STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345389	A. BUILDING _____ B. WING _____	C 02/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF FOREST GLENN	1101 HARTWELL STREET GARNER, NC 27529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 02/18/2022. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# L6W311.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 02/18/2022. One of the nine complaint allegations was substantiated resulting in deficiencies.	F 000		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview and record review the facility failed to provide effective oversight to ensure COVID-19 testing supplies were available for testing symptomatic residents and put transmission based precautions in place upon the identification of COVID-19 symptoms for 5 (Resident #3, Resident #12, Resident #13, Resident #14, and Resident #15) of 5 sampled residents. Findings included: A. Cross refer to F886: Based on observation,	F 835	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 3/17/2022. Preparation and/or execution of this Plan of Correction does not constitute admission to, nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the Statement of Deficiencies. This plan is prepared and/or	3/17/22

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

Electronically Signed | 02/28/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 835	Continued From page 1 staff interview, family interview, and record review the facility failed to provide COVID-19 testing upon the appearance of symptoms for 5 (Residents #3, #12, #13, #14, #15) of 5 sampled residents who tested positive for COVID-19 during a facility COVID-19 outbreak. This occurred during a coronavirus pandemic. B. Cross refer to F880: Based on staff interview and record review the facility failed to implement isolation and transmission based precautions upon the appearance of symptoms for 5 (Residents #3, #12, #13, #14, #15) of 5 sampled residents who tested positive for COVID-19 during a facility COVID-19 outbreak. This occurred during a coronavirus pandemic.	F 835	executed to ensure continued compliance with regulatory requirement. F835 Administration Upon discovery of the 5/5 residents, they were already covid recovered, so no intervention was needed for these residents. All residents have the potential to be affected. Immediately, upon notification of alleged deficiency, The Director of Nursing and Assistant Director of Nursing/Infection Control Preventionist verified that covid testing supplies were immediately available and any residents that were symptomatic for covid were immediately tested and transmission-based precautions in place, if applicable. No other concerns identified. Through our Quality Assurance Performance Improvement process, the potential root cause analysis was identified as insufficient staff education; therefore, the Regional Clinical Coordinator educated The Administrator, Director of Nursing and Assistant Director of Nursing/Infection Control Preventionist on 2/18/2022 regarding signs and symptoms of covid, notification to the licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission based precautions when applicable, location of testing supplies and notification if none available.	

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F 835	Continued From page 2	F 835	Then, education was provided to all direct care staff by The Director of Nursing and Assistant Director of Nursing/Infection Preventionist by 2/28/2022 regarding signs and symptoms of covid, notification to the licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission-based precautions when applicable, location of testing supplies and notification if none available. Additionally, new hirers providing direct care will be educated upon hire and at least annually regarding signs and symptoms of covid, notification to the licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission-based precautions when applicable, location of testing supplies and notification if none available. The Director of Nursing and/or Designee will ensure testing supplies are available to staff in the designated location accessible to staff in the event a resident presents with signs and symptoms of covid and needs to be tested. Monitoring of testing supplies will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately and additional education provided when	

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F 835	Continued From page 3	F 835	indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program. The Administrator, Director of Nursing, and other staff members as assigned will interview at least 10 direct care staff members on their knowledge of where testing supplies are located if a resident presents with signs and symptoms of covid and needs to be tested and who to contact if none available. Interviews will be completed five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program. The Administrator, Director of Nursing, and other staff members as assigned will interview and/or observe 10% of residents for new signs and symptoms of covid and if symptomatic, ensure they□re immediately tested and transmission-based precautions in place, if applicable, five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances	

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F 835	Continued From page 4	F 835	identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program. The Administrator, Director of Nursing, and other staff members as assigned will interview at least 10 direct care staff members for new signs and symptoms of covid of residents and if symptomatic, ensure they□re immediately tested and transmission-based precautions in place, if applicable, five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		3/17/22

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F 880	Continued From page 5	F 880		

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
(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

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F 880	Continued From page 6 (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 staff interview and record review the facility failed to implement isolation and transmission based precautions upon the appearance of symptoms for 5 (Residents #3, #12, #13, #14, #15) of 5 sampled residents who tested positive for COVID-19 during a facility COVID-19 outbreak. This occurred during a coronavirus pandemic. Findings included: Documentation in the facility Coronavirus (COVID-19) testing policy, dated as last reviewed on 2/16/2022, stated in part, "If a guest/resident presents with a fever or symptoms consistent with COVID-19, place guest/resident in Transmission Based Precautions and test for SARS-CoV." The policy also stated, "All recommended Covid-19 PPE (personal protective equipment) should be worn during care of guests/residents under observation or in Transmission Based Precautions, which includes use of an N95 or higher-level respirator (or surgical if a respirator is not available), eye protection (ie. goggles or a	F 880	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 3/17/2022. Preparation and/or execution of this Plan of Correction does not constitute admission to, nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the Statement of Deficiencies. This plan is prepared and/or executed to ensure continued compliance with regulatory requirement. F880 Infection Prevention & Control Upon discovery of the 5/5 residents, they were already covid recovered, so no intervention was needed for these residents.	

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F 880	Continued From page 7 face shield that covers the front and sides of the face), gloves and gown." Documentation in NHSN vaccination summary data for the week of 1/3/2022 to 1/9/2022 revealed 85.33% of all staff were fully vaccinated, 7.33% were partially vaccinated, and 7.33 % were unvaccinated. The documentation in the NHSN vaccination summary dated for the week of 1/3/2022 to 1/9/2022 also revealed 85.83% of the residents were fully vaccinated, 2.5% were partially vaccinated, and 11.67% were unvaccinated. 1. Documentation in the vaccine administration section of the medical record revealed, Resident #3 was up-to-date with all recommended COVID-19 vaccines. Resident #3 resided in a semi-private room at the facility. Documentation in the medical record of Resident #3 written by Nurse #2 in an electronic MAR - shift level administration note dated 1/10/2022 at 12:27 AM stated, "Cough, ADON (Assistant Director of Nursing) aware, resident will be tested this AM on [first] shift when supplies [available]." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report." Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had	F 880	All residents have the potential to be affected. Immediately, upon notification of alleged deficiency, The Director of Nursing and Assistant Director of Nursing/Infection Control Preventionist verified that covid testing supplies were immediately available and any residents that were symptomatic for covid were immediately tested and transmission-based precautions in place, if applicable. No other concerns identified. Through our Quality Assurance Performance Improvement process, the potential root cause analysis was identified as insufficient staff education; therefore, (re)education was provided to all direct care staff by The Director of Nursing and Assistant Director of Nursing/Infection Preventionist by 2/28/2022 regarding signs and symptoms of covid, notification to the licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission-based precautions when applicable, location of testing supplies and notification if none available. Additionally, new hirers providing direct care will be educated upon hire and at least annually regarding signs and symptoms of covid, notification to the licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission-based precautions when applicable, location of testing supplies and notification if none available.	

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F 880	Continued From page 8 symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 stated she was not able to test the residents due to a lack of reagent, and therefore the residents were not placed on transmission-based precautions or isolated during her shift. She called and informed the ADON when she realized she could not test the residents and passed along in shift change report to Nurse #3 the residents who needed to be tested. Nurse #3, the nurse who took the nursing shift change report from Nurse #2 on 1/10/2022, was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #3 did not recall any other information about events that occurred after she was notified some of the residents had symptoms and needed to be tested. An interview was conducted with the ADON on 2/17/2022 at 12:50 PM. The ADON stated she was not called by Nurse #2 on 1/9/2022 or 1/10/2022. The ADON revealed it was not communicated to her some of the residents were having symptoms of COVID-19 so that proper testing and isolation of the residents could be initiated. The ADON revealed NA #3 was assigned to test the residents for COVID-19 every Monday. If the testing was completed and residents tested positive, they would have been put on isolation precautions.	F 880	The Administrator, Director of Nursing, and other staff members as assigned will interview and/or observe 10% of residents for new signs and symptoms of covid and if symptomatic, ensure they□re immediately tested and transmission-based precautions in place, if applicable, five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program. The Administrator, Director of Nursing, and other staff members as assigned will interview at least 10 direct care staff members for new signs and symptoms of covid of residents and if symptomatic, ensure they□re immediately tested and transmission-based precautions in place, if applicable, five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality	

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F 880	Continued From page 9	F 880		

Documentation in a social service note dated 1/10/2022 at 5:55 PM revealed Resident #3 tested positive for COVID-19 on a rapid test and a voice mail was left with a family member for notification of the results.

Documentation in a social service progress note dated 1/11/2022 at 8:28 AM revealed a family member of Resident #3 was notified of the positive COVID-19 rapid test, an explanation given an additional test would be given, and if the second test was positive Resident #3 would be moved to the COVID-19 unit.

Documentation in an additional social service note dated 1/11/2022 at 3:16 PM revealed a family member was notified Resident #3 was to remain in her current room because her room was at that time a part of the COVID-19 unit.

An interview was conducted with the facility Administrator on 2/18/2022 at 9:58 AM. The facility Administrator explained COVID-19 testing of the residents was initiated on 1/10/2022 after 4:00 PM and was started on the 200 Hall area. Resident #3 and her roommate both tested positive for COVID-19 on the same day at the same time. The Health Department was contacted, and the facility received confirmation to put the residents who tested positive with the rapid test under transmission-based precautions. The COVID-19 unit was expanded at that time to include the room for which Resident #3 and her roommate resided.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022

Assurance Program.

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F 880	Continued From page 10	F 880		

and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken with the testing and isolation of the symptomatic residents, but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON stated Nurse #2 should have called her and notified her if several of the residents were showing symptoms of COVID-19. DON confirmed she did not receive a call from Nurse #2 on 1/10/2022.

An interview was conducted with the DON and Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility Administration was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents to include Resident #3 were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for

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the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The DON noted that no other symptoms of COVID-19 were documented for Resident #3 on 1/10/2022 or 1/11/2022. The DON indicated the reason the residents were not placed on transmission-based precautions was because of a communication problem. The DON stated she and her staff were aware residents who were symptomatic needed to be tested right away and placed on transmission-based precautions, but she nor the ADON ever received a phone call from Nurse #2 alerting them that residents were symptomatic and needed testing. If they had been notified, they could have provided for the immediate testing because the supplies were in the facility and then the residents who showed positive would have been isolated and place on transmission-based precautions. According to the DON, nurses could have called her or the ADON at any time and neither of them had a record of any phone calls from Nurse #2. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

2. Documentation in the vaccine administration section of the medical record revealed, Resident #14 was up-to-date with all recommended

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COVID-19 vaccines. Resident #14 resided in a semi-private room in the facility but did not have a roommate.

Documentation in the medical record of Resident #14 written by Nurse #2 in an electronic MAR (medication administration record) shift level administration note dated 1/10/2022 at 12:28 AM stated, "cough, sore throat, low fever, ADON (Assistant Director of Nursing) aware, resident to be tested this AM on 1rst shift when supplies [available]."

Documentation in the vital signs section of the medical record revealed Resident #14 had a low-grade fever of 99.3 degrees Fahrenheit on 1/10/2022 at 10:42 PM.

Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 stated she was not able to test the residents due to a lack of reagent, and therefore the residents were not placed on transmission-based precautions or isolated during her shift. She called and informed the ADON when she realized she could not test the residents and passed along in shift change report to Nurse #3 the residents who needed to be tested.

Nurse #3, the nurse who took the nursing shift

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change report from Nurse #2 on 1/10/2022, was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #3 did not recall any other information about events that occurred after she was notified some of the residents had symptoms and needed to be tested.

Documentation in a social service progress note dated 1/10/2022 at 5:53 PM revealed Resident #14 tested positive for COVID-19 and a voicemail was left for the guardian.

Documentation in a nurse practitioner progress note dated 1/11/2022 at 3:03 PM revealed Resident #14 was seen for an acute visit for COVID-19 positive test but was not showing any symptoms.

Documentation in a nursing note on 1/11/2022 at 4:10 PM revealed Resident #14 was moved to the COVID-19 unit that evening.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was

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not discussed in morning meeting so action could be taken with the testing and isolation of the symptomatic residents, but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON stated Nurse #2 should have called her and notified her if several of the residents were showing symptoms of COVID-19. DON confirmed she did not receive a call from Nurse #2 on 1/10/2022.

An interview was conducted with the DON and Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility Administration was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents to include Resident #3 were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the

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antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The DON noted that no other symptoms of COVID-19 were documented for Resident #3 on 1/10/2022 or 1/11/2022. The DON indicated the reason the residents were not placed on transmission-based precautions was because of a communication problem. The DON stated she and her staff were aware residents who were symptomatic needed to be tested right away and placed on transmission-based precautions, but she nor the ADON ever received a phone call from Nurse #2 alerting them that residents were symptomatic and needed testing. If they had been notified, they could have provided for the immediate testing because the supplies were in the facility and then the residents who showed positive would have been isolated and place on transmission-based precautions. According to the DON, nurses could have called her or the ADON at any time and neither of them had a record of any phone calls from Nurse #2. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

3. Documentation in the vaccine administration section of the medical record revealed, Resident #15 was up-to-date with all recommended COVID-19 vaccinations. Resident #15 resided in a private room in the facility.

Documentation in the medical record of Resident #15 written by Nurse #2 in an electronic MAR (Medication Administration Record) - shift level

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administration note dated 1/10/2022 at 12:39 AM stated, "Cough, sore throat, ADON (Assistant Director of Nursing) aware, resident will be tested this AM on first shift when [COVID-19] supplies available." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report."

Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 stated she was not able to test the residents due to a lack of reagent, and therefore the residents were not placed on transmission-based precautions or isolated during her shift. She called and informed the ADON when she realized she could not test the residents and passed along in shift change report to Nurse #3 the residents who needed to be tested.

Nurse #3, the nurse who took the nursing shift change report from Nurse #2 on 1/10/2022, was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #3 did not recall any other information about events that

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occurred after she was notified some of the residents had symptoms and needed to be tested.

Documentation in a social service note dated 1/11/2022 at 11:40 AM revealed Resident #15 tested positive for COVID-19.

Documentation in a Nurse Practitioner note dated 1/11/2022 at 11:58 AM stated in part, "I am seeing this patient following her rapid test positive COVID-19 test. Patient is fully vaccinated. She [complains of] mild scratchy throat but no other symptoms."

Documentation in the nursing notes dated 1/11/2022 at 6:00 PM revealed Resident #15 was transferred to the COVID-19 unit that evening.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken with the testing and isolation of the symptomatic residents, but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON stated Nurse #2 should have called her and notified her if several of the residents were showing symptoms of COVID-19. DON confirmed she did not receive a call from Nurse #2 on 1/10/2022.

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An interview was conducted with the DON and Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility Administration was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents to include Resident #3 were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The DON noted that no other symptoms of COVID-19 were documented for Resident #3 on 1/10/2022 or 1/11/2022. The DON indicated the reason the residents were not placed on transmission-based precautions was because of a communication problem. The DON stated she and her staff were

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aware residents who were symptomatic needed to be tested right away and placed on transmission-based precautions, but she nor the ADON ever received a phone call from Nurse #2 alerting them that residents were symptomatic and needed testing. If they had been notified, they could have provided for the immediate testing because the supplies were in the facility and then the residents who showed positive would have been isolated and place on transmission-based precautions. According to the DON, nurses could have called her or the ADON at any time and neither of them had a record of any phone calls from Nurse #2. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

4. Documentation in the vaccine administration section of the medical record revealed, Resident #12 was up-to-date with all recommended COVID-19 vaccinations. Resident #12 resided in a semiprivate room in the facility.

Documentation in the medical record of Resident #12 written by Nurse #2 in an electronic MAR (Medication Administration Record) - shift level administration note dated 1/10/2022 at 12:26 AM stated, "Resident has cough, ADON (Assistant Director of Nursing) aware, resident to be tested this AM when supplies [available]." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report."

Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at

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the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 stated she was not able to test the residents due to a lack of reagent, and therefore the residents were not placed on transmission-based precautions or isolated during her shift. She called and informed the ADON when she realized she could not test the residents and passed along in shift change report to Nurse #3 the residents who needed to be tested.

Nurse #3, the nurse who took the nursing shift change report from Nurse #2 on 1/10/2022, was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #3 did not recall any other information about events that occurred after she was notified some of the residents had symptoms and needed to be tested.

The documentation in the point of care antigen testing log dated 1/10/2022 at 4:55 PM revealed Resident #12 tested positive for COVID-19 at 5:10 PM.

Documentation in a social service progress note

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dated 1/10/2022 at 5:33 PM revealed Resident #12 was to be moved to the COVID-19 unit after testing positive for COVID-19.

An interview was conducted with the facility Administrator on 2/18/2022 at 9:58 AM. The facility Administrator explained COVID-19 testing of the residents was initiated on 1/10/2022 after 4:00 PM and was started on the 200 Hall area. Resident #12 and her roommate both tested positive for COVID-19 on the same day at the same time. The Health Department was contacted, and the facility received confirmation to put the residents who tested positive with the rapid test under transmission-based precautions. The COVID-19 unit was expanded at that time to include the room for which Resident #12 and her roommate resided.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken with the testing and isolation of the symptomatic residents, but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON stated Nurse #2 should have called her and notified her if several of the residents were showing symptoms of COVID-19. DON confirmed she did not receive a call from Nurse #2 on 1/10/2022.

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An interview was conducted with the DON and Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility Administration was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents to include Resident #3 were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The DON noted that no other symptoms of COVID-19 were documented for Resident #3 on 1/10/2022 or 1/11/2022. The DON indicated the reason the residents were not placed on transmission-based precautions was because of a communication problem. The DON stated she and her staff were

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aware residents who were symptomatic needed to be tested right away and placed on transmission-based precautions, but she nor the ADON ever received a phone call from Nurse #2 alerting them that residents were symptomatic and needed testing. If they had been notified, they could have provided for the immediate testing because the supplies were in the facility and then the residents who showed positive would have been isolated and place on transmission-based precautions. According to the DON, nurses could have called her or the ADON at any time and neither of them had a record of any phone calls from Nurse #2. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

5. Documentation in the vaccine administration section of the medical record revealed, Resident #13 was up-to-date with all recommended COVID-19 vaccinations. Resident #13 resided in a semiprivate room at the facility with another resident who was fully vaccinated and boosted and was never diagnosed with COVID-19 while at the facility.

Documentation in the medical record of Resident #13 written by Nurse #2 in an electronic MAR (Medication Administration Record) - shift level administration note dated 1/10/2022 at 12:31 AM stated, "cough, fatigue, ADON (Assistant Director of Nursing) aware, resident to be tested this AM on 1rst shift when [COVID-19] supplies available." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour

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report."

Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 stated she was not able to test the residents due to a lack of reagent, and therefore the residents were not placed on transmission-based precautions or isolated during her shift. She called and informed the ADON when she realized she could not test the residents and passed along in shift change report to Nurse #3 the residents who needed to be tested.

Nurse #3, the nurse who took the nursing shift change report from Nurse #2 on 1/10/2022, was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #3 did not recall any other information about events that occurred after she was notified some of the residents had symptoms and needed to be tested.

The documentation in the point of care antigen testing log dated 1/10/2022 at 4:23 PM revealed

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Resident #13 tested positive for COVID-19 at 4:43 PM.

Documentation in a social service note dated 1/10/2022 at 5:50 PM revealed Resident #13 tested positive for COVID-19 and was being moved to the COVID-19 unit.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken with the testing and isolation of the symptomatic residents, but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON stated Nurse #2 should have called her and notified her if several of the residents were showing symptoms of COVID-19. DON confirmed she did not receive a call from Nurse #2 on 1/10/2022.

An interview was conducted with the DON and Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility Administration was not aware of any other

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symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents to include Resident #3 were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The DON noted that no other symptoms of COVID-19 were documented for Resident #3 on 1/10/2022 or 1/11/2022. The DON indicated the reason the residents were not placed on transmission-based precautions was because of a communication problem. The DON stated she and her staff were aware residents who were symptomatic needed to be tested right away and placed on transmission-based precautions, but she nor the ADON ever received a phone call from Nurse #2 alerting them that residents were symptomatic and needed testing. If they had been notified, they could have provided for the immediate testing because the supplies were in the facility and then the residents who showed positive would have been isolated and place on transmission-based precautions. According to the

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F 880	Continued From page 27 DON, nurses could have called her or the ADON at any time and neither of them had a record of any phone calls from Nurse #2. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the	F 886		3/17/22

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F 886	Continued From page 28 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. §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 observation, staff interview, family interview, and record review the facility failed to provide COVID-19 testing upon the appearance of symptoms for 5 (Residents #3, #12, #13, #14, #15) of 5 sampled residents who tested positive	F 886	The Laurels of Forest Glenn wishes to have this submitted Plan of Correction to stand as allegation of compliance. Our date of compliance is 3/17/2022.	

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F 886	Continued From page 29 for COVID-19 during a facility COVID-19 outbreak. This occurred during a coronavirus pandemic. Findings included: The facility Coronavirus (COVID-19) Testing policy and procedure, dated as last reviewed on 2/16/2022, was reviewed. Documentation in the policy stated in part, "Guests/residents who have signs and symptoms of COVID-19, regardless of vaccination status, must be tested immediately. While results are pending, guests/residents with signs and symptoms should be placed on transmission-based precautions in accordance with CDC guidance. Once test results are obtained, the facility must take the appropriate actions based on the results." The documentation in the policy additionally stated, "A new COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a guest/resident triggers an outbreak investigation. In an outbreak investigation, rapid identification and isolation of new cases is critical in stopping further viral transmission." Documentation in NHSN vaccination summary data for the week of 1/3/2022 to 1/9/2022 revealed 85.33% of all staff were fully vaccinated, 7.33% were partially vaccinated, and 7.33 % were unvaccinated. The documentation in the NHSN vaccination summary dated for the week of 1/3/2022 to 1/9/2022 also revealed 85.83% of the residents were fully vaccinated, 2.5% were partially vaccinated, and 11.67% were unvaccinated. 1. Resident #3 was coded on her admission Minimum Data Set assessment, dated 12/30/2021, as cognitively intact with no moods or behaviors. Documentation in the vaccine	F 886	Preparation and/or execution of this Plan of Correction does not constitute admission to, nor agreement with, either the existence of, or the scope and severity of, any of the cited deficiencies or conclusions set forth in the Statement of Deficiencies. This plan is prepared and/or executed to ensure continued compliance with regulatory requirement. F886 COVID-19 Testing-Residents & Staff Upon discovery of the 5/5 residents, they were already covid recovered, so no intervention was needed for these residents. All residents have the potential to be affected. Immediately, upon notification of alleged deficiency, The Director of Nursing and Assistant Director of Nursing/Infection Control Preventionist verified that covid testing supplies were immediately available and any residents that were symptomatic for covid were immediately tested and transmission-based precautions in place, if applicable. No other concerns identified. Through our Quality Assurance Performance Improvement process, the potential root cause analysis was identified as insufficient staff education; therefore, (re)education was provided to all direct care staff by The Director of Nursing and Assistant Director of Nursing/Infection Preventionist by 2/28/2022 regarding signs and symptoms of covid, notification to the licensed nurse	

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administration section of the medical record revealed Resident #3 was up-to-date with all recommended COVID-19 vaccinations.

Resident #3 had a physician's order for Guaifenesin liquid 100 mg (milligrams) /5 ml (milliliters) to be given as 10 milliliters by mouth every 4 hours as needed for a cough initiated on 1/9/2022. Guaifenesin is used to relieve chest congestion. Documentation on the medication administration record (MAR) revealed Resident #3 received the medication Guaifenesin liquid on 1/12/2022 at 6:48 PM and 1/13/2022 at 5:13 PM.

Nurse # 4, who obtained the order for Guaifenesin from the physician for Resident #3, was interviewed on 2/18/2022 at 2:37 PM. Nurse #4 revealed she obtained the order for Resident #3 because Nurse #2, requested in report at change of shift on 1/9/2022 she contacted the physician for cough medicine because Resident #3 had a cough. Nurse #4 stated she did not know if Resident #3 had a cough on 1/9/2022 and only contacted the physician at the request of Nurse #2.

There was no documentation in the medical record on 1/8/2022 or 1/9/2022 indicating Resident #3 was coughing or had congestion.

Documentation in the medical record of Resident #3 written by Nurse #2 in an electronic MAR - shift level administration note dated 1/10/2022 at 12:27 AM stated, "Cough, ADON (Assistant Director of Nursing) aware, resident will be tested this AM on [first] shift when supplies [available]." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report."

on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission-based precautions when applicable, location of testing supplies and notification if none available.

Additionally, new hirers providing direct care will be educated upon hire and at least annually regarding signs and symptoms of covid, notification to the licensed nurse on duty, how to test utilizing current testing supplies, immediate testing of resident and initiating transmission-based precautions when applicable, location of testing supplies and notification if none available.

The Administrator, Director of Nursing, and other staff members as assigned will interview and/or observe 10% of residents for new signs and symptoms of covid and if symptomatic, ensure they□re immediately tested and transmission-based precautions in place, if applicable, five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program.

The Administrator, Director of Nursing,

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F 886	Continued From page 31 Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 indicated she went up to the front of the building to the "coffee shop" to get the testing supplies to test the residents she identified as having COVID-19 symptoms. Nurse #2 explained at the front of the building she found testing swabs and cards but no reagent solution to conduct the testing. Nurse #2 stated she called the ADON and was told both she and the DON (Director of Nursing) could not come to the building. Nurse #2 revealed she was directed by the ADON to tell Nurse #3 when she came in at 7:00 AM to have the residents with symptoms of COVID-19 to be tested when the reagent solution was obtained. Nurse #2 confirmed she gave a list of the residents with COVID-19 symptoms to Nurse #3 in report at 7:00 AM and told Nurse #3 the residents needed to be tested for COVID-19 when the reagent solution was available in the morning. Nurse #3 was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent	F 886	and other staff members as assigned will interview at least 10 direct care staff members for new signs and symptoms of covid of residents and if symptomatic, ensure they□re immediately tested and transmission-based precautions in place, if applicable, five times per week for two weeks, then three times per week for two weeks, then weekly for four weeks, and then as determined by the Quality Assurance Committee□The administrator and/or Director of Nursing will take to the Quality Assurance Meeting. Any variances identified will be addressed immediately and additional education provided when indicated. Continued compliance will be monitored through the facility□s Quality Assurance Program.	

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solution was available to perform the testing. Nurse #2 stated she did not recall if the COVID-19 testing was done or who did the testing on that day. Nurse #2 surmised NA #3 did the COVID-19 testing on that day because it was her job to test all the residents every Monday.

An interview was conducted with the ADON on 2/17/2022 at 12:50 PM. The ADON revealed the facility kept a COVID-19 testing log which documented the time and date and result for each resident in the facility. The ADON revealed the testing log for Resident #3 could not be located. The ADON stated she was not called by Nurse #2 on 1/9/2022 or 1/10/2022.

Documentation in a social service note dated 1/10/2022 at 5:55 PM revealed Resident #3 tested positive for COVID-19 on a rapid test and a family member was notified.

An interview was conducted with a family member of Resident #3 on 2/18/2022 at 10:21 AM. The family member stated she visited Resident #3 on 1/8/2022 along with other visitors. The family member stated Resident #3 said to her and the other visitors during the visit to not get too close to her because she had a cough and congestion and might have COVID-19. The family member stated Resident #3 indicated she had informed the facility nursing staff of her symptoms.

Documentation in a nurse practitioner note dated 1/13/2022 at 2:11 PM revealed under the assessment and plan portion of the note, a chest x-ray revealed Resident #3 had pneumonia. The nurse practitioner started Resident #3 on Levaquin 500 milligrams daily for 7 days and

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Dexamethasone 1 mg daily for 10 days. Levaquin is prescribed to treat bacterial infections and Dexamethasone was found to have benefits for recovering COVID-19 patients.

An observation was made on 2/18/2022 at 11:30 AM in the front of the building in the coffee shop of the COVID-19 testing supplies available to the nurses. Seventeen boxes of COVID-19 testing supplies were stacked on top of each other. Documentation on the outside of the COVID-19 testing boxes stated, "Rapid test for the qualitative detection of COVID-19 antigen in nasal swab specimens." The Documentation on the box revealed each box was to contain, "40 [Brand Name] COVID-19 Ag cards, 40 nasal swabs, 1 positive control swab, 1 reagent bottle, 1 product insert, and 1 procedure card." Observations were made of each COVID-19 testing supply box and each box contained a varying amount of the supplies that were listed to be in the box. None of the boxes contained a reagent bottle. Documentation on the procedure card revealed the reagent bottle was required for the testing process.

An interview was conducted with NA #3 on 2/18/2022 at 11:49 AM. NA #3 confirmed she performed COVID-19 testing of the residents in the facility every other Monday. NA #3 confirmed she was working on Monday, 1/10/2022. NA #3 stated there were only two places she knew where to obtain COVID-19 testing supplies in the facility, in the coffee shop and at the front desk with the receptionist.

An interview was conducted with the Receptionist/Administrative Assistant on 2/18/2022 at 12:02 PM in her office. One box of

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COVID-19 testing supplies including a reagent solution bottle was observed at the time of the interview in the office of the receptionist. The Receptionist/Administrative Assistant revealed a box of COVID-19 testing supplies are kept in her office should anyone arrive at the front door and need to be tested for COVID-19 after screening for COVID-19. The Receptionist/Administrative Assistant stated testing supplies are kept in the coffee shop and the front desk area as well as the speech therapy office.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON confirmed the COVID-19 testing log for Resident #3 could not be found. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON explained the testing supplies in the coffee shop in the boxes without reagent were kept so that supplies were not wasted, and additional reagent solution was ordered so the supplies could be used. The DON explained the facility routinely kept a box of testing supplies with reagent in the coffee shop, but it was removed upon the arrival of the survey team. The DON further explained the nursing staff also had access to the box of testing supplies at the receptionist area until 11:30 PM, when the screener leaves for the day. The DON

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stated if the testing supplies were locked up at the receptionist desk and Nurse #2 could not find reagent solution, she should have called her directly so the testing supplies could have been made available to her immediately, because the facility had more reagent available. The DON stated that she had staff members who could have come to the building immediately, retrieved the reagent solution for Nurse #2, and the testing could have been immediately completed if Nurse #2 had called her. An observation was made at the time of the interview of additional COVID-19 testing supplies that were kept locked in the speech therapy room. The DON confirmed the nursing staff do not have access to the COVID-19 testing supplies in the speech therapy room, but they are stored there if needed.

An interview was conducted with the DON and the Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents to include Resident #3 were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate

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the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The DON noted that no other symptoms of COVID-19 were documented for Resident #3 on 1/10/2022 or 1/11/2022. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

2. Documentation in the vaccine administration section of the medical record revealed, Resident #14 was up-to-date with all recommended COVID-19 vaccinations.

Documentation in the medical record of Resident #14 written by Nurse #2 in an electronic MAR (medication administration record) shift level administration note dated 1/10/2022 at 12:28 AM stated, "cough, sore throat, low fever, ADON (Assistant Director of Nursing) aware, resident to be tested this AM on 1rst shift when supplies [available]."

Documentation in the vital signs section of the medical record revealed Resident #14 had a low-grade fever of 99.3 degrees Fahrenheit on 1/10/2022 at 10:42 PM.

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Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 indicated she went up to the front of the building to the "coffee shop" to get the testing supplies to test the residents she identified as having COVID-19 symptoms. Nurse #2 explained at the front of the building she found testing swabs and cards but no reagent solution to conduct the testing. Nurse #2 stated she called the ADON and was told both she and the Director of Nursing (DON) could not come to the building. Nurse #2 revealed she was directed by the ADON to tell Nurse #3 when she came in at 7:00 AM to have the residents with symptoms of COVID-19 to be tested when the reagent solution was obtained. Nurse #2 confirmed she gave a list of the residents with COVID-19 symptoms to Nurse #3 in report at 7:00 AM and told Nurse #3 the residents needed to be tested for COVID-19 when the reagent solution was available in the morning.

Nurse #3 was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing.

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Nurse #2 stated she did not recall if the COVID-19 testing was done or who did the testing on that day. Nurse #2 surmised NA #3 did the COVID-19 testing on that day because it was her job to test all the residents every Monday.

Documentation in a social service progress note dated 1/10/2022 at 5:53 PM revealed Resident #14 tested positive for COVID-19.

Documentation in a nurse practitioner progress note dated 1/11/2022 at 3:03 PM revealed Resident #14 was seen for an acute visit for COVID-19 positive test but was not showing any symptoms.

An observation was made on 2/18/2022 at 11:30 AM in the front of the building in the coffee shop of the COVID-19 testing supplies available to the nurses. Seventeen boxes of COVID-19 testing supplies were stacked on top of each other. Documentation on the outside of the COVID-19 testing boxes stated, "Rapid test for the qualitative detection of COVID-19 antigen in nasal swab specimens." The Documentation on the box revealed each box was to contain, "40 [Brand Name] COVID-19 Ag cards, 40 nasal swabs, 1 positive control swab, 1 reagent bottle, 1 product insert, and 1 procedure card." Observations were made of each COVID-19 testing supply box and each box contained a varying amount of the supplies that were listed to be in the box. None of the boxes contained a reagent bottle. Documentation on the procedure card revealed the reagent bottle was required for the testing process.

An interview was conducted with NA #3 on 2/18/2022 at 11:49 AM. NA #3 confirmed she

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performed COVID-19 testing of the residents in the facility every other Monday. NA #3 confirmed she was working on Monday, 1/10/2022. NA #3 stated there were only two places she knew where to obtain COVID-19 testing supplies in the facility, in the coffee shop and at the front desk with the receptionist.

An interview was conducted with the Receptionist/Administrative Assistant on 2/18/2022 at 12:02 PM in her office. One box of COVID-19 testing supplies including a reagent solution bottle was observed at the time of the interview in the office of the receptionist. The Receptionist/Administrative Assistant revealed a box of COVID-19 testing supplies are kept in her office should anyone arrive at the front door and need to be tested for COVID-19 after screening for COVID-19. The Receptionist/Administrative Assistant stated testing supplies are kept in the coffee shop and the front desk area as well as the speech therapy office.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON confirmed the COVID-19 testing log for Resident #3 could not be found. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON explained the testing

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supplies in the coffee shop in the boxes without reagent were kept so that supplies were not wasted, and additional reagent solution was ordered so the supplies could be used. The DON explained the facility routinely kept a box of testing supplies with reagent in the coffee shop, but it was removed upon the arrival of the survey team. The DON further explained the nursing staff also had access to the box of testing supplies at the receptionist area until 11:30 PM, when the screener leaves for the day. The DON stated if the testing supplies were locked up at the receptionist desk and Nurse #2 could not find reagent solution, she should have called her directly so the testing supplies could have been made available to her immediately, because the facility had more reagent available. The DON stated that she had staff members who could have come to the building immediately, retrieved the reagent solution for Nurse #2, and the testing could have been immediately completed if Nurse #2 had called her. An observation was made at the time of the interview of additional COVID-19 testing supplies that were kept locked in the speech therapy room. The DON confirmed the nursing staff do not have access to the COVID-19 testing supplies in the speech therapy room, but they are stored there if needed.

An interview was conducted with the Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the

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following day on 1/11/2022, because the facility was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

3. Documentation in the vaccine administration section of the medical record revealed, Resident #15 was up-to-date with all recommended COVID-19 vaccinations.

Documentation in the medical record of Resident #15 written by Nurse #2 in an electronic MAR (Medication Administration Record) - shift level administration note dated 1/10/2022 at 12:39 AM

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stated, "Cough, sore throat, ADON (Assistant Director of Nursing) aware, resident will be tested this AM on first shift when [COVID-19] supplies available." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report."

Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 indicated she went up to the front of the building to the "coffee shop" to get the testing supplies to test the residents she identified as having COVID-19 symptoms. Nurse #2 explained at the front of the building she found testing swabs and cards but no reagent solution to conduct the testing. Nurse #2 stated she called the ADON and was told both she and the Director of Nursing (DON) could not come to the building. Nurse #2 revealed she was directed by the ADON to tell Nurse #3 when she came in at 7:00 AM to have the residents with symptoms of COVID-19 to be tested when the reagent solution was obtained. Nurse #2 confirmed she gave a list of the residents with COVID-19 symptoms to Nurse #3 in report at 7:00 AM and told Nurse #3 the residents needed to be tested for COVID-19 when the reagent solution was available in the morning.

Nurse #3 was interviewed on 2/18/2022 at 9:18

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AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #2 stated she did not recall if the COVID-19 testing was done or who did the testing on that day. Nurse #2 surmised NA #3 did the COVID-19 testing on that day because it was her job to test all the residents every Monday.

Documentation in a social service note dated 1/11/2022 at 11:40 AM revealed Resident #15 tested positive for COVID-19.

Documentation in a Nurse Practitioner note dated 1/11/2022 at 11:58 AM stated in part, "I am seeing this patient following her rapid test positive COVID-19 test. Patient is fully vaccinated. She [complains of] mild scratchy throat but no other symptoms."

An observation was made on 2/18/2022 at 11:30 AM in the front of the building in the coffee shop of the COVID-19 testing supplies available to the nurses. Seventeen boxes of COVID-19 testing supplies were stacked on top of each other. Documentation on the outside of the COVID-19 testing boxes stated, "Rapid test for the qualitative detection of COVID-19 antigen in nasal swab specimens." The Documentation on the box revealed each box was to contain, "40 [Brand Name] COVID-19 Ag cards, 40 nasal swabs, 1 positive control swab, 1 reagent bottle, 1 product insert, and 1 procedure card." Observations were made of each COVID-19 testing supply box and each box contained a varying amount of the

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supplies that were listed to be in the box. None of the boxes contained a reagent bottle. Documentation on the procedure card revealed the reagent bottle was required for the testing process.

An interview was conducted with NA #3 on 2/18/2022 at 11:49 AM. NA #3 confirmed she performed COVID-19 testing of the residents in the facility every other Monday. NA #3 confirmed she was working on Monday, 1/10/2022. NA #3 stated there were only two places she knew where to obtain COVID-19 testing supplies in the facility, in the coffee shop and at the front desk with the receptionist.

An interview was conducted with the Receptionist/Administrative Assistant on 2/18/2022 at 12:02 PM in her office. One box of COVID-19 testing supplies including a reagent solution bottle was observed at the time of the interview in the office of the receptionist. The Receptionist/Administrative Assistant revealed a box of COVID-19 testing supplies are kept in her office should anyone arrive at the front door and need to be tested for COVID-19 after screening for COVID-19. The Receptionist/Administrative Assistant stated testing supplies are kept in the coffee shop and the front desk area as well as the speech therapy office.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON confirmed the COVID-19 testing log for Resident #3 could not be found. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM.

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The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON explained the testing supplies in the coffee shop in the boxes without reagent were kept so that supplies were not wasted, and additional reagent solution was ordered so the supplies could be used. The DON explained the facility routinely kept a box of testing supplies with reagent in the coffee shop, but it was removed upon the arrival of the survey team. The DON further explained the nursing staff also had access to the box of testing supplies at the receptionist area until 11:30 PM, when the screener leaves for the day. The DON stated if the testing supplies were locked up at the receptionist desk and Nurse #2 could not find reagent solution, she should have called her directly so the testing supplies could have been made available to her immediately, because the facility had more reagent available. The DON stated that she had staff members who could have come to the building immediately, retrieved the reagent solution for Nurse #2, and the testing could have been immediately completed if Nurse #2 had called her. An observation was made at the time of the interview of additional COVID-19 testing supplies that were kept locked in the speech therapy room. The DON confirmed the nursing staff do not have access to the COVID-19 testing supplies in the speech therapy room, but they are stored there if needed.

An interview was conducted with the DON and the Administrator on 2/18/2022 at 2:00 PM. The

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Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The Administrator reiterated that all the residents were asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

4. Documentation in the vaccine administration section of the medical record revealed, Resident

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#12 was up-to-date with all recommended COVID-19 vaccinations.

Documentation in the medical record of Resident #12 written by Nurse #2 in an electronic MAR (Medication Administration Record) - shift level administration note dated 1/10/2022 at 12:26 AM stated, "Resident has cough, ADON (Assistant Director of Nursing) aware, resident to be tested this AM when supplies [available]." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report."

Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 indicated she went up to the front of the building to the "coffee shop" to get the testing supplies to test the residents she identified as having COVID-19 symptoms. Nurse #2 explained at the front of the building she found testing swabs and cards but no reagent solution to conduct the testing. Nurse #2 stated she called the ADON and was told both she and the Director of Nursing (DON) could not come to the building. Nurse #2 revealed she was directed by the ADON to tell Nurse #3 when she came in at 7:00 AM to have the residents with symptoms of COVID-19 to be tested when the reagent solution was obtained. Nurse #2 confirmed she gave a list of the

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residents with COVID-19 symptoms to Nurse #3 in report at 7:00 AM and told Nurse #3 the residents needed to be tested for COVID-19 when the reagent solution was available in the morning.

Nurse #3 was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #2 stated she did not recall if the COVID-19 testing was done or who did the testing on that day. Nurse #2 surmised NA #3 did the COVID-19 testing on that day because it was her job to test all the residents every Monday.

The documentation in the point of care antigen testing log dated 1/10/2022 at 4:55 PM revealed Resident #12 tested positive for COVID-19 at 5:10 PM.

An observation was made on 2/18/2022 at 11:30 AM in the front of the building in the coffee shop of the COVID-19 testing supplies available to the nurses. Seventeen boxes of COVID-19 testing supplies were stacked on top of each other. Documentation on the outside of the COVID-19 testing boxes stated, "Rapid test for the qualitative detection of COVID-19 antigen in nasal swab specimens." The Documentation on the box revealed each box was to contain, "40 [Brand Name] COVID-19 Ag cards, 40 nasal swabs, 1 positive control swab, 1 reagent bottle, 1 product insert, and 1 procedure card." Observations were made of each COVID-19 testing supply box and

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each box contained a varying amount of the supplies that were listed to be in the box. None of the boxes contained a reagent bottle. Documentation on the procedure card revealed the reagent bottle was required for the testing process.

An interview was conducted with NA #3 on 2/18/2022 at 11:49 AM. NA #3 confirmed she performed COVID-19 testing of the residents in the facility every other Monday. NA #3 confirmed she was working on Monday, 1/10/2022. NA #3 stated there were only two places she knew where to obtain COVID-19 testing supplies in the facility, in the coffee shop and at the front desk with the receptionist.

An interview was conducted with the Receptionist/Administrative Assistant on 2/18/2022 at 12:02 PM in her office. One box of COVID-19 testing supplies including a reagent solution bottle was observed at the time of the interview in the office of the receptionist. The Receptionist/Administrative Assistant revealed a box of COVID-19 testing supplies are kept in her office should anyone arrive at the front door and need to be tested for COVID-19 after screening for COVID-19. The Receptionist/Administrative Assistant stated testing supplies are kept in the coffee shop and the front desk area as well as the speech therapy office.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON confirmed the COVID-19 testing log for Resident #3 could not be found. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the

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residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON explained the testing supplies in the coffee shop in the boxes without reagent were kept so that supplies were not wasted, and additional reagent solution was ordered so the supplies could be used. The DON explained the facility routinely kept a box of testing supplies with reagent in the coffee shop, but it was removed upon the arrival of the survey team. The DON further explained the nursing staff also had access to the box of testing supplies at the receptionist area until 11:30 PM, when the screener leaves for the day. The DON stated if the testing supplies were locked up at the receptionist desk and Nurse #2 could not find reagent solution, she should have called her directly so the testing supplies could have been made available to her immediately, because the facility had more reagent available. The DON stated that she had staff members who could have come to the building immediately, retrieved the reagent solution for Nurse #2, and the testing could have been immediately completed if Nurse #2 had called her. An observation was made at the time of the interview of additional COVID-19 testing supplies that were kept locked in the speech therapy room. The DON confirmed the nursing staff do not have access to the COVID-19 testing supplies in the speech therapy room, but they are stored there if needed.

An interview was conducted with the

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Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it contains genetic material from the COVID-19 virus. The rapid COVID-19 test, also called the antigen test detects proteins from the virus which causes COVID-19. The rapid test is considered most accurate in those individuals who are experiencing symptoms of COVID-19. The DON also confirmed it was the facility policy to notify an outside provider before sending a resident who has tested positive for COVID-19 to an appointment, so a decision could be made to determine if the resident should be seen by the outside provider for the appointment. The Administrator reiterated that all the residents were

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asymptomatic on 1/10/2022 and after the nurse practitioner saw the residents who tested positive on 1/10/2022, all were asymptomatic except for one.

5. Documentation in the vaccine administration section of the medical record revealed, Resident #13 was up-to-date with all recommended COVID-19 vaccinations.

Documentation in the medical record of Resident #13 written by Nurse #2 in an electronic MAR (Medication Administration Record) - shift level administration note dated 1/10/2022 at 12:31 AM stated, "cough, fatigue, ADON (Assistant Director of Nursing) aware, resident to be tested this AM on 1rst shift when [COVID-19] supplies available." The documentation also revealed the note was to, "show on shift report" and "show on 24-hour report."

Nurse #2 was interviewed on 2/17/2022 at 7:17 PM. Nurse #2 revealed she worked weekends at the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 explained on the evening of 1/9/2022 into the morning of 1/10/2022 she was doing her respiratory assessments of the residents on her hall. Upon assessment Nurse #2 discovered several of the residents, whose names she could not recall at the time of the interview, had symptoms of COVID-19 and concluded the whole hall should be tested for COVID-19. Nurse #2 indicated she went up to the front of the building to the "coffee shop" to get the testing supplies to test the residents she identified as having COVID-19 symptoms. Nurse #2 explained at the front of the building she found testing swabs and cards but no reagent solution to conduct the testing. Nurse #2 stated she called the ADON and

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was told both she and the Director of Nursing (DON) could not come to the building. Nurse #2 revealed she was directed by the ADON to tell Nurse #3 when she came in at 7:00 AM to have the residents with symptoms of COVID-19 to be tested when the reagent solution was obtained. Nurse #2 confirmed she gave a list of the residents with COVID-19 symptoms to Nurse #3 in report at 7:00 AM and told Nurse #3 the residents needed to be tested for COVID-19 when the reagent solution was available in the morning.

Nurse #3 was interviewed on 2/18/2022 at 9:18 AM. Nurse #3 stated she remembered the conversation with Nurse #2 but did not remember what day the conversation happened. Nurse #3 revealed she recalled receiving a list of residents from Nurse #2 who needed to be tested for COVID-19 on the first shift because no reagent solution was available to perform the testing. Nurse #2 stated she did not recall if the COVID-19 testing was done or who did the testing on that day. Nurse #2 surmised NA #3 did the COVID-19 testing on that day because it was her job to test all the residents every Monday.

The documentation in the point of care antigen testing log dated 1/10/2022 at 4:23 PM revealed Resident #13 tested positive for COVID-19 at 4:43 PM.

Documentation in a social service note dated 1/10/2022 at 5:50 PM revealed Resident #13 tested positive for COVID-19 and was being moved to the COVID-19 unit.

An observation was made on 2/18/2022 at 11:30 AM in the front of the building in the coffee shop

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of the COVID-19 testing supplies available to the nurses. Seventeen boxes of COVID-19 testing supplies were stacked on top of each other. Documentation on the outside of the COVID-19 testing boxes stated, "Rapid test for the qualitative detection of COVID-19 antigen in nasal swab specimens." The Documentation on the box revealed each box was to contain, "40 [Brand Name] COVID-19 Ag cards, 40 nasal swabs, 1 positive control swab, 1 reagent bottle, 1 product insert, and 1 procedure card." Observations were made of each COVID-19 testing supply box and each box contained a varying amount of the supplies that were listed to be in the box. None of the boxes contained a reagent bottle. Documentation on the procedure card revealed the reagent bottle was required for the testing process.

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An interview was conducted with the Receptionist/Administrative Assistant on 2/18/2022 at 12:02 PM in her office. One box of COVID-19 testing supplies including a reagent solution bottle was observed at the time of the interview in the office of the receptionist. The Receptionist/Administrative Assistant revealed a box of COVID-19 testing supplies are kept in her office should anyone arrive at the front door and need to be tested for COVID-19 after screening

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for COVID-19. The Receptionist/Administrative Assistant stated testing supplies are kept in the coffee shop and the front desk area as well as the speech therapy office.

An interview was conducted with the Director of Nursing (DON) on 2/18/2022 at 12:08 PM. The DON confirmed the COVID-19 testing log for Resident #3 could not be found. The DON revealed NA #3 was working on the floor as a nursing assistant on the morning of 1/10/2022 and did not start the COVID-19 testing of the residents until after her shift ended at 3:00 PM. The DON confirmed it was noted on the 24-hour report on the morning of 1/10/2022, Resident #3 had a cough and needed to be tested for COVID-19. The DON did not know why this was not discussed in morning meeting so action could be taken but she surmised the daily meeting going over the 24-hour report was not held until later in the day. The DON explained the testing supplies in the coffee shop in the boxes without reagent were kept so that supplies were not wasted, and additional reagent solution was ordered so the supplies could be used. The DON explained the facility routinely kept a box of testing supplies with reagent in the coffee shop, but it was removed upon the arrival of the survey team. The DON further explained the nursing staff also had access to the box of testing supplies at the receptionist area until 11:30 PM, when the screener leaves for the day. The DON stated if the testing supplies were locked up at the receptionist desk and Nurse #2 could not find reagent solution, she should have called her directly so the testing supplies could have been made available to her immediately, because the facility had more reagent available. The DON stated that she had staff members who could

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have come to the building immediately, retrieved the reagent solution for Nurse #2, and the testing could have been immediately completed if Nurse #2 had called her. An observation was made at the time of the interview of additional COVID-19 testing supplies that were kept locked in the speech therapy room. The DON confirmed the nursing staff do not have access to the COVID-19 testing supplies in the speech therapy room, but they are stored there if needed.

An interview was conducted with the Administrator on 2/18/2022 at 2:00 PM. The Administrator confirmed NA #3 was working caring for residents from 7:00 AM to 3:00 PM on 1/10/2022 and did not start testing residents for COVID-19 until after 3:00 PM. The Administrator stated the facility was in the middle of a COVID-19 outbreak so any of the residents who were not tested on 1/10/2022 were tested the following day on 1/11/2022, because the facility was not aware of any other symptoms in any other residents at that time. The Administrator added that some of the residents who tested positive were receiving therapy services and none of the therapists documented any signs or symptoms of COVID-19 in the residents on 1/10/2022. On 1/10/2022 some of the residents were testing positive for COVID-19 so the health department was contacted. The Administrator stated the facility was directed by the health department to isolate the residents on the COVID-19 unit based on the rapid test for COVID-19 and not to wait for the PCR (polymerase chain reaction test) results because it was taking 6 to 10 days to get results. The PCR test is a diagnostic test that determines if you are infected by analyzing a sample to see if it

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