DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165307	A. BUILDING ___ B. WING ___	C 10/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILLAR OF CEDAR VALLEY	1410 WEST DUNKERTON ROAD WATERLOO, IA 50703

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F 000	INITIAL COMMENTS	F 000		

Correction Date 1/7/21

A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on 10/5/20 in conjunction with an investigation of complaints 93089-C, 91028-C, 93752-C, 92773-C, and 89267-C, and facility reported incident 89501-I. The facility was found to not be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.

All of the complaints were substantiated.
The facility reported incident was substantiated.

Total residents: 116

(See Code of Federal Regulations (42CFR) Part 483, Subpart B -C).

F 684 SS=D — Quality of Care
CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, policy review, and resident and staff interviews, the facility failed to ensure that residents received

F684 (F 684)

On 10/19/20 an investigation was completed by DON. physician and family notified. and plan put into place to ensure medications and labs were completed as ordered by physician for IV therapy for resident #1.

On 10/19/20 DON/Designee audited IV orders and labs to ensure timely completion.

On 1/5/21 education was provided to all nursing staff and nurse managers.

Facility will follow physician's orders and will provide timely notification to physician for order not given as ordered.

DON and/or designee will audit 5 resident charts x 1 per week for 4 weeks. DON and/or designee will audit 3 resident charts x 1 per week for additional 8 weeks.

Compliance Date: 1/7/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla Maldonado MHA, LNHA
TITLE: Administrator
(X6) DATE: 12/23/2020 1/5/21

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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care and treatment in accordance with professional standards of practice, specifically the facility failed to administer intravenous medication and physician ordered labs for 1 of 3 residents reviewed. Resident #1 was admitted to the facility on 9/9/20 for treatment of osteomyelitis (serious infection of the bone) with an order for Vancomycin (antibiotic used to treat complicated infections) intravenously every 24 hours titrated on labs ordered to be drawn as a trough (blood levels utilized to determine the correct dose) at intervals directed by the physician. The facility failed to draw the lab as ordered on 9/15/20, 9/29/20, 9/30/20 and 10/8/20 and omitted the Vancomycin on 9/18/20, 9/20/20, and 9/21/20 without an order. The facility reported a census of 116 residents.

Findings Include:

1. The Minimum Data Set (MDS) assessment dated 9/14/20 revealed Resident #1 had admitted to the facility on 9/9/20 from an acute care hospital and had diagnoses that included osteomyelitis, borderline personality disorder, anxiety, depression, hypertension (high blood pressure), morbid obesity, and discitis (infection of the spine). The MDS documented the resident required extensive assistance by 2 or more staff members for transfers to and from bed and chair, and toilet use. Resident #1 scored 15 on the Brief Interview for Mental Status (BIMS). A score of 15 identified an intact cognitive status.

Review of the Medication Administration Record (MAR) for 9/1/20-9/30/20 revealed medication ordered by the physician included:

Vancomycin HCl in NaCl Solution 1.5-0.9 gm/250

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ml. Use 1.75 gram intravenously (IV) in the morning related to osteomyelitis until 10/22/20. The order further directed not to administer unless vanco/trough has been drawn prior to administration. Ensure lab draw is drawn from PICC line (peripherally inserted central catheter intravenous access) at least 30 minutes prior to the administration of the antibiotic. The MAR further revealed the Vancomycin HCl medication listed with administration times established as 5 a.m., the medication was not signed as administered on 9/18/20, 9/20/20, and 9/21/20.

The Director of Nursing (DON) provided a handwritten timeline of Vancomycin medication and lab orders based on review of the nursing progress notes, physician orders, and lab reports. The timeline included:

9/15/20 Vancomycin trough 14.6-lab done after 8 am due to no supplies-waited for order from MD-new order to increase Vancomycin to 1.75 gm daily IV
9/18/20-Unable to draw trough, dose held
9/20/20-Unable to draw trough, dose held
9/21/20-Unable to draw trough, dose held-IMPACT (geriatric provider team) notified and missed doses on 9/20 and 9/21, new order received for lab to draw Vancomycin trough via stick and notify pharmacy regarding missed doses and lab. Lab notified of stat labs.
9/21/20-Vancomycin trough (6.3)- Infection Disease Specialist nurse notified and discussed missed doses and labs by DON, new order to continue same dose and draw Vancomycin trough on 9/25
9/29/20-Vancomycin trough (46.4) done after Vancomycin given. DON spoke with nurse at Infection Disease Specialist office and she stated

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F 684	Continued From page 3 the doctor would never order a Vancomycin level after dose is given. New order to continue same but do not give today, restart at 5 a.m. as her normal time and do Vancomycin trough on 10/1. 10/6/20-Vancomycin trough (19.4) New orders received to give 1 gram Vancomycin daily and draw trough on 10/8. Order was transcribed to be drawn on 10/7-so it was done on 10/7. 10/7/20-Vancomycin trough (14.6) 10/8/20- Infection Disease Specialist nurse called inquiring about Vancomycin trough from this a.m., notified that trough was done on 10/7 and results given to her. New order to obtain Vancomycin trough on 10/9. During review of the provided timeline and interview with the DON on 10/13/20 at 4:00 p.m., the DON confirmed Vancomycin not administered as ordered on 9/18, 9/20, and 9/21/20, medication was omitted without an order. DON stated night nurses often unable to obtain blood sample for lab, so medication was held. Further stated, would have been better to do on the day shift, but had better coverage for Registered Nurses on the night shift. Further interview on 10/14/20 at 3:15 p.m. revealed the DON would expect staff to draw lab and administer IV Vancomycin within established time frames, one hour before or after designated time, and notify physician if unable to complete. Confirmed Vancomycin was a high risk medication, dependent on lab levels to titrate dosage. DON aware too low dose of Vancomycin ineffective in treating infection, and too high dose can result in kidney damage, and further confirmed lab not able to be drawn as ordered as follows: 9/15/20-lab done after 8 a.m. due to no supplies 9/29/20-lab drawn after dose given	F 684		

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9/30/20-unable to draw lab after two attempts
10/7/20-lab ordered to be drawn on 10/8, drawn on 10/7 in error

During a phone interview on 10/8/20 at 11:00 a.m. with office nurse at Infectious Disease Specialist office confirmed Vancomycin has been given contrary to the physician's orders, 3 doses not given. Lab ordered not being drawn as ordered 30 minutes prior to infusion. Stated lab is critical in accurate dosing for effective treatment of infection and can result in kidney damage if Vancomycin dosing too high. Labs reviewed and revealed no negative outcome.

A radiology report dated as completed on 10/9/20 as a follow up on osteomyelitis of the lumbar spine revealed no findings that suggest osteomyelitis.

According to a medication error incident report, initiated by the DON and dated 9/21/20 Resident #1 had not received IV Vancomycin on 9/18, 9/20, and 9/21 due to inability to obtain Vancomycin trough due to PICC line. The report further indicated staff educated on 9/22/20 of the importance of calling for clarification on ability to administer Vancomycin if trough level is unable to be drawn.

During an interview on 10/18/20 at 5:15 a.m., Staff M Registered Nurse (RN) stated he routinely cared for resident during the night shift and routinely administered the IV Vancomycin. Confirmed Vancomycin lab is to be drawn 30 minutes prior to infusion. Stated he had run into complications completing as ordered and provided the following examples: resident being asleep, unable to complete venipuncture, and not

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having the correct supplies. If unable to draw lab, doesn't administer the medication and communicated to the next shift.

Review of facility policy and procedure titled, Medication Administration directed staff: Unless otherwise specified by the physician, medication will be administered within 60 minutes before or after the facility's dosing schedule. The policy further directed medication not administered within the allowed time frame which is greater than 1 hour from its scheduled administration, or missed would be considered a medication error.

F 689 SS=J Free of Accident Hazards/Supervision/Devices
CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff and resident interviews and clinical record review, the facility failed to ensure 1 of 4 sampled residents received nursing supervision while consuming an altered textured diet and failed to protect residents against hazards in the environment. Resident #4 returned from the hospital to the facility on 9/24/20 and was placed in isolation. Resident #4 was to receive a pureed diet and was to be supervised while eating due to the altered textured diet, a diagnosis of dysphagia and the need for cueing Resident #4 received a

Provider's Plan of Correction:

F 684

F689

F 689

On 10/14/2020 at 1:53pm, education was provided to all staff through OnShift text message. Staff present in the building have also been educated in person by their supervisor with a signature. Staff not present have been told to see their supervisor before their next shift so that they can be educated in person with a signature. Education was also posted at the time clock, the nurses' station and on the dietary carts. Agency staff will see the education in one of those three areas. Education was as follows: No dietary staff are to deliver room trays to isolation residents ever. Nursing staff will deliver and assist residents on isolation. A sign will be placed on any isolation room door for those residents requiring assistance. Any diet changes will require reprinting of tray card tickets that have new diet orders to verify accuracy. Reminder, residents with pureed diets or swallowing difficulties as recommended by a speech therapist, must be supervised while eating.

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F 689	Continued From page 6 mechanically soft diet (wrong diet) and was not supervised during his breakfast meal on 9/30/20. Resident #4 choked on the food given to him and required staff to administer the Heimlich maneuver to remove the food trapped in his airway. Resident #4 died the following morning less than 24 hours after the incident occurred. This situation constituted Immediate Jeopardy to resident health and safety. The facility identified a census of 116 residents. Findings include: 1. A Face Sheet titled Admission Record printed on 10/22/2020 at 3:26 p.m., documented Resident #4's most recent hospital stay was 9/10/20 to 9/24/20. It documented diagnoses included schizoaffective disorder, mild intellectual disabilities, mixed obsessional thoughts and acts, polydipsia (constant excessive drinking related to excessive thirst) and dysphagia (swallowing difficulties). Date of discharge was documented as 10/1/20 with mortician name and license number left blank. A care plan with a focus date of 3/16/20, directed staff that resident had a diagnosis of dysphagia. The resident was on a pureed diet with pudding thick consistency liquids. The goal was that Resident #4 would continue to remain free from aspiration with an intervention directing staff to follow diet recommendations. The care plan with a focus date of 3/16/20, directed staff that resident had a mental health disorder: schizoaffective disorder with a goal the resident was to remain free from major injury. An intervention directed staff to notify psychiatrist of any acute changes in behavior.	F 689	An audit of all residents' diets was completed on 9/30/20 and no further issues were identified for residents on isolation. All other residents needing dining assistance were receiving assistance per our policy. Another audit was completed on 10/14/20 by the Dietary Service Manager and Director of Nursing to ensure all diets match both Point Click Care and the Tray Card System. The staff member that delivered the tray to the isolation room was re-educated on the isolation policy and procedure. Diet audits and supervision audits will be completed weekly x2, then biweekly x4, then monthly thereafter. **Compliance Date 10/15/2020**	

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A progress note dated 9/10/20 at 2:57 p.m., stated resident had a weight loss and a house supplement was added as well as antibiotic: Augmentin for possible aspiration and Zyprexa for behaviors.

A progress note dated 9/10/20 at 3:47 p.m., documented resident made himself fall over a mat and his mental status was definitely in question.

A progress note dated 9/10/20 at 4:30 documented that IMPACT (geriatric care team) ordered that Resident #4 be sent to the hospital for altered mental status.

In an interview on 10/14/20, the DON provided scanned documentation of papers that were sent with resident to the hospital on 9/10/20. The papers included a Medication Review Report printed on 9/10/20 at 4:41 p.m., which documented Regular Diet Pureed Texture, Honey consistency.

A Nutrition Note dated 9/15/20 at 10:09 a.m., documented by the hospital dietitian showed the resident's diet was mechanical soft ground meat with honey thick liquids. Dietitian visited with resident in his room. A sitter was at his bedside.

A Nutrition Note dated 9/22/20 at 11:23 a.m., the hospital dietitian documented resident's diet was mechanical soft ground meat with honey thick liquids. Dietitian visited with resident in his room. A Patient Care Tech (PCT) was also present. The PCT reported the resident was on his 3rd meal tray already that day.

In an interview on 10/14/20 at 1:08 p.m., the

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hospital dietitian stated she did not know for sure if resident had a sitter with him for all meals while he was at the hospital. She stated a Speech Therapist would have decided if a sitter was needed. The dietitian then stated it did not look like a speech therapist saw him at the hospital. The dietitian verified "PCT" meant "Patient Care Technician." She said that if a resident has a sitter it would be 24/7. A sitter could be there for various reasons. She did believe this resident did have a sitter with him.

In an interview on 10/14/20 with the Director of Risk Management at the hospital verified that resident did have a sitter with him. She stated when the resident was initially admitted they monitored him per video. The next day on the 9/11/20 they started staffing a sitter. She reported this resident could become violent and he was agitated at times. They found it best to have someone with him. He had intellectual disabilities. He started seeking food at 5 in the morning. They ordered more food to the unit. They did not want him to leave and felt it best that they had someone with him 24/7.

A Discharge Diet communication from the discharging hospital dated 9/24/20, documented the resident's diet as regular mechanical soft and honey thick liquid diet.

Progress note entries dated 9/24/20 documented the facility had entered orders.

Progress note dated 9/25/20 at 4:58 a.m., documented this resident left his room several times during the shift. The nurse attempted to explain the purpose of isolation and COVID monitoring measures but the resident was unable

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F 689	Continued From page 9 to follow the teaching due to intellectual disabilities. A progress note dated 9/25/20 at 9:58 a.m., documented IMPACT was notified regarding resident's refusal to stay in his room and resident knocking trays and food off the tables in the hallway. An order for 1 mg Ativan intramuscular (injection) was obtained. A progress note dated 9/25/20 at 7:52 p.m., documented the resident forgot he ate supper and lunch, and that resident is supposed to be on precautionary isolation but doesn't understand that he needs to stay in his room. A progress note dated 9/26/20 at 5:33 p.m., documented resident was still exit seeking and leaving his isolation room. A progress note dated 9/27/20 at 12:39 p.m., documented new orders received that included a Speech Therapist to evaluate resident and a pureed diet. A progress note dated 9/27/20 at 1:06 p.m., documented resident was compliant with isolation precautions only leaving room to come to the nurses' station a few times. A progress note dated 9/28/20 at 2:50 p.m., documented resident did not meet SNF (skilled nursing) and will be notified to change level of care to ICF (intermediate level of care). A progress note dated 9/30/20 at 8:25 a.m., documented LPN was called into resident's room to assess resident, resident was laying on back in bed with eyes open and breakfast tray in front of	F 689		

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him. Resident was not able to respond when asked if he was okay. The LPN performed the Heimlich maneuver and resident started to spit food up. Resident then took a deep breath and started talking. The writer checked resident's mouth for any remaining food and encouraged to spit out any food on the floor which resident did. It was noted that resident was given a mechanical soft diet for breakfast instead of pureed, the tray was promptly removed. Primary care provider was notified of incident with no new orders. Kitchen was notified of diet error. Head of bed was placed at 90 degrees and resident was encouraged to sit up.

A progress note dated 9/30/20 at 12:00 p.m., documented the nurse sat with writer during lunch for safety.

A progress note dated 9/30/20 at 6:53 p.m., documented the resident ate 100% of his supper and staff monitored resident while he ate. When he was done he asked for some pie. Resident took medications crushed and in pudding without any difficulty.

A Progress note dated 10/1/20 at 5:57 a.m., documented resident's family was notified the resident had passed away.

Record review revealed there were no progress notes between the 9/30/20 at 6:53 p.m. entry and the 10/1/20 at 5:57 a.m. entries.

A Progress note dated 10/1/20 at 6:00 a.m., documented the medical examiner was paged to discuss if case needed to be examined.

An Incident Report dated 9/30/20 at 8:05 a.m.,

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documented there were no witnesses of the 9/30/20 8:25 choking incident and that the resident was unable to give a description. The notes on the Incident Report documented:

1. 9/30/20 Tray card system defaulted to previous diet. Has been updated and is accurate.
2. 9/30/20 Staff to be educated to be present if on an altered diet in isolation.
3. 9/30/20 will review all diets of residents that eat in their rooms will be done to ensure the residents on altered diets are eating in supervised setting or supervised by staff in lounge or dining room.
4. 10/2/20 dietary seating charts updated and staff notified for supervision of residents with altered diets.

On 10/14/20 the Nursing Home Administrator (NHA) provided a copy of the 4 above interventions with handwritten notes. The notes documented that in Oaks and Elms there was no one on isolation with altered diet. 9/30 updated seating chart nurses' station and dining room. Willowwood- no changes. This resident was the only one in isolation with an altered diet. Informed immediate education to those present. Also on Nurse 24 hour report

A Report Sheet dated 9/30/20 directed staff that resident is on a pureed diet, choked on breakfast this a.m., Heimlich performed, and directed staff resident needs supervision with meals and vital signs completed every shift for 72 hours.

In an interview on 10/12/20 at 2:00 p.m., the NHA stated resident did not pass away from being served the wrong diet. The NHA said they

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investigated the incident and the dietary supervisor did not know that when she put his diet order in the system, it didn't save. The resident received a mechanical soft diet while at the hospital and when he returned he was placed on a mechanical soft diet on 9/24/20 per doctor's order. The NHA reported the diet was changed to a pureed diet with honey consistency on 9/26/20 per doctor's orders, and added the medical examiner declined to come to the facility and said it was a heart attack.

In an interview on 10/12/20 at 2:10 p.m., the DON stated she talked with the county medical examiner (ME) and he said he didn't feel he needed to come and see the resident unless the medical director or family requested it. Family was notified and they declined further ME intervention. The DON added IMPACT was notified, and 2 ARNP's and 1 physician made the decision it was not necessary for the medical examiner to review. The DON reported the IMPACT team was aware of the choking episode per progress note on 9/30/20 at 10:02 a.m. and ordered vital signs for 72 hours.

An undated email from IMPACT ARNP (Advanced Registered Nurse Practitioner) to the Director of Nursing (DON) documented the death certificate was completed by the ARNP and Cause of Death was Cardiorespiratory arrest.

In an interview on 10/13/20 at 12:45 p.m., Staff A Licensed Practical Nurse (LPN), reported she had done the Heimlich on this resident that morning. It was at breakfast time and Staff B Certified Nurse Aide (CNA), told Staff A that this resident was choking. Staff A said she immediately noticed he was delivered the wrong diet. Staff A

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stated there might have been scrambled eggs and pancakes. Staff A knew that he was supposed to have pureed food. Staff A asked the Assistant Director of Nursing (ADON), to complete a respiratory assessment to confirm accuracy of Staff A's assessment. Staff A educated staff that residents on specialized diets should not be eating by themselves. She added the resident was on quarantine and his tray had already been delivered his tray. Staff A reported she observed the resident eating his pureed lunch and coached the resident to slow down as he was eating a little fast. Staff A stated the dietary staff do pass meal trays to residents in isolation and identified Staff D, Dietary Aide/CNA as the person who gave this resident the tray with the food that he choked on that morning. Staff A stated the ADON had a conversation with Staff D. Staff A reported the resident came back from the hospital on a mechanical soft diet and on 9/27/20 the order was changed to pureed. Staff A stated she was there the night of 9/27/20 and ensured he received the right diet.

In an interview on 10/13/20 at 1:18 p.m., Staff B, CNA, stated they were passing trays the morning of the choking episode. Staff B stated Staff D thought the resident was choking. Staff B stepped into the resident's room and then grabbed Staff A; the resident had been laying on his back but Staff B did not know this resident very well. Staff B was making the trays and Staff D was delivering them. The resident's diet went from mechanical soft when he came to the unit to a pureed diet. Staff B reported the nursing and dietary staff got into it over what the resident's diet was. Staff B said if she remembers right, he received mechanical soft the first day he was on Willowwood. Staff B had not seen the resident's

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tray before it went into the room. Staff B reported residents with altered diets usually eat in the common area, but this resident was in isolation at that time. Staff B said that normally they leave the trays outside of the room for those residents that are on an altered diet and was unsure why the resident got his tray. Staff B's understanding is that somebody needed to be in the room with this resident while he ate his meal. Staff B said there is often miscommunication between dietary aides and nursing staff in general, for example taking trays into isolation rooms. Staff B reports she knows residents diet from slips or word of mouth. Usually slips are accurate on trays. Staff B said there is a verbal shift to shift report between CNA's. The ADON told staff after this incident to be with residents on altered diets in their rooms. Staff B mentioned another resident who they all knew prior to him going into isolation so knew he had to be supervised eating, but added Staff B was unfamiliar with this resident because he had resided in the Aspen (Intermediate Care) wing prior to returning from the hospital to Willowwood.

In an interview on 10/13/20 at 1:50 p.m., Staff D Dietary Aide/CNA, had brought resident his tray that day. It was on the ticket as mechanical soft. One day he would get pureed and another day he would get mechanical soft. He was in isolation and it was the first time Staff B brought his tray. He was sitting on the edge of the bed and Staff D sat the tray on the tray table, left the room, and continued to pass trays. She was opening a milk for a resident who was across the hall from Resident #4, when she heard choking, so she went out into the hall, called out Resident #4's name and when he didn't answer she looked into his room. She say the resident laying on his bed

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and she went and got Staff B. Staff D stated that usually people in isolation are on Elms right. This resident was on a locked unit- Willowwood. Staff D said that residents that need supervision sit out in the dining room and usually would already be out there in the dining room so that's where she would deliver the trays. Staff D said the diets are on the tickets. Staff D had not received training on supervision with altered diets and said they don't tell us dietary aides which residents should be supervised and who isn't. Staff D went on to say that as a CNA you get told all that kind of stuff. This was the first time she had seen this resident and she did not know he was up there as she usually serves trays on Pine.

In an interview on 10/13/20 at 2:02, Staff D stated the resident received scrambled eggs that morning with toast. She reported the diet was not altered at all. She believed he received some kind of cold cereal but did not remember what kind and could not remember what this resident had to drink.

In an interview on 10/27/20 at 4:30 p.m., Staff U stated she sat with resident during supper the evening of the choking episode. Staff U stated resident did fine at supper and was up walking around. He did request pie but Staff U did not give it to him as he was on a pureed diet. Staff U does not recall if nursing staff sat with resident during mealtime in his room prior to the choking incident.

In an interview on 10/14/20 at 11:00 a.m., Staff E, Licensed Practical Nurse (LPN), from Aspen (the ICF unit resident lived on prior to going to the hospital and returning to Willowwood SNF), stated they would have to remind this resident to

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slow down as he would shovel in food. Resident's diet was pureed with honey thick (liquids). Staff E stated if there was ample staff this resident would eat in the PT (physical therapy) area and would sit by the wall otherwise he would eat in the community room. The resident did not eat in his room. This resident would eat too fast and too much and would cough occasionally. Staff E was here the day that resident was sent to the hospital. Staff E stated this resident had always been on a pureed diet since the day he admitted to the facility.

In an interview on 10/14/20 at 11:50 a.m., the DON stated this resident went to the hospital for increased behaviors. He was to be admitted to psych but they would not take him because he had a g-tube. She said his hemoglobin level was low so he was admitted and procedures were ordered, and then he returned to the facility in isolation. She verified the resident was at the hospital from 9/10/20 through 9/24/20.

In an interview on 10/14/20 at 11:55 a.m., the NHA stated this resident was so excited to come back to the PMI unit (Willowwood) as he had wanted to go to that unit all along. The NHA concurred the isolation was set up for the resident upon his return with a cart outside of his room.

In an undated typed and signed statement, Staff F, Dietary Director stated this resident's diet was downgraded to pureed on 9/25/20. Staff F had the assistant manager change the already printed tickets through Wednesday 9/30/20 and that a ticket must have gotten missed because the resident received pureed up until that day. Staff F had an email out to the company that provided the food to see if there was a time and date

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F 689	Continued From page 17 stamp of diets changed. In an interview on 10/14/20 at 11:30 a.m., Staff F, Dietary Manager stated on Friday the 25th of September she was off work and the ADON had emailed Staff F regarding a diet change for Resident #4. Staff F explained that she was off Friday and Monday so she had printed tickets through the next Wednesday on Thursday, the day before she had received the email from Staff C. Staff F reports she called Staff G, Dietary Director, (Staff F's assistant) who had quit during this survey, and told Staff G that this resident's diet was changed and to change the tickets. Staff F came in on Saturday 9/26/20, cooked breakfast, worked breakfast and lunch with no concerns brought to her Saturday, Sunday, Monday or Tuesday. Staff F cooked breakfast on Wednesday morning. Staff D told her that a resident had choked on his omelet. Staff F said she had made him a pureed tray. Staff F went in to her computer program to see if diet had been changed to mechanical soft. She noticed Staff G had not changed the diet in the system because the tickets were printed through Wednesday. Staff G would have handwritten on the tickets. Staff F stated she could have caught it after breakfast on that Wednesday because she would have printed off new tickets. Staff F stated she talked with Staff G about it and Staff G told her she had hand written pureed on all of his tickets. Staff F said when Resident #4 lived on Aspen he was always on a pureed, honey thick diet. This resident went to the hospital and they put him on mechanical soft. He returned to the facility on mechanical soft. Then the diet was downgraded to pureed on the 25th (of September). This resident had never been on Mechanical soft prior to that. He had always been pureed. All tickets	F 689		

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said mechanical soft until Staff F reprinted after changing the diet in the system on that Wednesday. Staff F said that dietary staff do not serve trays to isolation rooms. Staff F stated she was not made aware that Staff D had even done that (brought tray to a resident in an isolation room). Staff F said in all fairness the only isolation rooms were in Elms prior to this resident going to Willowwood. Staff F said she knew this resident was in isolation because he had returned from the hospital. Staff F stated she had not changed the diet order in the system.

In an interview on 10/14/20 at 11:07 a.m., the ADON, stated she came into the facility shortly after the choking incident had happened and was notified when she came to the unit that the Heimlich had been done. Staff A asked her to check Resident #4's lungs because she had done an assessment but was having difficulty with the resident moving around. The ADON listened to the resident's lungs, the resident did fine with lunch, and Staff C received no reports of any further concerns. The ADON stated after finding out about the diet, she had asked who had served him the tray, and then spoke with Staff F about the tray ticket. Staff F said she had changed it in the system but it hadn't saved correctly and Staff D served the resident a mechanically altered. The ADON told Staff D that if a resident has an altered diet you cannot leave a tray in a resident's room; anybody in isolation and on an altered diet had to have staff stay with them in the room. The ADON stated she educated staff on Willowwood and added there are seating charts for all units and she, the DON, Staff F, and another ADON had met after this incident and went over seating charts to make sure everyone was out of their rooms who had an

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altered diet. On 10/14/20 at 12:05 p.m., Staff C stated she had put up the isolation sign before Resident #4 came back from the hospital. Staff C set an isolation bin outside of room door and garbage and laundry bins inside of the room. The isolation sign went on the mantle of the door. Staff C reiterated that the resident had all isolation set up prior to him coming back from the hospital. The Isolation cart had gowns, gloves, goggles, and face shields.

In an interview on 10/14/20 at 12:12 p.m., Staff H, Development Assistant (DA), stated he worked with this resident in Aspen prior to his hospitalization and verified the resident ate a pureed diet in the common PT area so staff could be present when he ate. Staff D added the resident drank honey consistency liquids and was on the same diet the whole time he was in Aspen. Staff H said he had no problems with the resident choking but staff had to remind him to take a drink in between bites.

In an interview on 10/14/20 at 2:30 p.m., Staff G, Dietary Director, heard Staff F say that she (Staff F) could not believe that she (Staff F) did not change the slips on the day the resident choked. Staff G stated that when diets needed to be changed somebody would tell Staff F what the changes were and Staff F would update the computer. Staff G said the residents who came to the dining room already had COVID-19 and those who hadn't ate in their rooms. Staff G added she was the evening supervisor, did not deliver trays, and was never told to change diet slips for this resident. Staff G said Staff F never said anything about changing diet slips. When asked about Staff F calling her to ask her to change the slips, Staff G checked her phone and said she did not

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receive any calls from Staff F on 9/25/20. Staff G has gotten an email before. Staff G, when asked if she received any communication either email, a phone call, etc., about changing the diet tickets for Resident #4, Staff G stated she did not. Staff G stated she did not change any slips, she did not cross out mechanical soft diet and did not write pureed on this resident's diet slips.

An email correspondence dated September 25, 2020, was initiated by the Speech Therapist at 12:01 p.m. and sent to the ADON and documented the resident came back from hospital with orders of an upgraded diet to mechanical soft diet. The Speech Therapist had called the hospital and there was no record of speech therapy. The Speech Therapist requested Staff C get an order to return resident to pureed with honey liquids. Staff C responded at 12:04 p.m. and forwarded on to Staff F asking Staff F to downgrade Resident #4's diet to pureed with honey thick. Staff C wrote that she had requested the order to be officially changed but for nursing judgement can change it now. Staff F responded at 1:24 p.m., OK. The mechanical soft made me (face emoji with a straight lined mouth).

In an interview on 10/14/20 at 4:00 p.m., Staff F stated she had taken everything off of her phone and there was no way to show that she had called Staff G to ask her to change the order on diet tickets. When asked about her call history, Staff F stated, no, that it wouldn't be in there. Staff F said she remembers seeing tickets that had the changes written on them. Staff F said other dietary staff could verify. Staff F said Staff I would have worked some of the days during the time the tickets were changed.

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In an interview on 10/14/20 at 4:05 p.m., Staff I, FSW, stated she didn't remember this resident having changes on his ticket/slip but she sees hundreds of tickets each day. Staff I said she did not remember seeing anything scratched out or written on this resident's diet slips. Staff I verified that she worked some of the days between 9/25/20 to 9/30/20.

In an interview on 10/19/20 at 1:44 p.m., Staff J, Facility Contracted Dietitian, Staff J stated she would evaluate a resident returning from the hospital if she was requested to do so. Staff J stated she was unaware of an issue with Resident #4. Staff J works on Minimum Data Sheets (MDS) for residents. Staff J prints weight reports then she deals with concerns by faxing the ADONs to do follow up and added she had sent emails to Staff F when she would like to add pudding or something for an individual resident. Staff J reported a lot of information is communicated through emails and the nurses are responsible to obtain any doctor's orders.

In a progress note dated 8/14/20 at 4:16 p.m., Staff J documented weight decrease for Resident #4. Due to pureed diet with honey thick liquid diet and fluid restriction, Staff J recommended trying a yogurt as am snack with no fruit pieces and a pudding as an afternoon snack to see if the snacks would satisfy his hunger and stop him from going to the kitchen to obtain food and see if his weight would then be maintained. Staff J faxed the doctor with this information and recommendation for adding 4 ounces of honey thick Shaklee twice a day to help stabilize his weight.

In an interview on 10/13/20 at 9:54 a.m., Staff K

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Speech Therapist for facility, stated she had checked with the hospital after resident had returned from the hospital to see if resident had been seen by speech therapy there. Staff K stated whenever someone is on an altered diet they should have somebody with them during meals. Resident #4 had coughing and eating difficulties. He was unable to follow strategies due to Intellectual Disabilities and poor impulse control. Staff K stated if this resident was on anything other than a pureed diet then he would have been at risk for choking as his impulses could not be controlled and he required constant reminders. Staff K said the resident returned on the 24th (of September) and she did her evaluation on the 25th (of September). After changing a resident's diet, Staff K's expectation would be for staff to monitor a resident and to observe and report any difficulties. Staff K had seen Resident #4 previously so pureed texture wasn't a new diet but mechanical soft was. Based on prior knowledge of diet, Staff K changed him back to pureed diet stating he felt it was for his safety.

An email dated 9/24/20 at 10:52 was provided by Staff K on 10/20/20. The email went to Team Pillar and received by Staff K. It stated Resident #4 would be returning that day to Room 221 Willlowwood. Staff K stated she was alerted to the resident's return from the hospital by this email.

In a Speech Therapy SLP evaluation and Plan of Treatment dated 9/25/20, Staff K documented her goal was to determine safest diet and clarify diet change upon re-admit. Potential for achieving rehab goals was documented as excellent with staff participation. Staff K documented that the

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F 689	Continued From page 23 current referral reason was Resident #4 resided at the facility and was placed in the hospital. Resident returned to this facility with orders for Speech Therapy to evaluate and treat as indicated. Resident left with orders for a pureed diet. Resident returned with orders for mechanical soft diet with no explanation of the change given. Staff K documented the prior treatment outcome was compensatory strategies to upgrade from pureed diet to mechanical soft diet was addressed. After multiple sessions, the resident was not able to independently use the strategies and was at risk for aspiration. The resident was discontinued on a diet of mechanical soft food. The prior level of function was documented as pureed consistencies, honey liquid thick liquids with minimum of close supervision. Under the Current Level of Function and Underlying Impairments, Staff K documented swallowing abilities was minimum of close supervision. Liquids assessed during evaluation were honey thick liquids and solids assessed during evaluation were mechanical soft textures and pureed consistencies. A mechanical soft assessment showed moderate clinical signs and symptoms of dysphagia as the resident had a wet voice and refused more than two bites. The swallow onset time was 4 seconds and the pureed assessment showed clinical signs and symptoms of dysphagia was resident filled his spoon with as much food as the spoon would hold. This resident ignored cues to take smaller bites and had minimal mastication (chewing). Swallow onset time was 3 seconds. Staff K documented her clinical impressions as: resident presented with confabulation, stating he had not had breakfast and wanted bacon and eggs. This resident presented with difficulty with mechanical soft food and showed no signs or symptoms of	F 689		

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aspiration with pureed texture. The reason documented for therapy was skilled services for dysphagia were warranted to assess and determine least restrictive diet. Services were required due to the resident having difficulty learning new information. The risk factor for skilled intervention was that without skilled therapeutic intervention the resident was at risk for aspiration. Staff K documented recommendations as pureed consistency diet with honey thick liquids. Resident to have close supervision. The resident should be upright to eat and staff should cue resident to take small bites and swallow before taking another bite. Staff K documented that resident was unable to cooperate for further examination or consult related to this resident was unable to cooperate and the results would not change the clinical management of the patient.

An undated list of diet orders revealed the following diet orders for Resident #4:

3/13/20 Regular diet Pureed texture, pudding consistency, discontinued 6/10/20
6/10/20 Regular diet, Pureed texture, Honey consistency, discontinued 9/24/20
8/31/20 House supplement, discontinued 10/1/20
9/24/20 Regular diet, Mechanical Soft texture, Honey consistency, discontinued 9/26/20
9/26/20 CCHO (Consistent Carbohydrate diet for diabetics) diet pureed texture with honey consistency, discontinued 10/1/20

A Doctor's Order dated 9/24/20, documented a Regular diet with Mechanical Soft texture and Honey thickened fluids was ordered to start on 9/24/20.

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A Doctor's Order dated 9/26/20 documented a CCHO diet with pureed texture and honey thickened fluids was ordered to start on 9/26/20

The situation detailed above resulted in Immediate Jeopardy (IJ) for the facility. The facility was notified of the Immediate Jeopardy on 10/14/20. The facility abated the IJ Jeopardy situation on 10/14/20, and the scope and severity was lowered from a "J" to an "E." The facility abated the IJ by developing, implementing, and educating staff on required nursing supervision of all residents on altered diets that are in isolation, including educating dietary staff that no dietary staff are to deliver room trays to isolation residents. The nursing staff will deliver and assist residents on Isolation precautions and any diet changes will require reprinting of tray card tickets that have new diet orders to verify accuracy. An audit was done to ensure all diets matched both Point Click Care and Tray card system.

2. Environmental tour on 10/15/20 at 9:20 AM revealed the NorthWest shower room floor on Willow Wood with a large piece of laminate flooring missing directly in front of the shower immediately to the left inside the door to the shower room. The edge of the bordering laminate flooring was loose and would catch on the toe of the surveyor's shoe, lifting up and causing a potential trip hazard. The area of missing flooring measured 5 feet wide and 8-20 inches in height when measured with a tape measure provided by Staff N, Licensed Practical Nurse (LPN). Staff N confirmed the measurements. When questioned, Staff N responded the floor had been this way since she had started approximately one year ago. Staff N, LPN further stated the missing and loose laminate posed a trip hazard. She was unaware

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F 689	Continued From page 26 of any incidence of residents falling in the shower room, and further had not reported the missing and loose flooring for repair. In an interview on 10/19/20 at 11:30 AM, the Administrator stated flooring in shower room had been cut away, re-secured, and painted. Upon inspection at this same time flooring had been secured and painted. The Administrator stated plans have been made to repair all flooring as now aware of how fragile flooring is. Further interview at 11:50 AM the Administrator stated had viewed all the shower rooms on 10/9/20 as part of facility environmental rounds and found the flooring in the Willow Wood shower had been intact. Stated she would have noticed if the flooring had been torn and missing. Stated would have expected staff to report immediately if laminate flooring had torn and was a trip hazard. The Administrator was unable to provide any documentation from rounds, and no reports of shower room flooring being in disrepair could be found. In an interview on 10/20/20 at 9:30 AM the Maintenance Supervisor acknowledged flooring had been found after reported by surveyor to have a large piece of laminate missing with a loose edge which posed a trip hazard. He further stated would expect staff to report so could be repaired. Reported in process of replacing all flooring. Confirmed that Maintenance Supervisor participated in facility environmental rounds and assured floor in shower room was not that way the week before.	F 689		
F 801 SS=C	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		

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F 801	Continued From page 27 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801	**F801** On 11/2/2020 the facility hired a full-time registered dietician who meets criteria for dietary service manager. **Compliance Date: 11/2/2020**	

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November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure there was a qualified full-time dietitian or a certified dietary manager. The facility reported a census of 116 residents.

Findings include:

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In an interview on 10/7/20 at 10:20 a.m., Staff F, Dietary Director revealed she was not a certified dietary manager. Staff F reported she started classes last year but had not finished them.

In an interview on 10/7/20 at 12:30 p.m., The NHA provided a copy of the state rules. The NHA stated Staff F had 8 years of previous dietary management experience prior to her employment with the facility. The NHA felt the facility was in compliance as long as Staff F had started classes. The NHA said Staff F started classes shortly after beginning employment.

In an interview on 10/19/20 at 1:44 p.m., Staff J, Contract Dietitian, stated she has worked at the facility for 17 years. Staff J works approximately 18 hours a week and no other dietitian was working for the facility at that time. Staff J stated she did not know if Staff F was certified. Staff J stated the 2 previous dietary managers prior to Staff F's employment were certified.

In an interview on 10/20/20 at 4:30 p.m., the NHA stated she hired Staff F knowing she had not gone through the classes to become certified. NHA provided a photo copy and said it was proof of Staff F started the classes after beginning her employment with this facility. NHA stated the classes and course are on line.

An undated photo copied sheet of a Professional Training Program with My Grades as a heading, showed an order date of 12/24/19 at 9:26 a.m., an end date of 12/24/19 at 9:26 a.m., a DMS Getting Started Tutorial Quiz with a date of 1/3/20 at 7:52 a.m. and a Quiz 1 with a date of 3/9/20 at 3:25 p.m.

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F 801	Continued From page 30 An email dated 10/13/20 at 5:28 a.m., showed an Order Confirmation and Receipt for the Nutrition and Foodservice Professional Training Program-first extension. It noted that Staff F will receive 6 additional months to complete the course. A New Employee Data form showed a hire date for Staff F of 9/30/19. This form showed she was hired as the Director of Dietary as a manager. No dietary management certificate was documented on this form.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews,	F 812	**F812** On 01/05/2021 education on serve sanitation to all dietary staff completed. Audits by DSM or designee on serve sanitation to be completed at 6 meals per week x 4 weeks, and 3 meals per week thereafter. **Compliance Date 1/7/2020**	

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facility staff failed to consistently practice proper food handling safety measures. One staff was observed handling food without gloves and touching items with gloved hands and then touching food without the removal of gloves and proper hand hygiene. The facility reported a census of 116 residents.

Findings include:

In an observation on 10/8/20 at 8:05 a.m., Staff L, Cook, touched waffles with their bare hands. At 8:12 a.m., Staff L placed waffles in the toaster with their gloved right hand. The cook then placed the waffles in a pan, grabbed
the pan with both hands, changed out pans out in the steam table, and touched new waffles without changing their gloves. At 8:30 a.m, Staff L threw away containers of pureed food and at 8:38 a.m., folded and threw away a cardboard box. At 8:40 a.m., Staff L touched trays and transferred waffles, and also put new waffles in the toaster. At 8:42 a.m., the cook handed packets to staff, then touched some waffles again. The waffles were served to residents.

In summary, observation revealed Staff L donned a glove on her right hand at 8:12 a.m. and did not remove the glove or wash her hands throughout these observations.

In an interview on 10/8/20 at 10:30 a.m., Staff L stated she should have washed her hands and donned a clean glove between each task.

In an interview on 10/26/20 at 2:54 p.m., Staff F stated she had talked with Staff L regarding the above observations. Staff F stated after touching items and prior to touching food, staff should was

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F 812	Continued From page 32 their hands and change their gloves. Staff F added she also told Staff L she should have used tongs to handle the waffles.	F 812		
F 868 SS=B	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the quality assessment and assurance committee consisted of a minimum of the nursing home administer (NHA) or representative, director of nursing (DON), the Medical Director or representative, and 2 other members of the facility's staff were present at quality assessment and assurance meetings on a minimum of a quarterly basis. The facility reported a census of 116 residents. Findings include:	F 868	**F868** On 01/04/2021 education provided on QAPI regulations to administrator, DON, and Department managers Quarterly audit to be conducted ensure compliance with regulations. **Compliance Date: 12/7/2021**	

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Attendance records provided by the NHA revealed the quality assessment and assurance committee meetings held with the minimum of the above mentioned staff present were held on 2/4/2020 and 9/28/20.

The Quality Assessment and Assurance Committee Attendance sheet dated 3/24/20 revealed the Medical Director or designee was not present.

In an email dated 4/8/20 at 3:41 p.m., the NHA alerted Team Pillar that QAPI (Quality Assurance and Performance Improvement) meetings would not be held until further notice related to facility being on quarantine.

In an email dated as sent on 6/1/20 at 2:24 p.m., the NHA informed Team Pillar that in order to make best use of the Medical Director's time there would be a Zoom QAPI meeting the following day at 9:00 a.m. The meeting would be limited to just the NHA, the DON, and the Medical Director joining via ZOOM. The NHA requested the team members submit their portion of the meeting and any issues that needed to be discussed to her via email.

A Quality Assessment and Assurance Committee Attendance sheet dated 6/2/20 had "For May" written on the top of the sheet. The sheet was signed by the NHA, the DON and had the Medical Director's name written down with a star in front of his name and via ZOOM after his name.

A Quality Assessment and Assurance Committee Attendance sheet dated 6/19/20, revealed the Medical Director or designee was not present.

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F 868	Continued From page 34 A Quality Assessment and Assurance Committee Attendance sheet dated 7/22/20, revealed the Medical Director or the NHA or their designees were not present. A Quality Assessment and Assurance Committee Attendance sheet dated 8/21/20, revealed the Medical Director or designee was not present. A Quality Assessment and Assurance Committee Attendance sheet dated 9/28/20, revealed all necessary members were present. In an interview on 10/26/20 at 5:40 p.m., the NHA stated they had a QAPI meeting planned for 5/5/20. It was not held. The NHA stated both the facility and the Medical Director were busy with COVID related issues, including positive resident cases in the facility as well as the Medical Director having responsibilities as the head of Hospice. The NHA, DON, and Staff C, Assistant Director of Nursing (ADON) held 2 meetings with the Medical Director in May, but the meetings were focused on COVID processes and infection control and did not include other facility wide issues. The NHA verified that the facility did not meet the regulation of quarterly QA meetings with the minimum required staff present.	F 868		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed	F 885	**F885** On 01/04/2021 education was provided to Administrator and all Department Managers to ensure that notifications for COVID + are made by 5:00pm the next calendar day. Quarterly audit to be conducted ensure compliance with regulations. **Compliance Date: 1/4/2021**	

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infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—

(i) Not include personally identifiable information;
(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, and facility record review, the facility failed to inform all residents, their representatives, and/or families by 5 PM the next calendar day, to give updates to residents, their representatives and family following the occurrence of a single confirmed Covid-19 infection and of the mitigating actions taken. Confirmation was given to the facility of a positive Covid-19 test for 1 resident and 6 staff since the Infection Control Revisit Survey on 7/15/20. The facility census was 116 residents.

Findings include:

An untitled and undated sheet provided by the Nursing Home Administrator (NHA), showed 6 employees and 1 resident had tested positive since the last survey on 7/15/20. The positive testing result dates for the staff are as follows:

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Staff O-Dietary Aide: 8/6/20, Staff P-Aspen Nurse: 9/3/20, Staff Q-Laundry Assistant: 9/5/20, Staff R-Registered Nurse: 9/11/20, Staff S-Dietary Aide: 9/13/20, and Staff T-Laundry: 10/1/20.

According to an untitled and undated form, Resident #12 tested positive on 5/25/20 and 9/11/20, with recovery dates of 6/4/20 and 9/21/20 respectively.

In an interview on 10/22/20 at 1:50 p.m., the NHA verified the the facility did not inform residents, their representatives, or their families of any of these positive cases by 5 pm the following day. The NHA added since they had communicated regarding the positive cases, they had also not detailed mitigating actions and/or cumulative updates, either. The NHA explained she had interpreted the regulation incorrectly. She reported there have not been any further positive cases for residents or staff since the last staff tested positive on 10/1/20.

In a subsequent interview on 10/26/20 at 5:45 p.m., the NHA stated there has been no spread according to their surveillance testing.