B was not sure if all staff had been routinely tested every three to seven days. 3. Review of https://www.cms.gov/files/document/qso-20-38-nh.pdf Centers for Medicare & Medicaid Services (CMS) August 2020 memorandum revealed: *"Outbreak (Any new case arises in facility)." *"For outbreak testing, all staff and residents should be tested, 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." Refer to F880, findings 1, 2, 3, 4, 5, 6, and 7.	F 886		