STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125058	A. BUILDING: _____ B. WING _____	C 10/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

(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) COMPLETE DATE
4 000	Initial Comments A focused infection control and relicensing survey was conducted by the Office of Health Care Assurance (OHCA) on 10/20/20 to 10/30/20. The facility reported census at time of entrance was 46 residents.	4 000		
4 088	11-94.1-16(a) Governing body and management (a) Each facility shall have an organized governing body, or designated persons functioning as the governing body, that has overall responsibility for the conduct of all activities. The facility shall maintain methods of administrative management that assure that the requirements of this section are met. This Regulation is not met as evidenced by: Based on interviews and record review, the facility failed to produce evidence of a governing body (GB). This deficient practice facilitated the facility's mismanagement of the COVID-19 outbreak and broken Quality Assurance & Performance Improvement (QAPI) program to mitigate the spread of the COVID-19 virus. The deficient practice resulted in an uncontrolled spread of COVID-19 infection in the facility. There were 77 residents and 37 staff members infected with the COVID-19 virus. Twenty-seven (27) resident deaths were related to the COVID-19 outbreak. Findings include: 1. Surveyor interviewed the Administrator on 10/21/20 at 3:13 PM. The surveyor asked the Administrator to identify the members of the facility's GB and he did not identify them. He was asked to whom he reports, and he replied that he	4 088		

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4 088	Continued From page 1 reports to the facility's RVP. He was asked if the RVP was on the GB and he replied that the RVP was his "Boss." 2. Surveyor interviewed the Medical Director on 10/26/20 at 08:14 AM by phone and asked about the facility's GB. He was unsure of the facility's GB and said, "Not sure what you mean governing body?" He further said that he is on the regional board of a SC that oversees operations of the facility. 3. In a follow up phone interview with the Administrator conducted on 10/28/20 at 10:22 AM, he said that the DON, Medical Directors and himself form the facility's GB with the SC. He further said, "We are not the licensed owner and operator. SC is the governing body and we meet with SC every month." He also said that they have not had a formal GB meeting recently. Surveyor again requested a copy of the GB organizational chart and the administrator emailed a "Sample Chain of Command/Delegation of Authority Flow Chart" to the surveyor on 10/28/20 at 11:13 AM. It showed the SC "Board of Directors" as overseeing the "Facility Administrator." In a phone interview on 10/29/20 at 10:38 AM with the SC liaison, surveyor asked SC liaison about the "Sample Chain of Command/Delegation of Authority Flow Chart" showing the SC Board of Directors overseeing the Administrator. He stated that SC is not the GB of the facility. He clarified that SC is the owner of the building and is not involved with the facility's operations. SC monitors its management contract with the facility and ensures that the facility is abiding by the Federal and contract	4 088		

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4 088	Continued From page 2 requirements. 4. On 10/23/20, surveyor conducted a RR of the facility's GB policy which states "The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility." Such as, the facility to failed to provide evidence to mitigate the spread of the COVID-19 virus once the outbreak begun in the facility; there was no documented communication between the administration and GB; and the repeated noncompliance with infection control continued. Due to not knowing who comprises their governing body, the facility failed to have an active oversight of management practices such as, lack in communication between the Administration and the GB regarding the continued outbreak of COVID-19 and lack of GB's direction, guidance, and input on their COVID-19 policies and procedures.	4 088		
4 091	11-94.1-17(1) Administrator All freestanding and hospital-based nursing facilities shall be administered by: (1) A person appointed by the governing body and responsible for the management of the facility; and (2) Licensed by the State as a nursing home administrator; or (3) In the absence of the administrator, an employee who has been designated, in writing,	4 091		

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4 091	Continued From page 3 to act on the administrator's behalf for a determined period of time as approved by the department. This Regulation is not met as evidenced by: Based on observation, interview, and record review (RR), the Administrator failed to be responsible for the management of the facility by failing to take appropriate action to mitigate the spread of COVID-19 at the facility as evidenced by: 1. Since his employment which begun in 04/2020, the Administrator did not communicate with the governing body (GB) about the ineffective infection control practices. 2. The Administrator did not conduct timely and ongoing quality assurance performance improvement (QAPI) meetings to address any vulnerabilities identified in the facility's infection control plan and conduct a retrospective evaluation of the plan, which resulted in the continued noncompliance and lack of facility's oversight. These deficient practices resulted in an uncontrolled spread of COVID-19 infection in the facility which begun on 08/20/20. There were 77 residents and 37 staff members infected with the COVID-19 virus. Twenty-seven (27) resident deaths were related to the COVID-19 outbreak. Findings include: 1. The survey team interviewed the Administrator and Director of Nursing/Infection Preventionist (DON/IP) on 10/20/20 at 09:17 AM. Surveyor asked the Administrator to describe his role as facility Administrator. He responded that his role is to "manage and delegate to staff that	4 091		

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4 091	Continued From page 4 all things are being done." When asked how the Administrator communicates problems or concerns to the GB, he responded that he communicates to the Regional Vice President (RVP). The Administrator did not address the process for communicating concerns to the GB, (refer F837). When surveyor asked who is on the GB, the Administrator did not respond on membership, and only that the Administrator, Medical Directors, department heads and pharmacy services staff are all on the quality assessment and assurance (QAA) committee. Surveyor interviewed Administrator, DON, RVP, and the two Regional Nurse Consultants (RNCs) on 10/23/20 at 10:30 AM in the Administrator's office. Surveyor asked the Administrator if he attended any of the GB meetings and when was the last time he met with the GB. The Administrator responded, "at the QAPI meeting." The RVP interjected, that he (the Administrator) has not met with the GB since the pandemic started and he started working at the facility in April 2020. The RVP validated the Administrator has not had any involvement with the GB nor did he identify the members of the GB. Surveyor interviewed the Administrator via phone call on 10/28/20 at 10:22 AM to follow up on the previous interview with him on 10/21/20 with questions about his involvement with the GB. When asked to identify the members of the GB he provided an organizational chart that the surveyors previously asked for but had not received. Administrator replied that the "GB is me, the DON and the two Medical directors. We are not the licensed owner and operator." Surveyor reviewed the organizational chart, "Sample Chain of Command/Delegation of	4 091		

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4 091	Continued From page 5 Authority Flow Chart," that was provided by email on 10/28/20 at 11:13 AM. At the top is the state corporation (SC), directly under them is the facility administrator, directly under him is the director of nursing then the assistant Director of Nursing/Infection Preventionist, (refer F837). In a phone interview on 10/29/20 at 10:38 AM with the SC liaison between SC and the facility, liaison stated that SC is not the GB of the facility. He clarified that SC is the owner of the building and is not involved with the facility's operations. SC monitors its management contract with the facility and ensures that the facility is abiding by the Federal and its contract requirements (refer F837). On 10/26/20, surveyor reviewed the Administrator's Job Description. Job title; Administrator. Job summary states: "To act as the representative of the governing body of the nursing facility for internal management, and to be responsible for the efficient administration of all activities, subject to the policies, procedures and orders of the governing body." Essential Duties and Responsibilities: "Ensures that each resident receives the necessary nursing, medical and psychological services to attain and maintain the highest possible mental and physical functional status." On 10/23/20, surveyor requested records or evidence of meetings with the GB or medical directors, such as meeting dates, email's that show agenda, action plan, meeting minutes, or outcome of any meetings. The facility failed to provide any evidence of meetings. 2. Surveyor interviewed the Administrator on	4 091		

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4 091	Continued From page 6 10/21/20 at 3:13 PM. When asked how the Administrator prioritizes the issues and concerns that are brought to his attention, he replied that he could talk to the DON, and together prioritize the concerns and bring them to the QAPI meeting. The facility failed to provide evidence of QAPI meetings after several requests were made. Surveyor asked if the facility identified any vulnerabilities since the beginning of the COVID-19 outbreak that would help mitigate the spread of COVID-19 in the facility. The Administrator replied that information would be in the QAPI, then stated that the information in the QAPI won't be shared with the survey team. He stated that those vulnerabilities were identified, they made those changes and went with the most current guidelines. Administrator refused to provide documentation of the QAPI plan or meeting minutes to show there were vulnerabilities identified and strategies implemented to mitigate the spread COVID-19, (refer F867). On 10/28/20 surveyor reviewed the QAPI Program, Analysis and Committee Membership policy revision dated 08/2018. "The facility will develop a program that describes the process for conducting QAPI activities... such as identifying and correcting quality deficiencies...which will lead to improvement in the lives of residents, through continuous attention to quality of care, quality of life, and resident safety...2. the GB and/ or executive leadership is responsible and accountable for the process that addresses systems of clinical care, management practices, quality of life."	4 091		
4 152	11-94.1-39(e) Nursing services	4 152		

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4 152	Continued From page 7 (e) There shall be a policies and procedures manual that is kept current and consistent with current nursing and medical practices and approved by the medical advisor or director and the person responsible for nursing procedures. The policies and procedures shall include but not be limited to: (1) Written procedures for personnel to follow in an emergency including: (A) Care of the resident; (B) Notification of the attending physician and other persons responsible for the resident; and (C) Arrangements for transportation, hospitalization, or other appropriate services; (2) All treatment and care provided relative to the resident's needs and requirements for documentation; and (3) Medication or drug administration procedures that clearly define drug administration process, documentation, and authorized This Regulation is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to produce evidence of an organized governing body (GB); Administrator failed to be responsible for the management of the facility by failing to take appropriate action to mitigate the spread of COVID-19; and the facility failed to ensure the protection of its 10 COVID-19 negative residents. These deficient practices	4 152		

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4 152	Continued From page 8 facilitated the facility's mismanagement of the COVID-19 outbreak and broken Quality Assurance & Performance Improvement (QAPI) program to mitigate the spread of the COVID-19 virus. The deficient practice resulted in an uncontrolled spread of COVID-19 infection in the facility. There were 77 residents and 37 staff members infected with the COVID-19 virus. Twenty-seven (27) resident deaths were related to the COVID-19 outbreak. Findings include: 1. Surveyor interviewed the Administrator on 10/21/20 at 3:13 PM. The surveyor asked the Administrator to identify the members of the facility's GB and he did not identify them. He was asked to whom he reports, and he replied that he reports to the facility's RVP. He was asked if the RVP was on the GB and he replied that the RVP was his "Boss." a. Surveyor interviewed the Medical Director on 10/26/20 at 08:14 AM by phone and asked about the facility's GB. He was unsure of the facility's GB and said, "Not sure what you mean governing body?" He further said that he is on the regional board of a SC that oversees operations of the facility. b. In a follow up phone interview with the Administrator conducted on 10/28/20 at 10:22 AM, he said that the DON, Medical Directors and himself form the facility's GB with the SC. He further said, "We are not the licensed owner and operator. SC is the governing body and we meet with SC every month." He also said that they have not had a formal GB meeting recently. Surveyor again requested a copy of the GB	4 152		

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4 152	Continued From page 9 organizational chart and the administrator emailed a "Sample Chain of Command/Delegation of Authority Flow Chart" to the surveyor on 10/28/20 at 11:13 AM. It showed the SC "Board of Directors" as overseeing the "Facility Administrator." In a phone interview on 10/29/20 at 10:38 AM with the SC liaison, surveyor asked SC liaison about the "Sample Chain of Command/Delegation of Authority Flow Chart" showing the SC Board of Directors overseeing the Administrator. He stated that SC is not the GB of the facility. He clarified that SC is the owner of the building and is not involved with the facility's operations. SC monitors its management contract with the facility and ensures that the facility is abiding by the Federal and contract requirements. c. On 10/23/20, surveyor conducted a RR of the facility's GB policy which states "The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility." Such as, the facility to failed to provide evidence to mitigate the spread of the COVID-19 virus once the outbreak begun in the facility; there was no documented communication between the administration and GB; and the repeated noncompliance with infection control continued. Due to not knowing who comprises their governing body, the facility failed to have an active oversight of management practices such as, lack in communication between the Administration and the GB regarding the	4 152		

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4 152	Continued From page 10 continued outbreak of COVID-19 and lack of GB's direction, guidance, and input on their COVID-19 policies and procedures. 2. Administrator failed to be responsible for the management of the facility by failing to take appropriate action to mitigate the spread of COVID-19 at the facility as evidenced by: 1. Since his employment which begun in 04/2020, the Administrator did not communicate with the governing body (GB) about the ineffective infection control practices. 2. The Administrator did not conduct timely and ongoing quality assurance performance improvement (QAPI) meetings to address any vulnerabilities identified in the facility's infection control plan and conduct a retrospective evaluation of the plan, which resulted in the continued noncompliance and lack of facility's oversight. These deficient practices resulted in an uncontrolled spread of COVID-19 infection in the facility which begun on 08/20/20. There were 77 residents and 37 staff members infected with the COVID-19 virus. Twenty-seven (27) resident deaths were related to the COVID-19 outbreak. 2a. The survey team interviewed the Administrator and Director of Nursing/Infection Preventionist (DON/IP) on 10/20/20 at 09:17 AM. Surveyor asked the Administrator to describe his role as facility Administrator. He responded that his role is to "manage and delegate to staff that all things are being done." When asked how the Administrator communicates problems or concerns to the GB, he responded that he communicates to the Regional Vice President (RVP). The Administrator did not address the	4 152		

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4 152	Continued From page 11 process for communicating concerns to the GB, (refer F837). When surveyor asked who is on the GB, the Administrator did not respond on membership, and only that the Administrator, Medical Directors, department heads and pharmacy services staff are all on the quality assessment and assurance (QAA) committee. Surveyor interviewed Administrator, DON, RVP, and the two Regional Nurse Consultants (RNCs) on 10/23/20 at 10:30 AM in the Administrator's office. Surveyor asked the Administrator if he attended any of the GB meetings and when was the last time he met with the GB. The Administrator responded, "at the QAPI meeting." The RVP interjected, that he (the Administrator) has not met with the GB since the pandemic started and he started working at the facility in April 2020. The RVP validated the Administrator has not had any involvement with the GB nor did he identify the members of the GB. Surveyor interviewed the Administrator via phone call on 10/28/20 at 10:22 AM to follow up on the previous interview with him on 10/21/20 with questions about his involvement with the GB. When asked to identify the members of the GB he provided an organizational chart that the surveyors previously asked for but had not received. Administrator replied that the "GB is me, the DON and the two Medical directors. We are not the licensed owner and operator." Surveyor reviewed the organizational chart, "Sample Chain of Command/Delegation of Authority Flow Chart," that was provided by email on 10/28/20 at 11:13 AM. At the top is the state corporation (SC), directly under them is the facility administrator, directly under him is the director of nursing then the assistant Director of	4 152		

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4 152	Continued From page 12 Nursing/Infection Preventionist, (refer F837). In a phone interview on 10/29/20 at 10:38 AM with the SC liaison between SC and the facility, liaison stated that SC is not the GB of the facility. He clarified that SC is the owner of the building and is not involved with the facility's operations. SC monitors its management contract with the facility and ensures that the facility is abiding by the Federal and its contract requirements (refer F837). On 10/26/20, surveyor reviewed the Administrator's Job Description. Job title; Administrator. Job summary states: "To act as the representative of the governing body of the nursing facility for internal management, and to be responsible for the efficient administration of all activities, subject to the policies, procedures and orders of the governing body." Essential Duties and Responsibilities: "Ensures that each resident receives the necessary nursing, medical and psychological services to attain and maintain the highest possible mental and physical functional status." On 10/23/20, surveyor requested records or evidence of meetings with the GB or medical directors, such as meeting dates, email's that show agenda, action plan, meeting minutes, or outcome of any meetings. The facility failed to provide any evidence of meetings. 2b. Surveyor interviewed the Administrator on 10/21/20 at 3:13 PM. When asked how the Administrator prioritizes the issues and concerns that are brought to his attention, he replied that he could talk to the DON, and together prioritize the concerns and bring them to the QAPI	4 152		

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4 152	Continued From page 13 meeting. The facility failed to provide evidence of QAPI meetings after several requests were made. Surveyor asked if the facility identified any vulnerabilities since the beginning of the COVID-19 outbreak that would help mitigate the spread of COVID-19 in the facility. The Administrator replied that information would be in the QAPI, then stated that the information in the QAPI won't be shared with the survey team. He stated that those vulnerabilities were identified, they made those changes and went with the most current guidelines. Administrator refused to provide documentation of the QAPI plan or meeting minutes to show there were vulnerabilities identified and strategies implemented to mitigate the spread COVID-19, (refer F867). On 10/28/20 surveyor reviewed the QAPI Program, Analysis and Committee Membership policy revision dated 08/2018. "The facility will develop a program that describes the process for conducting QAPI activities... such as identifying and correcting quality deficiencies...which will lead to improvement in the lives of residents, through continuous attention to quality of care, quality of life, and resident safety...2. the GB and/ or executive leadership is responsible and accountable for the process that addresses systems of clinical care, management practices, quality of life." 3. The facility allowed screened staff and visitors to enter the facility with questions that were answered correctly; but the facility failed to follow up as the form/P&P required. One surveyor and facility staff screening forms indicated a "Yes" answer to the screening question "Did any facility/ location you visited have recognized	4 152		

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	125058	A. BUILDING: _____ B. WING _____	C 10/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YUKIO OKUTSU STATE VETERANS HOME	1180 WAIANUENUE AVENUE HILO, HI 96720

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4 152	Continued From page 14 COVID-19 cases", that should prompt the screener to contact the director of nursing (DON) and acting infection preventionist (IP) for further evaluation of the visitor/ staff entering the facility. The screener failed to call the DON to evaluate the staff/ visitor in question. Also, the facility placed two residents who were persons under investigation (PUI) for COVID-19 and placed on droplet precautions on the same wing with 10 COVID-19 negative residents. Additionally, the same direct care staff were caring for both PUI/negative residents. No education was provided to the resident or their family for the risk versus benefit of moving or staying on the unit with the negative residents. Furthermore, the facility did not establish/implement an effective surveillance plan based on a facility assessment for identifying, tracking, and monitoring staff and residents with COVID-19. a. Surveyor entered the screening station at the facility entrance on 10/20/20 at approximately 08:25 AM and proceeded to be screened. The screener began to ask the screening questions. When asked the question "Did any facility/ location you visited have recognized COVID-19 cases yes or no?" Surveyor answered "Yes". The screener looked up at the surveyor and continued to ask the remaining questions. Screener checked the surveyor's temperature, gave a sticker that indicates the person passed the screening and allowed the surveyor to pass the station into the facility. At no time was the surveyor asked to wait to enter the facility until the director of nursing (DON) was called. Survey team interviewed the screener on 10/20/20 at 11:45 AM. She was asked about the screening process, hand hygiene, the "Yes"	4 152		

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4 152	Continued From page 15 answer to one of the questions on the screening document, and what to do when this occurs. She responded, "For a yes answer, the director of nursing is notified." Survey team mentioned that one of the surveyors had a "Yes" answer, was not seen by the DON, but allowed to come into the building. On 10/20/20, the survey team received and reviewed 43 forms and out of 43, there were seven (Yes) responses to the question that were not referred to the DON for follow up. Survey team met with the DON (and acting as Infection Preventionist) on 10/20/20 at 09:14 AM to discuss the abatement plan for the IJ #1. The DON was discussing the screening tool and stated that she is to be notified if any of the screening questions are answered with a "yes" and that she is on call 24/7. In the event the DON is not available, the managers are the back up and will be called in the event there is a "yes" during the screening of staff and visitors to the facility. The DON stated that she was not contacted by the screener regarding any questionable answers that day. Surveyor reviewed the facility's IJ #1 removal plan update 10/20/20 "Screening tool will be updated to reflect any "y" answers are reported to DON/designee." Surveyor reviewed the Healthcare management Clinical systems COVID-19 policy dated 09/09/20. "Everyone entering the facility will be screened according to centers for disease control and prevention (CDC) guidelines. Entry into the facility will be in accordance with CDC Guidelines." Page 2. "Screen and Triage Everyone entering a healthcare facility for signs	4 152		

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4 152	Continued From page 16 and symptoms of COVID-19 ...although screening for symptoms will not identify asymptomatic or pre-symptomatic individuals with SARS-Cov-2 infection, symptom screening remains an important strategy to identify those who could have COVID - 19 so appropriate precautions can be implemented." b. Surveyor toured the second-floor resident rooms which housed the COVID-19 recovered residents and 10 COVID-19 negative residents. During the tour, surveyor observed room 239, and noted a droplet precautions sign on the outside of the room with a personal protective equipment (PPE) cart next to the door. Observed occupational therapist (OT)1 donning a PPE gown preparing to enter the room. When surveyor asked why the resident in room 239 was on droplet precautions, OT1 replied, "This resident went out of the facility for a chest X-ray and returned to the facility and the resident is now on isolation precautions for 14 days." Surveyor observed a second room, 238 with droplet precautions sign on the door and a PPE cart next to the room. Queried RN5 if the resident in that room is on droplet precautions and replied yes, the resident went out of the facility for a procedure and when he came back was placed in isolation precautions for 14 days. Queried RN5 if the other residents on this wing were COVID-19 recovered or COVID negative? RN5 stated that there are 10 COVID-19 negative residents on this wing with the two residents who are on droplet precautions. On 10/26/20, surveyor reviewed the facility Health Care Management Clinical systems COVID-19 policy dated 09/09/20. "The facility will	4 152		

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4 152	Continued From page 17 isolate symptomatic patients ... Place patients with suspected or confirmed COVID-19 symptoms." The policy did not state how residents who go out of the facility for appointments and return to the facility will be isolated or cohorted. On 10/26/20, surveyor reviewed the COVID-19 Long-Term Care Facility Guidance dated April 2, 2020. "Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not or have an unknown status. To this end, long-term care facilities should work with State and local community leaders to identify and designate facilities dedicated to patients and residents with known COVID-19-positive and those with suspected COVID-19, ensuring they are separate from patients and residents who are COVID-19-negative." On 10/26/20, surveyor reviewed the American Healthcare Association (AHA) Cohorting guidance on residents to limit the spread of COVID-19, dated April 4, 2020. "To ensure transparency and comfort, it is absolutely necessary to have clear communication with residents and families explaining the rationale for cohorting (minimizing exposure risk) and need for transfer or a move to another location in the building." Surveyor interviewed the facility Social Worker (SW)1 on 10/23/29 at 09:50 AM. SW1 stated part of her role includes calling families to report the positive test result and or when a need to change rooms occurs. SW1 explained that when she made the calls to R11 and R12's families on 10/20/20, she explained that the state is asking	4 152		

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4 152	Continued From page 18 them to move to different rooms. "R12's wife adamantly refused, although I was able to talk her into it." SW1 stated when she talked to R11's son, "He was hot, he adamantly refused to move him." SW1 let him know that she would do her best to advocate to not having R11 move. When asked if at any time there was education for the resident or family that they were possibly affecting others by staying in their room, SW1 stated "No, I defer any education that needs to be provided to the residents to the nursing staff." SW1 did not provide encouragement for the move to the resident to move to another room. Surveyor interviewed the Nurse Manager (NM) on 2nd floor on 10/23/20 at 11:00 AM to question the process for providing rationale to a resident who may need to change rooms due to an unknown or positive COVID-19 test result, specifically, does the nurse provide the risk versus benefit of moving to the resident and their family? the NM stated it is always the SW who calls the family when a resident needs to change rooms. The facility informed the residents of the need to change rooms because the state said they needed to move, which angered the residents families instead of offering a rationale for moving them to another room to prevent the risk of infecting other COVID-19 negative residents who resided on the same unit. c. An interview was conducted with the DON on 10/22/20 at 2:15 PM about infection control. Surveyor asked why the "Monthly Infection Surveillance Report (MISR)" did not include all the infections known in the facility during August 2020 and September 2020. The DON responded, "That would be our normal monthly surveillance we do every month for antibiotic stewardship, we	4 152		

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4 152	Continued From page 19 were keeping track of our COVIDs with the line listing." Surveyor reviewed the MISR on 10/22/20. The report showed an incomplete recording of the infections in the facility. The 46 positive COVID-19 cases in August 2020 and the 25 positive cases in September were not included in the monthly report. Since the positive cases of COVID-19 were not included in the monthly surveillance report the positivity rate was not reflected correctly. The surveillance record reflected a 2.96 positivity rate in August 2020 and for September 2020 it was 5.23. When the DON combined all the infections in the facility, the positivity rate for August 2020 was 19.95 and September was 18.32.	4 152		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the protection of its 10 COVID-19 negative residents as evidenced by the following: 1. The facility allowed screened staff and visitors to enter the facility with questions that were answered correctly; but the facility failed to follow up as the form/P&P required. One surveyor and	4 203		

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4 203	Continued From page 20 facility staff screening forms indicated a "Yes" answer to the screening question "Did any facility/ location you visited have recognized COVID-19 cases", that should prompt the screener to contact the director of nursing (DON) and acting infection preventionist (IP) for further evaluation of the visitor/ staff entering the facility. The screener failed to call the DON to evaluate the staff/ visitor in question. 2. The facility placed two residents who were persons under investigation (PUI) for COVID-19 and placed on droplet precautions on the same wing with 10 COVID-19 negative residents. Additionally, the same direct care staff were caring for both PUI/negative residents. No education was provided to the resident or their family for the risk versus benefit of moving or staying on the unit with the negative residents. 3. The facility did not establish/implement an effective surveillance plan based on a facility assessment for identifying, tracking, and monitoring staff and residents with COVID-19. The deficient practices placed the COVID-19 negative residents at risk for contracting the COVID-19 infection. There were 77 residents and 37 staff members infected with the COVID-19 virus. Twenty-seven (27) resident deaths were related to the COVID-19 outbreak which begun on August 20, 2020. Findings include: 1. Surveyor entered the screening station at the facility entrance on 10/20/20 at approximately 08:25 AM and proceeded to be screened. The screener began to ask the screening questions.	4 203		

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4 203	Continued From page 21 When asked the question "Did any facility/ location you visited have recognized COVID-19 cases yes or no?" Surveyor answered "Yes". The screener looked up at the surveyor and continued to ask the remaining questions. Screener checked the surveyor's temperature, gave a sticker that indicates the person passed the screening and allowed the surveyor to pass the station into the facility. At no time was the surveyor asked to wait to enter the facility until the director of nursing (DON) was called. Survey team interviewed the screener on 10/20/20 at 11:45 AM. She was asked about the screening process, hand hygiene, the "Yes" answer to one of the questions on the screening document, and what to do when this occurs. She responded, "For a yes answer, the director of nursing is notified." Survey team mentioned that one of the surveyors had a "Yes" answer, was not seen by the DON, but allowed to come into the building. On 10/20/20, the survey team received and reviewed 43 forms and out of 43, there were seven (Yes) responses to the question that were not referred to the DON for follow up. Survey team met with the DON (and acting as Infection Preventionist) on 10/20/20 at 09:14 AM to discuss the abatement plan for the IJ #1. The DON was discussing the screening tool and stated that she is to be notified if any of the screening questions are answered with a "yes" and that she is on call 24/7. In the event the DON is not available, the managers are the back up and will be called in the event there is a "yes" during the screening of staff and visitors to the facility. The DON stated that she was not	4 203		

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4 203	Continued From page 22 contacted by the screener regarding any questionable answers that day. Surveyor reviewed the facility's IJ #1 removal plan update 10/20/20 "Screening tool will be updated to reflect any "y" answers are reported to DON/designee." Surveyor reviewed the Healthcare management Clinical systems COVID-19 policy dated 09/09/20. "Everyone entering the facility will be screened according to centers for disease control and prevention (CDC) guidelines. Entry into the facility will be in accordance with CDC Guidelines." Page 2. "Screen and Triage Everyone entering a healthcare facility for signs and symptoms of COVID-19 ...although screening for symptoms will not identify asymptomatic or pre-symptomatic individuals with SARS-Cov-2 infection, symptom screening remains an important strategy to identify those who could have COVID - 19 so appropriate precautions can be implemented." 2. Surveyor toured the second-floor resident rooms which housed the COVID-19 recovered residents and 10 COVID-19 negative residents. During the tour, surveyor observed room 239, and noted a droplet precautions sign on the outside of the room with a personal protective equipment (PPE) cart next to the door. Observed occupational therapist (OT)1 donning a PPE gown preparing to enter the room. When surveyor asked why the resident in room 239 was on droplet precautions, OT1 replied, "This resident went out of the facility for a chest X-ray and returned to the facility and the resident is now on isolation precautions for 14 days." Surveyor observed a second room, 238 with	4 203		

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4 203	Continued From page 23 droplet precautions sign on the door and a PPE cart next to the room. Queried RN5 if the resident in that room is on droplet precautions and replied yes, the resident went out of the facility for a procedure and when he came back was placed in isolation precautions for 14 days. Queried RN5 if the other residents on this wing were COVID-19 recovered or COVID negative? RN5 stated that there are 10 COVID-19 negative residents on this wing with the two residents who are on droplet precautions. On 10/26/20, surveyor reviewed the facility Health Care Management Clinical systems COVID-19 policy dated 09/09/20. "The facility will isolate symptomatic patients ... Place patients with suspected or confirmed COVID-19 symptoms." The policy did not state how residents who go out of the facility for appointments and return to the facility will be isolated or cohorted. On 10/26/20, surveyor reviewed the COVID-19 Long-Term Care Facility Guidance dated April 2, 2020. "Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not or have an unknown status. To this end, long-term care facilities should work with State and local community leaders to identify and designate facilities dedicated to patients and residents with known COVID-19-positive and those with suspected COVID-19, ensuring they are separate from patients and residents who are COVID-19-negative." On 10/26/20, surveyor reviewed the American Healthcare Association (AHA) Cohorting guidance on residents to limit the spread of	4 203		

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4 203	Continued From page 24 COVID-19, dated April 4, 2020. "To ensure transparency and comfort, it is absolutely necessary to have clear communication with residents and families explaining the rationale for cohorting (minimizing exposure risk) and need for transfer or a move to another location in the building." Surveyor interviewed the facility Social Worker (SW)1 on 10/23/29 at 09:50 AM. SW1 stated part of her role includes calling families to report the positive test result and or when a need to change rooms occurs. SW1 explained that when she made the calls to R11 and R12's families on 10/20/20, she explained that the state is asking them to move to different rooms. "R12's wife adamantly refused, although I was able to talk her into it." SW1 stated when she talked to R11's son, "He was hot, he adamantly refused to move him." SW1 let him know that she would do her best to advocate to not having R11 move. When asked if at any time there was education for the resident or family that they were possibly affecting others by staying in their room, SW1 stated "No, I defer any education that needs to be provided to the residents to the nursing staff." SW1 did not provide encouragement for the move to the resident to move to another room. Surveyor interviewed the Nurse Manager (NM) on 2nd floor on 10/23/20 at 11:00 AM to question the process for providing rationale to a resident who may need to change rooms due to an unknown or positive COVID-19 test result, specifically, does the nurse provide the risk versus benefit of moving to the resident and their family? the NM stated it is always the SW who calls the family when a resident needs to change rooms. The facility informed the residents of the	4 203		

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4 203	Continued From page 25 need to change rooms because the state said they needed to move, which angered the residents families instead of offering a rationale for moving them to another room to prevent the risk of infecting other COVID-19 negative residents who resided on the same unit. 3. An interview was conducted with the DON on 10/22/20 at 2:15 PM about infection control. Surveyor asked why the "Monthly Infection Surveillance Report (MISR)" did not include all the infections known in the facility during August 2020 and September 2020. The DON responded, "That would be our normal monthly surveillance we do every month for antibiotic stewardship, we were keeping track of our COVIDs with the line listing." Surveyor reviewed the MISR on 10/22/20. The report showed an incomplete recording of the infections in the facility. The 46 positive COVID-19 cases in August 2020 and the 25 positive cases in September were not included in the monthly report. Since the positive cases of COVID-19 were not included in the monthly surveillance report the positivity rate was not reflected correctly. The surveillance record reflected a 2.96 positivity rate in August 2020 and for September 2020 it was 5.23. When the DON combined all the infections in the facility, the positivity rate for August 2020 was 19.95 and September was 18.32.	4 203		