STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1-044-2138	A. BUILDING B. WING	04/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE ARBOR	**304 FIFTH AVENUE DECATUR, GA 30030**

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E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was conducted on April 30, 2021 at East Lake Arbor. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey in conjunction with a complaint survey investigating #GA00211683, #GA00212693, #GA00212691, #GA00206759, GA00212584 and #GA00213946 was conducted on 4/5/2021 through 4/30/2021. Complaint #GA00212693 was unsubstantiated. Complaint #GA00211683, #GA00212691, #GA00212584, #GA00213946 and #GA00206759 were substantiated, and regulatory violations were cited. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility's census on 4/5/2021 was 85 residents. On 4/20/2021 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 4/20/2021 at 10:30 a.m. The noncompliance related to the IJ was identified to	F 000		

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	have existed on 2/12/2021. The IJ is outlined as follows: According to a COVID-19 Infection Control Line Listing for the facility, two staff members tested positive for COVID-19: one on 2/12/2021 and another on 3/11/2021. Two residents also tested positive for COVID-19 on 3/12/2021. There is no evidence that the facility conducted outbreak testing for 13 of 22 residents reviewed. There is no evidence that 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were tested weekly according to outbreak testing status and/or based on county positivity rate, with no evidence that 11 of those 14 nursing staff were tested at all. R#10, who tested positive on 3/12/2021, was transferred to hospital on 3/26/2021 with worsening COVID symptoms and expired on 3/27/2021. Outbreak testing was initiated on 4/7/2021 during the survey. R#11 tested positive for COVID-19 and expired at the facility on 4/12/2021. R#21 and R#22 tested positive and were placed on the 200 Hall (later designated as a COVID-19 unit and Observation unit). Three staff members also tested positive. The facility did not have separate COVID and observation units and did not have dedicated staff. The facility had discarded barriers needed for the COVID unit and had to reorder. The facility had not contacted the local Department of Public Health (DPH) for guidance after continued outbreaks in the facility. The facility had no evidence of routine monitoring of residents for signs and symptoms of COVID-19 for 19 of 22 residents reviewed. The IJ was related to the facility's noncompliance with the program requirements at 42 CFR 483.35(a)(1)(2) Sufficient Nursing Staff, F725; 42 CFR 483.70 Administration, F835; 42 CFR 483.70(d)(1)(2) Governing Body,			

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	F837; 42 CFR 483.75(g)(2)(ii) Qapi/QAA Improvement Activities, F867; 42 CFR 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control, F880; and 42 CFR 483.80 (h)(1)-(6) Covid-19 Testing-Residents & Staff, F886. F725, F835, F837, F867, F880, and F886 were at a Scope and Severity (S/S) of a "L". At the time of the exit on 4/30/2021, the IJ remained ongoing.			
F 0656 SS= D	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 0656		

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	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy titled "Care plans, Comprehensive Person-Centered" and staff interview, the facility failed to develop a comprehensive care plan for falls for one resident (R) (#4) of 14 residents reviewed for falls. Findings include: Review of the facility policy titled "Care Plans, Comprehensive Person-Centered" revised December 2016, revealed the Interdisciplinary Team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 8. The Comprehensive, person-centered care plan will: g. Incorporate identified problem areas; h. Incorporate risk factors associated with identified problems. 12. The comprehensive person-centered care plan is developed within seven days of the completion of the required comprehensive assessment (MDS - Minimum Data Set). 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.			

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	Review of the clinical record for R#4 revealed he was admitted to the facility on 1/28/2021 with diagnoses including but not limited to Atrial Fibrillation, hypertension, diabetes, Cerebral Vascular Accident (CVA) and right rib fracture. Review of a Clinical Admission Evaluation dated 1/28/2021 revealed a Functional Assessment that R#4 has unsteady gait and poor balance. Review of the Admission MDS dated 2/7/2021 revealed R#4 had a history of a fall in one month prior to admission to the facility. The Care Area Assessment Summary (CAAS) triggered falls as an area of concern, with the decision made to care plan for falls. Observation on 4/19/2021 at 10:47 a.m. revealed R#4 was in the smoking patio area when he fell to the ground. He had no injury. Review of the EMR revealed R#4 had falls without injury on 3/20/2021, 3/30/2021, and 4/19/2021. Review of the care plan for R#4 revealed that there was not a care plan addressing falls. During an interview on 4/12/2021 at 8:55 a.m., Licensed Practical Nurse (LPN) AA stated that she does not update resident's care plans after residents have a fall. She stated the MDS Nurse develops and updates the care plans. Interview on 4/24/2021 at 10:30 a.m. with the MDS Coordinator revealed that the Charge Nurses are supposed to be updating the care plans when residents have falls. She stated that she realized they are not getting done. She			

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	stated that she thought she had created a care plan for R#4 for falls and did not realize he did not have one until this weekend. Cross refer to F689.			
F 0689 SS= D	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy titled "Assessing Falls and Their Causes," and staff interviews, the facility failed to complete fall risk assessments and implement interventions to prevent falls for one resident (R) (#4) of 14 residents reviewed for falls. Findings include: Review of the facility policy titled "Assessing Falls and their Causes" with revised date of October 2010, revealed the purpose is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. When a resident falls, the following information should be recorded in the resident's medical record: 5. Completion of a falls risk assessment. 6. Appropriate interventions taken to prevent	F 0689		

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	future falls. Review of the clinical record for R#4 revealed he was admitted to the facility on 1/28/2021 with diagnoses including but not limited to Atrial Fibrillation, hypertension, diabetes, Cerebral Vascular Accident (CVA) and right rib fracture. The Quarterly Minimum Data Set (MDS) dated 3/24/2021 documented a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Section G - Functional Status revealed that the resident required extensive one person assist for transfers, walk in room, walk in corridor, locomotion on/off the unit, and toilet use. Review of the Electronic Medical Record (EMR) Clinical Admission Evaluation dated 3/17/2021 revealed R#4 is able to move all extremities. Upper extremity ROM (range of motion): Impairment on one side. Lower extremity ROM: Impairment on one side. Resident is able to self-position. Resident uses a manual wheelchair. Review of R#4 EMR revealed a Fall Risk Evaluation, dated 1/29/2021 revealed score of 8, where score greater than 10 is High Risk for potential falls. There is no evidence that the Fall Risk Evaluation had been updated quarterly, per facility requirements. Review of the EMR revealed there is no evidence that a Fall Risk Assessment was completed for R#4 after documented falls without injury on 3/20/2021, 3/30/2021, and 4/19/2021. Continued review of the EMR revealed no evidence that interventions were implemented after the following falls: Review of Nurses Note written on 3/20/2021 at 3:01 p.m. revealed R#4 was shifting self on side			

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	of bed, mattress slid off bed frame and resident slid to floor with mattress. No injuries. Review of Nurses Note written on 3/30/2021 at 2:52 p.m. revealed R#4 slipped and "caught himself" before falling. No injuries. Review of Nurses Note written on 4/19/2021 at 10:38 a.m. revealed R#4 was out on the patio, lost his balance and fell to the grass. No injuries. Observation on 4/19/2021 at 10:47 a.m. revealed R#4 was in the supervised smoking patio area when he fell to the ground. During an interview on 4/12/2021 at 8:55 a.m., Licensed Practical Nurse (LPN) AA stated that when residents have falls, she will do an assessment for injuries. If no apparent injuries, she gets them up into the chair and takes them to their room. She stated that she notifies the Physician or Nurse Practitioner and the Responsible Party about the fall. She stated that if the fall was unwitnessed, then she monitors neurological status for 72 hours. She stated that she completes the post fall paperwork, which included a Fall Assessment and Post Fall Evaluation. During further interview, she stated that she does not update resident care plans after they have a fall. She stated the MDS Nurse updates the care plans. Interview on 4/24/2021 at 10:30 a.m. with LPN MM revealed that she finds out from the morning meeting about residents that have had falls. She stated that the Charge Nurses are supposed to be implementing interventions when residents have falls. During further interview, she stated that she realized they are not getting done. Interview on 4/26/2021 at 11:50 a.m. with			

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	Director of Nursing (DON) revealed that the Fall Evaluation is completed on admission and identifies a resident's history or risk for falls. She stated it is to be updated quarterly. She stated that the Fall Assessment should be completed by the Charge Nurse after each fall. She stated the Charge Nurses should be implementing fall interventions after each fall, but they are not being done.			
F 0725 SS= L	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide sufficient	F 0725		

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	nursing staff to assure the needs of 19 of 22 residents, (R) (R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, R#11, R#15, R#16, R#17, R#18, R#19, R#20, R#21, and R#22) were met for residents to achieve the highest practicable level of well-being. Specifically, residents were not tested and/or monitored for COVID-19 and 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were not tested in a manner consistent with current standards of practice for conducting COVID-19 testing, due to insufficient staff. On 4/20/2021 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on 4/20/2021 at 10:30 a.m. The noncompliance related to the IJ was identified to have existed on 2/12/2021. The IJ is outlined as follows: According to a COVID-19 Infection Control Line Listing for the facility, two staff members tested positive for COVID-19: one on 2/12/2021 and another on 3/11/2021. Two residents also tested positive for COVID-19 on 3/12/2021. There is no evidence that the facility conducted outbreak testing for 13 of 22 residents reviewed. There is no evidence that 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were tested weekly according to outbreak testing status and/or based on county positivity rate, with no evidence that 11 of those 14 nursing staff were tested at all. R#10, who tested positive on 3/12/2021, was transferred to hospital on 3/26/2021 with worsening COVID symptoms and expired on 3/27/2021.			

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	Outbreak testing was initiated on 4/7/2021 during the survey. R#11 tested positive for COVID-19 and expired at the facility on 4/12/2021. R#21 and R#22 tested positive and were placed on the 200 Hall (later designated as a COVID-19 unit and Observation unit). Three staff members also tested positive. The facility did not have separate COVID and Observation units and did not have dedicated staff. The facility had discarded barriers needed for the COVID unit and had to reorder. The facility had not contacted the local Department of Public Health (DPH) for guidance after continued outbreaks in the facility. The facility had no evidence of routine monitoring of residents for signs and symptoms of COVID-19 for 19 of 22 residents reviewed. The IJ was related to the facility's noncompliance with the program requirements at 42 CFR 483.35(a)(1)(2) Sufficient Nursing Staff, F725; 42 CFR 483.70 Administration, F835; 42 CFR 483.70(d)(1)(2) Governing Body, F837; 42 CFR 483.75(g)(2)(ii) Qapi/QAA Improvement Activities, F867; 42 CFR 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control, F880; and 42 CFR 483.80 (h)(1)-(6) Covid-19 Testing-Residents & Staff, F886. F725, F835, F837, F867, F880, and F886 were at a Scope and Severity (S/S) of a "L". At the time of the exit on 4/30/2021, the IJ remained ongoing. Findings include: Review of April 2021 Nurses Open Shifts posted at the time clock revealed open shifts with no coverage as follows: 4/10/2021-one first shift, one second shift and one third shift			

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	4/11/2021-one second shift and two third shifts 4/12/2021-one first shift, two second shifts, and one third shift 4/13/2021-two third shifts 4/14/2021-two second shifts 4/15/2021-one second shift 4/16/2021- two second shifts and three third shifts 4/17/2021-three second shifts and two third shifts 4/18/2021-three second shifts and two third shifts 4/19/2021 two third shifts, with one being filled Review of residents Medication Administration Records (MAR) revealed the DON worked medication carts on 2/1/2021, 2/14/2021, 3/16/2021, 4/14/2021, and 4/26/2021. Observation on 4/12/2021 at 11:06 a.m. revealed the 200 Hall, which houses COVID-19 positive residents and Observation residents, had no dedicated coverage and the duties of administering medications was being split between Licensed Practical Nurse (LPN) AA and LPN QQ who were also administering medications on other units. Observation on 4/13/2021 at 9:15 a.m. revealed the DON was administering medications to residents on the 500 Hall. Observation on 4/13/2021 at 11:30 a.m. and 4/14/2021 at 9:00 a.m. revealed the 200 Hall, which houses COVID-19 positive residents and Observation residents, had no dedicated coverage and the duties of administering medications was being split between LPN AA and LPN KK who were also administering medications on other units.			

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	Observation on 4/14/2021 at 9:15 a.m. revealed the DON was administering medications to residents on the 400 Hall. Observation on 4/15/2021 at 9:10 a.m. revealed Registered Nurse (RN) RR was administering medications from two medication carts, one for the 100 Hall and one for the 300 Hall. Observation on 4/19/2021 at 10:10 a.m. revealed RN VV working with two medication carts, 400 Hall and 500 Hall. Observation on 4/20/2021 at 9:20 a.m. revealed the 200 Hall, which houses COVID-19 positive residents and Observation residents, had no dedicated coverage and the duties of administering medications was being split between LPN AA and LPN WW who were also administering medications on other units. Observation and interview on 4/21/2021 at 9:20 a.m. with LPN GG revealed there was no nurse assigned to work the 500 Hall cart at this time. She stated that an RN from another facility is supposed to come administer the medications. Observation on 4/26/2021 at 11:03 a.m. revealed the Administrator was administering resident's medications on the 500 Hall. (He is a nurse) Observation on 4/26/2021 at 2:25 p.m. revealed the Minimum Data Set (MDS) nurse was administering medications on the 300 Hall. Interview on 4/15/2021 at 1:00 p.m. with ADON revealed she has been employed at the facility for two months. She stated that she helped the			

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	DON with the COVID-19 testing for staff and residents. The ADON resigned on 4/19/2021 during the survey. In accordance with the Center for Medicare and Medicaid Services (CMS) memo QSO-20-38-NH, dated 8/26/2020, the facility was required to conduct twice weekly testing of staff from 2/1/2021 to 2/8/2021. Weekly testing of staff was required from 2/15/2021 through 3/8/2021. Outbreaks occurred on 2/12/2021, 3/11/2021, 3/12/2021, and 4/5/2021 which required residents and staff be tested every three to seven days until no new positives. Review of the actual nurse staffing hours for facility nursing staff revealed that from 2/1/2021 through 4/5/2021, Registered Nurse (RN) NN, RN UU, Licensed Practical Nurse (LPN) FF, LPN CCC, LPN DDD, LPN EEE, Certified Nursing Assistant (CNA) FFF, CNA GGG, CNA HHH, CNA III, and CNA JJJ worked during this time period. There is no evidence that the above staff were tested for COVID-19 during that time period. According to facility testing documents for staff, the DON was tested on 3/4/2021 and 3/26/2021 only, the Assistant Director of Nursing (ADON) was tested on 3/15/2021 only, and Agency LPN AA was tested on 2/23/2021 only. Review of the clinical record revealed the following COVID-19 testing information for previously negative residents for 2/1/2021 through 4/5/2021: R#1, R#4, R#11, and R#22 were not tested. R#9 and R#10 were tested on 3/12/2021 only. R#2, R#3, R#5, R#7, R#8, and R#22 were tested on 3/19/2021 only. R#6 was tested on 3/28/2021 only. In addition, review of the clinical records			

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	revealed no evidence that R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, R#11, R#15, R#16, R#17, R#18, R#19, R#20, R#21, and R#22 were routinely monitored for signs/symptoms of COVID-19 until 4/14/2021. Review of Department of Public (DPH) recommendations dated 4/8/2021 revealed staffing support was needed, for COVID Unit and as unit managers for directing/managing staff to get tested each week. During an interview on 4/6/2021 at 11:37 a.m., CNA BB stated that her regular shift is the 11:00 p.m. to 7:00 a.m., but she works two to three double shifts per week, because there is not enough staff working to care for the residents. Interview on 4/6/2021 at 1:11 p.m. with DON revealed that there is no specific day that the COVID testing is done, but usually done on Tuesday's and Friday's. She stated that if staff do not come to the COVID clinic, she contacts the department heads and informs them staff need to be tested. She stated she is unable to follow up to see if the staff that missed testing were actually tested later. Further interview on 4/13/2021 at 3:34 p.m. with DON revealed she has been employed at the facility for eight months but has been in the DON role for three months. She stated that it is hard to get staff to come to work when they are scheduled. She stated the facility has a lot of open vacancies for Nurses and CNA's, so ninety to ninety five percent of the staff are agency. She further stated that she must substitute for the lack of charge nurses by administering medications to residents three to four times per week and she is responsible for duties of the Infection Control Preventionist (ICP) Nurse, Staffing Coordinator and COVID-19 testing.			

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	Interview on 4/14/2021 at 9:20 a.m. with LPN AA revealed she has worked at the facility through the staffing agency since December 2020. LPN AA revealed the facility does not have enough nurses to work, so she usually must split working the 200 Hall with the nurse working the 300 Hall. Further interview on 4/14/2021 at 2:04 p.m. with DON revealed that there was no-one in the role of ICP when she was hired, but the previous DON was supposed to be collecting the surveillance data. She stated she has been inconsistent with the data collection and surveillance tracking because she has had to work on the medication cart three to four days per week, and she just did not have time to do it. Interview on 4/20/2021 at 11:20 a.m. with LPN FF revealed that the facility does not have enough staff. She stated that she and another nurse often have to share the assignment of a third nurse, because there is no third nurse that day. LPN FF revealed nurses just do not come to work at this facility. Interview on 4/21/2021 at 9:05 a.m. with CNA XX revealed that she gets pulled from Restorative to work on the floor often, and when that happens, the CNA's are supposed to continue the Restorative Program for their assigned residents. She stated that she does not have time to provide care to her assigned residents and provide Restorative Care for all the residents in the Program. During an interview on 4/23/2021 at 4:00 p.m., CNA ZZ stated that she works 16 hour shifts most of the time, 3:00 p.m. to 7:00 a.m., due to open shifts. Cross refer to F886.			

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F 0727 SS= F	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide adequate staff coverage to prevent the Director of Nursing (DON) from having to work as charge nurse when the census was greater than 60 residents for two of 22 days of the Complaint Investigation survey. The facility census was 85 residents. Findings include: Observation on 4/13/2021 at 9:15 a.m. revealed the DON was administering medications on the 500 Hall. During an interview on 4/13/2021 at 3:34 p.m., the DON stated that she has been employed at the facility for eight months and has been in the role of DON for three months. She stated that the facility hires staff, but they do not show up	F 0727		

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	and the facility is using approximately ninety percent agency staff, but she still has to work the medication cart three to four days per week. Observation on 4/14/2021 at 9:15 a.m. revealed the DON was administering medications on the 400 Hall. Interview on 4/14/2021 at 9:20 a.m. with Registered Nurse (RN) NN revealed that he works as needed (PRN) at the facility and generally works about four night shifts per month. He stated that he worked last night and is staying over a few hours to do morning medication pass, since the agency nurse called out. Interview on 4/14/2021 at 9:30 a.m. with DON revealed she placed calls to the staffing agencies to try to find a nurse to come in, but they had not found anyone yet. Interview on 4/14/2021 at 10:55 a.m. with DON revealed that RN NN left, and she will have to work both the 400 Hall cart and the 500 Hall cart, because the agencies have not been able to find anyone to work. Interview on 4/19/2021 at 11:19 a.m. with Administrator revealed that he is aware that the DON is working the medication cart, when staff call out. During further interview, he stated that he has also worked the medication cart when staff do not show up or call out. (The Administrator is an RN) In addition: Review of the February 2021 Medication Administration Record (MAR) for R#20 and R#28 revealed the DON administered medications on the 100 hall.			

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	Review of the March 2021 MAR for R#29 revealed the DON administered medications on the 300 hall. Review of the April 2021 MAR for R#3 and R#6 revealed the DON administered medications on the 400 hall.			
F 0835 SS= L	483.70 Administration §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 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, review of the job descriptions for the Administrator and Director of Nursing (DON), the facility administration failed to provide oversight and monitoring of the Infection Control Program by not implementing the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) recommended practices for COVID-19; and failed to ensure facility had adequate staff to provide for the needs of the residents. On 4/20/2021 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 4/20/2021 at 10:30 a.m. The noncompliance related to the IJ was identified to have existed on 2/12/2021.	F 0835		

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	The IJ is outlined as follows: According to a COVID-19 Infection Control Line Listing for the facility, two staff members tested positive for COVID-19: one on 2/12/2021 and another on 3/11/2021. Two residents also tested positive for COVID-19 on 3/12/2021. There is no evidence that the facility conducted outbreak testing for 13 of 22 residents reviewed. There is no evidence that 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were tested weekly according to outbreak testing status and/or based on county positivity rate, with no evidence that 11 of those 14 nursing staff were tested at all. R#10, who tested positive on 3/12/2021, was transferred to hospital on 3/26/2021 with worsening COVID symptoms and expired on 3/27/2021. Outbreak testing was initiated on 4/7/2021 during the survey. R#11 tested positive for COVID-19 and expired at the facility on 4/12/2021. R#21 and R#22 tested positive and were placed on the 200 Hall (later designated as a COVID-19 unit and Observation unit). Three staff members also tested positive. The facility did not have separate COVID and observation units and did not have dedicated staff. The facility had discarded barriers needed for the COVID unit and had to reorder. The facility had not contacted the local Department of Public Health (DPH) for guidance after continued outbreaks in the facility. The facility had no evidence of routine monitoring of residents for signs and symptoms of COVID-19 for 19 of 22 residents reviewed. The IJ was related to the facility's noncompliance with the program requirements at 42 CFR 483.35(a)(1)(2) Sufficient Nursing Staff, F725; 42 CFR 483.70 Administration, F835; 42 CFR 483.70(d)(1)(2) Governing Body, F837; 42 CFR 483.75(g)(2)(ii) Qapi/QAA			

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	Improvement Activities, F867; 42 CFR 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control, F880; and 42 CFR 483.80 (h)(1)-(6) Covid-19 Testing-Residents & Staff, F886. F725, F835, F837, F867, F880, and F886 were at a Scope and Severity (S/S) of a "L". At the time of the exit on 4/30/2021, the IJ remained ongoing. Findings include: Review of "Job Description and Performance Standards" for the Administrator, dated 1/11/2021, revealed the purpose of this position is to establish and maintain systems that are effective and efficient to operate the facility in a manner to safely meet residents' needs in compliance with federal, state, and local requirements. To establish and maintain systems that are effective and efficient to operate the facility in a financially sound manner. Authority is delegated to the individual in this position to develop, maintain and implement operational policies and procedures to meet residents' needs in compliance with federal, state, and local requirements; determine the personnel requirements of the facility and hire or arrange for sufficient staff to implement the facility policies and procedures; develop a monitoring system to assure compliance with federal, state and local requirements. Review of "Job Description and Performance Standards" for the DON, dated 1/11/2021, revealed the purpose of this position is to provide nursing management, set resident care standards for all direct care providers and provide complete supervision and management for the nursing department. Authority is delegated in this position to assess resident needs and interview, hire and terminate adequate nursing personnel; set resident care standards in accordance with accepted current			

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	standards of care to provide high quality care to residents; develop and implement policies and procedures for nursing care of residents; supervise and manage all aspects of the nursing department; assess, direct and supervise residents' care needs; cooperate with administration to assure efficient, cost effective operation of the facility. The facility had a change in Administrator and DON on 1/11/2021. The facility failed to provide effective oversight and monitoring of their infection control and prevention program. 1. Administration failed to provide sufficient nursing staff to assure the needs of 19 of 22 residents, (R) (R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, R#11, R#15, R#16, R#17, R#18, R#19, R#20, R#21, and R#22) were met for residents to achieve the highest practicable level of well-being. Specifically, residents were not tested and/or monitored for COVID-19 and 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were not tested in a manner consistent with current standards of practice for conducting COVID-19 testing, due to insufficient staff. Cross refer to F725. 2. Administration failed to ensure monitoring systems were provided with feedback for data collection related to Infection Control, including COVID-19 outbreak testing logs, and failed to identify issues with outbreak and routine testing for staff and outbreak testing for residents. Cross refer to F867. 3. Administration failed to ensure residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #15, #16, #17, #18, #19, #20, #21, and #22) were			

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	routinely monitored for signs/symptoms of COVID-19, failed to maintain communication with local health department during continued outbreaks, and failed to have a dedicated COVID-19 unit. Cross refer to F880. 4. Administration failed to ensure routine and outbreak testing for COVID-19 was conducted in a manner consistent with current standards of practice for 13 residents, (R) (R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, R#11, R#21, and R#22) of 22 residents reviewed for COVID-19 testing. Additionally, Administration failed to ensure testing was completed and results documented for 14 of 40 nursing staff working 2/1/2021 through 4/5/2021. Cross refer to F886. The facility was required to conduct twice weekly COVID testing of staff from 2/1/2021 to 2/8/2021, weekly testing of staff from 2/15/2021 through 3/8/2021; with outbreaks occurring on 2/12/2021, 3/11/2021, 3/12/2021, and 4/5/2021. Review of e-mail correspondence between Administrator and the Department of Public Health Epidemiology from 1/29/2021 through 4/5/2021 revealed submission of line listing with no request for assistance during an on-going outbreak of COVID-19. Review of the actual nurse staffing hours for facility nursing staff revealed that from 2/1/2021 through 4/5/2021, Registered Nurse (RN) NN, RN UU, Licensed Practical Nurse (LPN) FF, LPN CCC, LPN DDD, LPN EEE, Certified Nursing Assistant (CNA) FFF, CNA GGG, CNA HHH, CNA III, and CNA JJJ worked during this time period. There is no evidence that the above staff were tested for COVID-19 during that time period. According to facility testing documents for staff, the Director of Nursing (DON) was			

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	tested on 3/4/2021 and 3/26/2021 only, the Assistant ADON was tested on 3/15/2021 only, and Agency LPN AA was tested on 2/23/2021 only. During initial tour on 4/5/2021 at 10:30 a.m. with the DON revealed there was no dedicated COVID-19 unit, although it was reported the facility was currently COVID free, with six residents in Observation on the 200 Hall, due to new admission status. Observation on 4/8/2021 at 11:45 a.m. of the 200 Hall revealed three newly tested positive residents (R#11, R#21, and R#22) were being housed in the rooms on the right side of the 200 Hall (Observation Unit), without dedicated staff to attend to them. Observation on 4/13/2021 at 9:15 a.m. revealed the DON was administering medications on the 500 Hall. Observation on 4/14/2021 at 9:15 a.m. revealed the DON was administering medications on the 400 Hall. Observation on 4/26/2021 at 11:03 revealed the Administrator was administering medications on the 500 Hall. Interview on 4/6/2021 at 1:11 p.m. with DON revealed that there is no specific day that the COVID testing is done, but usually done on Tuesday's and Friday's. She stated that she splits the testing with the Assistant Director of Nursing (ADON). She stated that she makes an announcement on the paging system for staff to come get COVID tested, and that staff sign in when they come to the clinic. During further interview, she stated that if staff do not come to the COVID clinic, she contacts the department			

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	heads and informs them staff need to be tested. She stated she does not follow up to see if the staff that missed testing were actually tested later. During further interview on 4/13/2021 at 3:34 p.m., the DON stated that she has been employed at the facility for eight months and has been in the role of DON for three months. She stated that the facility hires staff, but they do not show up and the facility is using approximately ninety percent agency staff, but she still has to work the medication cart three to four days per week. Interview on 4/15/2021 at 1:00 p.m. with ADON revealed she has been employed at the facility for two months. She stated that she helped the DON with the COVID testing for staff and residents. She stated that she does not know how the tracking for the staff testing was being done. The Assistant DON resigned on 4/19/2021 during the survey. During an interview on 4/16/2021 at 10:30 a.m., the Administrator stated that he has been at this facility since January 2021. He stated that the COVID unit was taken down, because they did not have any COVID positive residents at that time, but stated the last two rooms on the 200 Hall are COVID rooms if they should need them. He stated that the decision to take the unit down was a joint decision with DON and Regional Administrator and was taken down sometime in January 2021. During further interview, he stated he is not sure what happened to the barrier walls for the COVID unit, but stated they were probably in storage somewhere onsite. When questioned if he contacted the Department of Public Health Epidemiology for assistance during an ongoing outbreak of COVID-19, he replied "yes, I contacted them			

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	about a week before you came" and they did a zoom visit on 4/8/2021 and an onsite visit on 4/9/2021. He stated they made some recommendations, and they are working on those recommendations now. Phone interview on 4/16/2021 at 11:46 a.m. with the Medical Director (MD) revealed he has weekly conversations with the Administrator, either in person or via phone. He stated that they do not have specific things they talk about but discuss what is happening in the facility. He stated that there was nothing mentioned to him about COVID outbreaks or any indications regarding staffing concerns. Interview on 4/19/2021 at 11:19 a.m. with Administrator, revealed that he is aware that the DON is working the medication cart, when staff call out. During further interview, he stated that he has also worked the medication cart when staff do not show up or call out. (He is an RN)			
F 0837 SS= L	483.70(d)(1)(2) Governing Body §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by:	F 0837		

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	1-044-2138	A. BUILDING B. WING	04/30/2021

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	Based on review of Facility Assessment, interviews and review of the facility policy titled, "Quality Assurance and Performance Improvement (QAPI) Program" the facility's Governing Body failed to ensure the QAPI program was effective in identifying, developing and implementing corrective actions to address concerns with the facilities Infection Control policies and procedures regarding COVID-19 testing; and failed to oversee facility staffing to ensure adequate staff to provide care and services to residents. The census was 85. On 4/20/2021 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 4/20/2021 at 10:30 a.m. The noncompliance related to the IJ was identified to have existed on 2/12/2021. The IJ is outlined as follows: According to a COVID-19 Infection Control Line Listing for the facility, two staff members tested positive for COVID-19: one on 2/12/2021 and another on 3/11/2021. Two residents also tested positive for COVID-19 on 3/12/2021. There is no evidence that the facility conducted outbreak testing for 13 of 22 residents reviewed. There is no evidence that 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were tested weekly according to outbreak testing status and/or based on county positivity rate, with no evidence that 11 of those 14 nursing staff were tested at all. R#10, who tested positive on 3/12/2021, was transferred to hospital on 3/26/2021 with worsening COVID symptoms			

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	and expired on 3/27/2021. Outbreak testing was initiated on 4/7/2021 during the survey. R#11 tested positive for COVID-19 and expired at the facility on 4/12/2021. R#21 and R#22 tested positive and were placed on the 200 Hall (later designated as a COVID-19 unit and Observation unit). Three staff members also tested positive. The facility did not have separate COVID and observation units and did not have dedicated staff. The facility had discarded barriers needed for the COVID unit and had to reorder. The facility had not contacted the local Department of Public Health (DPH) for guidance after continued outbreaks in the facility. The facility had no evidence of routine monitoring of residents for signs and symptoms of COVID-19 for 19 of 22 residents reviewed. The IJ was related to the facility's noncompliance with the program requirements at 42 CFR 483.35(a)(1)(2) Sufficient Nursing Staff, F725; 42 CFR 483.70 Administration, F835; 42 CFR 483.70(d)(1)(2) Governing Body, F837; 42 CFR 483.75(g)(2)(ii) Qapi/QAA Improvement Activities, F867; 42 CFR 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control, F880; and 42 CFR 483.80 (h)(1)-(6) Covid-19 Testing-Residents & Staff, F886. F725, F835, F837, F867, F880, and F886 were at a Scope and Severity (S/S) of a "L". At the time of the exit on 4/30/2021, the IJ remained ongoing. Findings include: A review of the facility policy titled "Quality Assurance and Performance Improvement (QAPI) Program" revised April 2014, policy statement is the facility shall develop, implement, and maintain an ongoing, facility-			

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	wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. Policy Interpretation: The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data-driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Five Strategic Elements 2. Governance and leadership: c. Members of the facility leadership are accountable for the QAPI efforts. e. Staff are encouraged to identify and report quality concerns as well as opportunities for improvement. The facility had a "Facility Assessment Tool" dated 2/25/2021. The "Facility Assessment Tool" documented that the assessment tool was completed by the Administrator that is no longer at the facility, the Director of Nursing (DON) marked through of previous DON and current DON had written, the Governing Body Rep (Representative) and the Medical Director (MD). The Facility Assessment Tool documented the facility Infection Preventionist monitors infections daily thru a process of review of documentation, orders and resident/patient assessments. Daily data collection and surveillance occurs to ensure infection criteria, process and standards are followed. Education is provided to staff, residents and family members as needed. The infection control program is evaluated monthly during the QAPI meeting and as needed. Review of undated document titled "East Lake Arbor Governing Body" revealed the Governing Body consists of Regional Executive Director Consultant, Regional Nurse Consultant and Executive Director/Administrator. Interview on 4/19/2021 at 11:11 a.m. with Administrator revealed that he has invited the			

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	Regional Executive Director to attend QAPI meetings, but he has not attended yet. Phone interview on 4/19/2021 at 11:33 a.m. with Regional Executive Director KKK stated that he was part of the governing body providing oversight to the facility. He stated facility Administrator is responsible for management of the facility and reports directly to him. He stated he is not sure how often the Governing Body meets, but he visits the facility one day per week. During further interview, he stated that he was notified about COVID outbreak in the facility but cannot recall when he was notified. He stated he believes the facility was testing for COVID as they were supposed to be doing, but not able to state how long COVID outbreak has been. He stated the facility is having success using staffing agencies. He stated that he was not sure what role the Governing Body plays in QAPI, he stated he does not attend the meetings. Phone interview on 4/19/2021 at 3:38 p.m. with Regional Executive Director LLL stated he provides oversight between the Governing Body and the Administrator for facility management and operations. He stated he also provides support to the Regional Executive Director KKK. He stated that he visits the facility every two to three weeks. He stated that the Governing Body has "zoom meetings" weekly, and stated the last meeting was two weeks ago. He stated he gets updates about COVID positive cases "all the time" but cannot recall when the last update was. He stated he was not aware of any concerns with lack of testing residents or staff members. He stated he was aware of the facilities use of agency nurses but was not aware that the DON was being utilized as Charge Nurse working on the medication cart. During further interview, he stated that he has from time to time attended QAPI meetings, but not regularly.			

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	Interview on 4/23/2021 at 10:10 a.m. with Administrator revealed that the facility did not have a policy for Governing Body. Cross Refer F725, F880, F886.			
F 0867 SS= L	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of facility policy titled "Quality Assurance and Performance Improvement (QAPI) Program," the facility failed to have an effective Quality Assurance process that identified concerns related to the Infection Control Prevention Program. The QAPI committee failed to identify deficient practice related to the policies and procedures for COVID-19 screening/testing and staffing. The census was 85. On 4/20/2021 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 4/20/2021 at 10:30 a.m. The noncompliance related to the IJ was identified to have existed on 2/12/2021.	F 0867		

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	The IJ is outlined as follows: According to a COVID-19 Infection Control Line Listing for the facility, two staff members tested positive for COVID-19: one on 2/12/2021 and another on 3/11/2021. Two residents also tested positive for COVID-19 on 3/12/2021. There is no evidence that the facility conducted outbreak testing for 13 of 22 residents reviewed. There is no evidence that 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were tested weekly according to outbreak testing status and/or based on county positivity rate, with no evidence that 11 of those 14 nursing staff were tested at all. R#10, who tested positive on 3/12/2021, was transferred to hospital on 3/26/2021 with worsening COVID symptoms and expired on 3/27/2021. Outbreak testing was initiated on 4/7/2021 during the survey. R#11 tested positive for COVID-19 and expired at the facility on 4/12/2021. R#21 and R#22 tested positive and were placed on the 200 Hall (later designated as a COVID-19 unit and Observation unit). Three staff members also tested positive. The facility did not have separate COVID and observation units and did not have dedicated staff. The facility had discarded barriers needed for the COVID unit and had to reorder. The facility had not contacted the local Department of Public Health (DPH) for guidance after continued outbreaks in the facility. The facility had no evidence of routine monitoring of residents for signs and symptoms of COVID-19 for 19 of 22 residents reviewed. The IJ was related to the facility's noncompliance with the program requirements at 42 CFR 483.35(a)(1)(2) Sufficient Nursing Staff, F725; 42 CFR 483.70 Administration, F835; 42 CFR 483.70(d)(1)(2) Governing Body, F837; 42 CFR 483.75(g)(2)(ii) Qapi/QAA Improvement Activities, F867; 42 CFR 483.80(a)(1)(2)(4)(e)(f) Infection Prevention &			

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	Control, F880; and 42 CFR 483.80 (h)(1)-(6) Covid-19 Testing-Residents & Staff, F886. F725, F835, F837, F867, F880, and F886 were at a Scope and Severity (S/S) of a "L". At the time of the exit on 4/30/2021, the IJ remained ongoing. Findings include: Review of the facility policy titled "Quality Assurance and Performance Improvement (QAPI) Program" revised April 2015, revealed: policy statement: the facility shall develop, implement, and maintain an ongoing, facility-wide Quality Assurance and Performance Improvement (QAPI) program that builds on the Quality Assessment and Assurance Program to actively pursue quality of care and quality of life goals. Policy Interpretation: The primary purpose of the Quality Assurance and Performance Improvement Program is to establish data-driven, facility-wide processes that improve the quality of care, quality of life and clinical outcomes of our residents. Five Strategic Elements include: design and scope; governance and leadership; feedback, data systems and monitoring; performance improvement projects; and systematic analysis and systematic action. Action Step: 13. Gathering and using QAPI data in an organized and meaningful way. Areas that may be appropriate to monitor and evaluate include: a. Clinical outcomes; pressure ulcers, infections, medication use, pain, falls, etc. 16. Recognizing patterns in system of care that can be associated with quality problems. 18. Planning, conducting and documenting PIP's (Performance Improvement Plans). 19. Conducting Root Cause Analysis to identify the underlying issues that contribute to recognized problems.			

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	A review of the Quality Assurance Performance Improvement (QAPI) meeting sign in sheets revealed that the members of the committee included but were not limited to the Administrator, Director of Nursing, Medical Director, Infection Control and Preventionist, Assistant Director of Nursing, Social Services Director, Wound Nurse, Minimum Data Set (MDS) Nurse, Activity Director, Dietary Manager, Human Resources, Admissions Director, Environmental Services, Staffing Coordinator, Consultant Pharmacist, and Nurse Practioner. During months of January 2021 through March 2021, there have been 11 committee members present, without a set agenda. Review of 1/28/2021 QAPI meeting minutes revealed the Staffing Coordinator voiced concerns related to staffing and Administrator agreed to work with her to try and increase staff in the facility. Review of 2/25/2021 QAPI meeting minutes revealed the Staffing Coordinator states we have less than 20 full-time employees and we need to increase the wages and get more staff into the facility. The Administrator instructed her to run some new ads on indeed and to contact additional agencies until we could hire our own staff. An ad was placed for a full-time Wound Nurse and she was hired but never showed up for orientation. Review of 3/25/2021 QAPI meeting minutes revealed the Administrator signed a contract with a new staffing agency. The staffing PAR was increased to 3.1. This was the approved new budget status although the minimum is 2.5. Due to shortage of wound care nurse, the Director of Nursing, the Assistant Director of Nursing, Charge Nurses and the Administrator will assist with wound care.			

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	Review of a QAPI Plan dated 4/7/2021 provided by the Regional Nurse Consultant with identified problem statement as: Insufficient routine screening and/or monitoring of residents for signs and/or symptoms of Covid-19. Lack of Covid-19 testing based on the county's positivity rate for all dedicated and/or contracted staff members. Goals: Licensed staff will routinely screen and monitor for signs and/or symptoms of Covid-19 at the beginning of the shift and prn (as needed). Plan: New tracking methods to be utilized for screening and testing. Facility leadership staff will monitor compliance of the screening and testing. Root Cause(s) include staff education on the requirements of the screening and testing process, tracking of screening/testing, and testing station location. Barriers include current tracking tools, lack of follow-up and lack of licensed staff education. Interview on 4/7/2021 at 3:29 p.m. with the Regional Nurse Consultant revealed that she held an Ad Hoc QAPI meeting today and provided one on one education with the Director of Nursing about the new process and forms for tracking. She stated that there had not been any concerns with COVID-19 testing or outbreak status presented in any prior QAPI meetings. During an interview on 4/19/2021 at 1:05 p.m., the Administrator stated that QAPI meets monthly, and each department will have opportunity to discuss concerns within their department. He stated that he was not aware of issues with the Infection Prevention Program. Cross Refer to F880, F886			
F 0880 SS= L	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an	F 0880		

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	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 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			

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	(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. §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: Based on observations, record review, interviews, and review of facility policy titled "Visitation and Infection Control Policy" the facility failed to implement an effective Infection Control Program to prevent the spread of infections, including COVID-19. Specifically, the facility failed to have a dedicated COVID-19 positive unit with dedicated staff, failed to routinely monitor 19 of 22 residents (R) (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #15, #16, #17, #18, #19, #20, #21, and #22) for signs/symptoms of COVID-19, and failed to don/doff appropriate Personal Protective Equipment (PPE). In addition, the facility failed to maintain communication with local health			

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	department during continued COVID-19 outbreaks, failed to store resident personal care items appropriately, failed to conduct non-COVID-19 infection surveillance from July 2020 through December 2020 and failed to ensure PPE was stocked. The facility census was 85. On 4/20/2021 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on 4/20/2021 at 10:30 a.m. The noncompliance related to the IJ was identified to have existed on 2/12/2021. The IJ is outlined as follows: According to a COVID-19 Infection Control Line Listing for the facility, two staff members tested positive for COVID-19: one on 2/12/2021 and another on 3/11/2021. Two residents also tested positive for COVID-19 on 3/12/2021. There is no evidence that the facility conducted outbreak testing for 12 of 22 residents reviewed. There is no evidence that 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were tested weekly according to outbreak testing status and/or based on county positivity rate, with no evidence that 11 of those 14 nursing staff were tested at all. R#10, who tested positive on 3/12/2021, was transferred to hospital on 3/26/2021 with worsening COVID symptoms and expired on 3/27/2021. Outbreak testing was initiated on 4/7/2021 during the survey. R#11 tested positive for COVID-19 and expired at the facility on 4/12/2021. R#21 and R#22 tested positive and were placed on the 200 Hall (later designated			

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	as a COVID-19 and Observation unit). Three staff members also tested positive. The facility did not have separate COVID and observation units and did not have dedicated staff. The facility had discarded barriers needed for the COVID unit and had to reorder. The facility had not contacted the local Department of Public Health (DPH) for guidance after continued outbreaks in the facility. The facility had no evidence of routine monitoring residents for signs and symptoms of COVID-19 for 19 of 22 residents reviewed. The IJ was related to the facility's noncompliance with the program requirements at 42 CFR 483.35(a)(1)(2) Sufficient Nursing Staff, F725; 42 CFR 483.70 Administration, F835; 42 CFR 483.70(d)(1)(2) Governing Body, F837; 42 CFR 483.75(g)(2)(ii) Qapi/QAA Improvement Activities, F867; 42 CFR 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control, F880; and 42 CFR 483.80 (h)(1)-(6) Covid-19 Testing-Residents & Staff, F886. F725, F835, F837, F867, F880, and F886 were at a Scope and Severity (S/S) of a "L". At the time of the exit on 4/30/2021, the IJ remained ongoing. Findings include: Review of the facility policy titled "Visitation and Infection Control Policy" updated to address the Coronavirus Disease 2019 (COVID-19), revised 3/18/2021 revealed policy interpretation and implementation: 1. The facility, consistent with federal regulations, implements universal, standard infection control practices, including a. Standard Precautions b. Hand hygiene c. Respiratory hygiene d. Vaccinations e. Signs and symptoms of common communicable diseases. 2.c. Residents may be screened up to three (3) times per day; number 2f. Residents with confirmed COVID-19 who have not met			

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	criteria for discontinuing transmission-based precautions should be placed in an isolation unit. New admissions and re-admissions whose COVID status is unknown or not fully vaccinated should be placed on the observation unit; make PPE, including facemask, eye protection, gowns, gloves, and shields/goggles available immediately outside of the resident's room when it's determined PPE is needed for the resident; 2n. If necessary, the facility will identify dedicated employees to care for COVID-19 patients and provide infection control training. 1. Observation on 4/5/2021 at 10:30 a.m. during initial tour with the DON revealed the 200 Hall was identified as the Observation unit. At the end of the 200 Hall were two rooms (206 and 208) that were for COVID positive residents if they needed them. There was no type of protective barrier to separate rooms 206 and 208 from the Observation rooms. Interview on 4/5/2021 at 11:00 a.m. with the DON, Infection Control Preventionist (ICP), revealed she has had the role of DON and ICP for three months. She stated there are six residents on the Observation unit. Observation on 4/8/2021 at 11:45 a.m. of the 200 Hall revealed three newly tested positive residents (R#11, R#21 and R#22) were being housed in the rooms on the right side of the 200 Hall (Observation Unit), without dedicated staff to attend to them. Observation on 4/12/2021 at 11:06 a.m. revealed the 200 Hall, which houses COVID-19 positive residents and Observation residents, had no dedicated coverage and the duties of administering medications was being split between Licensed Practical Nurse (LPN) AA and LPN QQ who were also administering medications on other units.			

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	Observation on 4/13/2021 at 9:30 a.m. revealed there are six residents on the Observation unit and three residents in COVID isolation rooms. There is no barrier to separate the Observation unit from the COVID unit. Observation on 4/13/2021 at 11:30 a.m. and 4/14/2021 at 9:00 a.m. revealed the 200 Hall, which houses COVID-19 positive residents and Observation residents, had no dedicated coverage and the duties of administering medications was being split between LPN AA and LPN KK who were also administering medications on other units. Observation on 4/14/2021 at 9:10 a.m. of the 200 Hall revealed that on the COVID rooms, 206 and 208, plastic barriers for the doorways were lying on the floor, at the entrance of the room. Interview on 4/14/2021 at 9:10 a.m. with CNA BB, revealed the plastic barriers on the doorways on the 200 Hall are always falling down, because the tape is not holding the plastic on the doorway. Interview on 4/16/2021 at 2:05 p.m. with Maintenance Supervisor revealed he took the COVID barrier down back in January 2021 as he was directed to do by the Administrator. He stated that he cleaned the poles and stored them in the Maintenance office. He stated that when the last couple of residents tested positive for COVID, he cut the plastic to fit over individual room doors on the Observation unit, to have extra protection from the newly diagnosed COVID residents. During further interview, he stated that he ordered a new COVID barrier kit, and it is due to be delivered on 4/22/2021. Observation on 4/20/2021 at 9:20 a.m. revealed			

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	the 200 Hall, which houses COVID-19 positive residents and Observation residents, had no dedicated coverage and the duties of administering medications was being split between LPN AA and LPN WW who were also administering medications on other units. Observation on 4/21/2021 at 3:45 p.m. revealed the 200 Hall, which houses COVID-19 positive residents and Observation residents, had no dedicated coverage and the nursing aide duties were being shared by Certified Nursing Assistant (CNA) JJ and CNA BBB who were also working on other units. Observation on 4/22/2021 at 4:30 p.m. revealed a COVID plastic barrier wall assembled on the 200 Hall, separating rooms 206 and 208 from the Observation unit. Observation on 4/26/2021 at 11:12 a.m. revealed the plastic barrier wall was not sealed around the barrier poles on the 200 hall COVID unit, not creating a closed unit. During an interview on 4/26/2021 at 11:30 a.m., the Maintenance Assistant stated that the double-sided tape on the barrier plastic is not sticking due to unzipping the plastic, causing it to pull from the poles. Observation on 4/29/2021 at 10:50 a.m. revealed the COVID barrier wall on the 200 Hall had been taken down. There were no COVID-19 positive residents at this time. 2. Review of the clinical record for R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, R#11, R#15, R#16, R#17, R#18, R#19, R#20, R#21 and R#22 revealed no evidence that residents were being routinely monitored for signs and symptoms of the COVID-19 virus,			

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	until the evening shift of 4/14/2021 after surveyor made inquiries. Interview on 4/13/2021 at 3:34 p.m. with DON revealed that Charge Nurses should be routinely assessing residents for signs and symptoms of COVID-19 each shift and documenting in the electronic medical record (EMR) MAR. She verified residents were not being monitored for signs and symptoms of COVID-19. 3. Observation on 4/15/2021 at 2:20 p.m. revealed the Assistant Director of Nursing (ADON) was walking the all units, including the COVID-19 unit, without wearing a face shield (eye protection), as recommended by Department of Public Health (DPH) meeting on 4/9/2021. Observation on 4/15/2021 at 5:20 p.m. revealed RN UU exited a resident room on the 300 Hall, wearing gloves and pushing the meal cart down the hall. Interview on 4/15/2021 at 5:20 p.m. with RN UU, revealed that she did not touch any residents, so she thought it was ok to throw the gloves away in the trash can in the dining room. Observation on 4/19/2021 at 10:55 a.m. revealed an isolation gown observed hanging on Point of Care (POC) monitor in the hallway on the Observation unit. Observation on 4/19/2021 at 12:45 p.m. revealed housekeeping staff MMM was cleaning room 206 (COVID positive room) and exited the isolation room wearing gloves and gown and doffed at her cart.			

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	Observation on 4/22/2021 at 11:59 a.m. revealed an isolation gown was hanging on a POC monitor on the 200 COVID/Observation Hall. 4. Interview on 4/16/2021 at 10:30 a.m. with Administrator revealed that he has been at this facility since January 2021. He stated that the COVID unit was taken down sometime in January 2021 because they did not have any COVID positive residents (1/18/2021 was last COVID positive resident in January 2021). However, the last two rooms on the 200 Hall are COVID rooms if they should need them. He stated that the decision to take the unit down was a joint decision with DON and Regional Administrator. During further interview, he stated he is not sure what happened to the barrier walls, but stated they were probably in storage somewhere onsite. When questioned if he contacted the DPH Epidemiology for assistance during an ongoing outbreak of COVID-19, he replied "yes, I contacted them about a week before you came" and they did a zoom visit on 4/8/2021 and an onsite visit on 4/9/2021. He stated they made some recommendations, and they are working on those recommendations now. Review of DPH Epidemiology Infection Control Assessment and Response Tool (ICAR) dated 4/8/2021, 4/9/2021 (onsite) and 4/16/2021 (onsite) revealed areas of concern with staffing support needed for COVID unit and also to ensure testing each week, recommend increasing staff to assist DON, recommend fingernail education as nail extenders noted on staff, limited supply of Alcohol Based Hand Rub (ABHR) in four room suites, recommendation for all staff to wear eye protection, PPE education on when/where to don/doff, post CDC PPE donning/doffing signage on resident doors, recommend isolation carts outside each residents room with assigned personal to keep stocked, environmental staff cleaning without wearing gloves and need for Observation unit			

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	and COVID unit to be kept separate. Review of the facility's COVID-19 weekly line list of staff and residents, received from the facility, revealed that from the week of 1/5/2021 through the week of 1/28/2021 the facility had four new COVID positive Residents and six new positive staff. There was evidence to support resident and staff weekly testing related to the outbreaks in January 2021. However, review of email correspondence from DPH to the surveyor dated 4/7/2021 revealed that the last ICAR, prior to April 2021, during the survey, was conducted with the facility on 10/9/2020. Review of e-mail correspondence between Administrator and the DPH Epidemiology from 1/29/2021 through 4/5/2021 revealed submission of line listings with no request for assistance during an on-going outbreak of COVID-19. 5. Observation on 4/16/2021 at 9:25 a.m. in room 310 revealed un-bagged and un-labeled bath basin sitting on sink counter in a semi-private room. Observation on 4/16/2021 at 10:10 a.m. in room 502, revealed two un-bagged and un-labeled bath basins on the floor under the sink, in a semi-private room. Observation on 4/16/2021 at 10:13 a.m. in room 506, revealed an un-bagged and un-labeled bath basin on the floor under the sink. Observation on 4/16/2021 at 10:20 a.m. in room 401, revealed three un-bagged and un-labeled bath basins on top of a closet, in a semi-private room.			

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	Observation on 4/16/2021 at 10:22 a.m. in room 402, revealed an un-bagged and un-labeled urine measuring bowl in the bathroom, on the floor. Observation on 4/16/2021 at 3:30 p.m. in room 504 revealed an un-bagged and unlabeled bath basin on the counter and an un-bagged and un-labeled urinal hanging on the grab bar in the bathroom. Observation on 4/22/2021 at 1:45 p.m., in room 208, revealed a bath basin on the floor under the sink, not bagged. 6. Review of Infection Control Surveillance data for the past 12 months revealed there was no Infection Control or Antibiotic Stewardship data collected for the months of July 2020 through December 2020. Inconsistent COVID-19 data was the only data collected. Interview on 4/14/2021 at 2:04 p.m. with DON/ICP revealed that there was no one in the role of ICP when she was hired, but the previous DON was supposed to be collecting the surveillance data. She stated she has been inconsistent with the data collection and surveillance tracking because she has had to work on the medication cart three to four days per week, and she just did not have time to do it. 7. Observation on 4/15/2021 at 10:55 a.m. revealed the PPE cart outside room 201, observation room, was not stocked with gloves or gowns. Observation on 4/23/2021 at 11:40 a.m. revealed the PPE cart outside room 201, observation room, was not stocked with gowns or masks.			

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F 0883 SS= E	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 0883		

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	(iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and review of a facility policy titled, "Vaccination of Residents" the facility failed to offer and administer the pneumonia vaccine to five of 30 sampled residents (R) (#1, R#2, R#3, R#6, and R#7). Findings include: Review of the facility policy titled "Vaccination of Residents" version 2.3 requires that all residents will be offered vaccines that aid in preventing infectious diseases unless the vaccine is medically contraindicated, or the resident has already been vaccinated. Requirements under subparts include: 1. Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. 2. Provision of such education shall be documented in the resident's medical record. 3. All new residents shall be assessed for current vaccination status upon admission. 4. The resident or the resident's legal			

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	representative may refuse vaccines for any reasons. 5. If vaccines are refused, the refusal shall be documented in the resident's medical record. 6. If the resident receives a vaccine, at least the following information shall be documented in the resident's medical record: a. Site of administration: b. Date of administration: c. Lot number of the vaccine (located on the vial). d. Expiration date (located on the vial); and e. Name of person administering the vaccine. 7. Certain vaccines (e.g., influenza and pneumococcal vaccines) may be administered per the physician-approved facility protocol (standing orders) after the resident has been assessed by the physician for medical contraindications for each vaccine. The resident's Attending Physician must provide a separate written order for any other vaccination, and such orders shall be recorded in the resident's medical record. Review of Electronic Medical Record (EMR) showed no evidence that R#1, R#2, R#3, R#6, or R#7 had been educated or offered the pneumonia vaccine based on current recommended immunization schedule, set forth by the Centers for Disease Control (CDC). Review of April 2021 Medication Administration Record (MAR) revealed that residents (R)#3 and R#7 had no evidence of documentation that the pneumonia vaccine was offered or given. Review of the April 2021 MAR revealed R #1, R#2 and R#6 received the pneumonia vaccine on 4/23/2021 after the surveyor's entrance on 4/5/2021.			

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	Interview on 4/26/2021 at 11:50 a.m., with the Director of Nursing (DON) (who is the Infection Control Preventionist and a Registered Nurse) revealed that the goal was to do the Influenza and Pneumonia vaccine at the same time. The DON revealed the vaccination (influenza and pneumonia) education should be given before the vaccine is administered. The DON stated that she only purchased ten pneumonia vaccines and those ten vaccines were given to the residents. Further interview on 4/27/2021 at 11:30 a.m., with the DON revealed that R#3's consent form was signed for the pneumonia vaccine with a date of 10/8/2020. However, R#3 did not receive the vaccine because the facility did not have any pneumonia vaccines at that time.			
F 0886 SS= L	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §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: §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	F 0886		

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	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 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.			

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	§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: Based on record review and staff, Medical Director, and Regional Nurse Consultant interviews, the facility failed to conduct routine and outbreak testing for COVID-19 in a manner consistent with current standards of practice for 13 residents, (R) (R#1, R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#10, R#11, R#21, and R#22) of 22 residents reviewed for COVID-19 testing. Additionally, the facility failed to ensure testing was completed and results documented for 14 of 40 nursing staff working 2/1/2021 through 4/5/2021. On 4/20/2021 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation caused or had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Nursing were informed of the Immediate Jeopardy (IJ) on 4/20/2021 at 10:30 a.m. The noncompliance related to the IJ was identified to have existed on 2/12/2021. The IJ is outlined as follows: According to a COVID-19 Infection Control Line Listing for the facility, two staff members tested positive for COVID-19: one on 2/12/2021 and another on 3/11/2021. Two residents also tested positive for COVID-19 on 3/12/2021. There is			

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	no evidence that the facility conducted outbreak testing for 13 of 22 residents reviewed. There is no evidence that 14 of 40 nursing staff working 2/1/2021 through 4/5/2021 were tested weekly according to outbreak testing status and/or based on county positivity rate, with no evidence that 11 of those 14 nursing staff were tested at all. R#10, who tested positive on 3/12/2021, was transferred to hospital on 3/26/2021 with worsening COVID symptoms and expired on 3/27/2021. Outbreak testing was initiated on 4/7/2021 during the survey. R#11 tested positive for COVID-19 and expired at the facility on 4/12/2021. R#21 and R#22 tested positive and were placed on the 200 Hall (later designated as a COVID-19 unit and Observation unit). Three staff members also tested positive. The facility did not have separate COVID and observation units and did not have dedicated staff. The facility had discarded barriers needed for the COVID unit and had to reorder. The facility had not contacted the local Department of Public Health (DPH) for guidance after continued outbreaks in the facility. The facility had no evidence of routine monitoring of residents for signs and symptoms of COVID-19 for 19 of 22 residents reviewed. The IJ was related to the facility's noncompliance with the program requirements at 42 CFR 483.35(a)(1)(2) Sufficient Nursing Staff, F725; 42 CFR 483.70 Administration, F835; 42 CFR 483.70(d)(1)(2) Governing Body, F837; 42 CFR 483.75(g)(2)(ii) Qapi/QAA Improvement Activities, F867; 42 CFR 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control, F880; and 42 CFR 483.80 (h)(1)-(6) Covid-19 Testing-Residents & Staff, F886. F725, F835, F837, F867, F880, and F886 were at a Scope and Severity (S/S) of a "L". At the time of the exit on 4/30/2021, the IJ remained ongoing.			

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	Findings include: Review of the Georgia Department of Public Health COVID-19 PCR Test Positivity Rates and Classification, Georgia, revealed positivity rate for Dekalb County was as follows: 2/1/2021=11.6% 2/8/2021=10.1% 2/15/2021=8.4% 2/22/2021=7.3% 3/1/2021=6.5% 3/8/2021=5% 3/15/2021=4.3% 3/22/2021=4.2% 3/29/2021=4.5% 4/5/2021=4.5% The "Test Positivity Classification" for these time periods was "red which is greater than 10%" for weeks of 2/1/2021 and 2/8/2021; "yellow which is 5-10%" for 2/15/2021, 2/22/2021, 3/1/2021 and 3/8/2021; and "green which is less than 5%" for 3/15/2021 through 4/5/2021. Based on the county infection rates noted above, the Center for Medicare and Medicaid Services (CMS) identified in memo QSO-20-38-NH, dated 8/26/2020, the requirement that a facility test all staff, contracted staff working in the building, and consultants, twice a week when the county COVID-19 positivity rate for the county is greater than 10%. When the county COVID-19 positivity rate is 5-10% staff testing is to be conducted once per week; and for county COVID-19 positivity rate less than 5% staff testing should be conducted once per month. In addition, CMS identified in QSO-20-38-NH, dated 8/26/2020, the requirement for outbreak			

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	testing, all staff and residents should be tested, and all staff and residents that tested negative should be retested every three to seven 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. Review of the COVID-19 Staff Line Listing revealed staff tested positive for COVID-19 on 2/12/2021, 3/11/2021, and 4/5/2021. Review of the COVID-19 Resident Line Listing revealed a resident tested positive for COVID-19 on 3/12/2021. The facility began outbreak testing for residents and staff on 4/7/2021 during survey where additional residents and staff members tested positive for COVID-19 on 4/7/2021, 4/8/2021, 4/11/2021, and 4/15/2021. Review of the actual nurse staffing hours for facility nursing staff revealed that from 2/1/2021 through 4/5/2021, Registered Nurse (RN) NN, RN UU, Licensed Practical Nurse (LPN) FF, LPN CCC, LPN DDD, LPN EEE, Certified Nursing Assistant (CNA) FFF, CNA GGG, CNA HHH, CNA III, and CNA JJJ worked during this time period. There is no evidence that the above staff were tested for COVID-19 during that time period. According to facility testing documents for staff, the Director of Nursing (DON) was tested on 3/4/2021 and 3/26/2021 only, the Assistant ADON was tested on 3/15/2021 only, and Agency LPN AA was tested on 2/23/2021 only. Review of the clinical record revealed the following COVID-19 testing information for previously negative residents for 2/12/2021(when an outbreak occurred) through 4/5/2021: 1. R#1 was admitted to the facility on 6/1/2017 and was last tested on 1/6/2021. There is no evidence that COVID testing was performed after 1/6/2021 through 4/5/2021.			

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	2. R#2 was admitted to the facility on 12/23/2017 and was last tested on 3/19/2021 and 1/6/2021. There is no evidence of any other COVID testing from 2/12/2021 through 4/5/2021. 3. R#3 was admitted to the facility on 4/27/2018 and was last tested on 3/19/2021 and 1/27/2021. There is no evidence of any other COVID testing through 4/5/2021. 4. R#4 was admitted on 1/28/2021, transferred to the hospital on 3/6/2021 and was readmitted on 3/17/2021. There was no evidence of COVID testing through 4/5/2021. 5. R#5 was admitted to the facility on 1/22/2019 and was last tested on 3/19/2021. There is no evidence of any other COVID testing from 2/12/2021 through 4/5/2021. 6. R#6 was admitted to the facility on 3/3/2020 and was last tested on 3/28/2021 and 1/6/2021. There is no evidence of any other COVID testing from 2/12/2021 through 4/5/2021. 7. R#7 was admitted to the facility on 6/1/2017 and was last tested on 3/19/2021 and 1/27/2021. There is no evidence of any other COVID testing through 4/5/2021. 8. R#8 was admitted to the facility on 1/8/2018 and was last tested on 3/19/2021 and 1/6/2021. There is no evidence of any other COVID testing through 4/5/2021. 9. R#9 was admitted to the facility on 1/26/2021 and tested positive for COVID-19 on 3/12/2021. There is no evidence that COVID testing was			

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	done prior to 3/12/2021. 10. R#10 was admitted to the facility on 2/23/2021. The resident tested positive for COVID-19 on 3/12/2021. There is no evidence that COVID testing was performed prior to 3/12/2021. Further review of the clinical record revealed R#10 was transferred to hospital on 3/26/2021 with worsening COVID symptoms and expired on 3/27/2021. 11. R#11 was admitted to facility on 2/5/2021. R#11 tested positive on 4/7/2021. There is no evidence that COVID testing was performed prior to 4/7/2021. Further review of the clinical record revealed R#11 expired on 4/12/2021 at the facility. 12. R#21 was admitted to the facility on 3/24/2021 and was not tested until 4/7/2021 and tested positive. 13. R#22 was admitted to the facility on 2/12/2021. The resident was tested for COVID-19 on 3/19/2021 and 4/8/2021. Resident tested positive on 4/8/2021. There is no evidence that the resident was tested prior to 3/19/2021. There were no documented refusals of testing for residents or staff. Review of Quality Assessment and Performance Improvement Plan dated 4/7/2021 provided to surveyor by Regional Nurse Consultant with identified problem statement as: Lack of Covid-19 testing based on the county's positivity rate for all dedicated and/or contracted staff members. Plan: New tracking methods to be utilized for screening and testing. Facility leadership staff will monitor compliance of the screening and testing. Root Cause(s) include staff education on the requirements of the			

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	screening and testing process, tracking of screening/testing, testing station location. Barriers include current tracking tools, lack of follow up and lack of licensed staff education. Interview on 4/5/2021 at 11:00 a.m. with DON revealed she has been employed at the facility for eight months but has had the role of DON and Infection Control Preventionist (ICP) for three months. She stated that the County Positivity Rate was 4.2 and the facility is currently testing residents and staff once monthly. During further interview, she stated this morning she had two dietary staff members to test positive for COVID. Interview on 4/6/2021 at 1:11 p.m. with DON revealed that there is no specific day that the COVID testing is done, but usually done on Tuesday's and Friday's. She stated that she splits the testing with the Assistant Director of Nursing (ADON). She stated that she makes an announcement on the paging system for staff to come get COVID tested and that staff sign in when they come to the clinic. During further interview, she stated that if staff do not come to the COVID clinic, she contacts the department heads and informs them staff need to be tested. She stated she is unable to follow up to see if the staff that missed testing were actually tested later. She stated that staff know COVID testing is not "optional" and if staff do not come to get tested, they will be removed from the schedule. She further stated that the ADON will come in early to do testing of the night shift staff. During an interview on 4/7/2021 at 3:29 p.m., the Regional Nurse Consultant stated that she held an Ad Hoc QAPI meeting today and provided one on one education with the DON about the new process and forms for tracking. She stated that there had not been any concerns with COVID-19 testing or outbreak status presented in any prior QAPI meetings.			

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	Interview on 4/8/2021 at 12:20 p.m. with Housekeeping Supervisor revealed that she has been tested weekly on Wednesdays. She stated that if her staff are off on the Wednesday test day, then they are tested on their first day back to work. The DON confirmed during interview on 4/12/2021 at 12:10 p.m. that the tracking logs for resident and staff testing she provided to the surveyor was all that she could find. Interview on 4/15/2021 at 1:00 p.m. with ADON revealed she has been employed at the facility for two months. She stated that she helped the DON with the COVID testing for staff and residents. She stated that she would use a daily census sheet when testing residents and that is how they tracked testing. She stated that she did not do any type of documentation that residents had been tested, unless they tested positive. She further stated that she does not know how the tracking for the staff testing was being done. Phone interview on 4/16/2021 at 11:46 a.m. with the Medical Director revealed he has weekly conversations with the Administrator, either in person or via phone. He stated that there was nothing mentioned to him about COVID outbreaks in the facility.			
F 0925 SS= E	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and resident interviews the facility failed to maintain an effective pest control policy related to	F 0925		

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	roaches. This had the potential to affect all residents in the facility. The facility census was 85. Findings include: Observation on 4/7/21 at 1:05 p.m., in room 506, roaches running from under Oxygen concentrator when moved to check filter. Observation on 4/12/21 at 11:25 a.m. in room 506, roaches running from under Oxygen concentrator. Observation on 4/14/21 at 3:15 p.m. in room 506, approximately 5-6 roach bugs seen running from under Oxygen concentrator at head of bed. Observation on 4/15/21 at 2:25 p.m. in room 105, several small roaches noted on floor around base of toilet in the bathroom. Observation on 4/16/21 at 11:34 a.m. in room 102, two roaches observed crawling on the wall in the bathroom. Observation on 4/20/21 at 9:20 a.m. in room 506, roach bugs continue to be seen under the Oxygen concentrator. Observation on 4/21/21 at 9:15 a.m. at second floor Nurse's Station, dead roach bug squished on wall. Observation on 4/23/21 at 11:28 a.m. room 506, roach bugs crawling on floor by Oxygen concentrator.			

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	Observation on 4/26/21 at 09:38 a.m. room 506, roach bugs crawling on floor by Oxygen concentrator. A review of the facility's pest log "(name) Pest Remedy" with dates: 6/18/21, 7/16/21, 8/20/20, 9/17/20, 10/15/20. 11/14/20, 12/17/20, 1/21/21, 2/18/21, 3/18/21, 4/1/21, 4/8/21, 4/15/21, 4/16/21 documented pest control treatment targeted for German Roaches. Pest Control service was provided once per month, except for April, when service was provided weekly. Interview on 4/21/21 at 10:54 a.m., with R#6 revealed there are roaches in the hallway and in the bathroom. Interview on 4/22/21 at 12:37 p.m., with R#3 revealed there are roaches in my room every day. Interview on 4/22/21 at 1:00 p.m., with R#7 revealed roaches are on the floor by the bed and everywhere in his room. Interview on 4/20/21 at 11:03 a.m., with Certified Nursing Assistant (CNA) OO, who has worked at the facility for one year, revealed she has seen roaches in residents' rooms on the 400 hall and at the nursing station. During an interview on 4/15/21 at 5:35 p.m., the Administrator revealed the facility has no pest control policy. Interview on 4/16/21 at 12:24 p.m., with the Administrator revealed that the pest control company has been spraying each hall each week for the past two to three months.			

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	Interview on 4/20/21 at 11:40 a.m., with CNA PP, works on the 400/500 hall revealed she has seen roaches everywhere but mainly in the resident rooms. Interview on 4/26/21 at 2:30 p.m., with the Dietary Manager revealed roaches have been seen in the kitchen behind the stove and where the leftover food is discarded.			