STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	1/27/2022

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SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for a re-visit survey on 1/27/22. Census=145	F0000		
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received bathing/showers as ordered and ensure incontinence care was completed in a timely manner for two (R801 and R817) out of five residents reviewed for Activities of Daily Living (ADL). Findings include: R801 On 1/24/22 at approximately 10:32 AM, R801 was observed lying in bed in a gown. The resident was alert and was asked questions pertaining to ADLs. The resident reported that they were not getting showers on a regular basis and often would have to wait for long periods of time to get help changing their brief. R801 noted that they had voiced their concerns, but often would not get timely assistance. A review of R801's clinical record noted the resident was admitted to the facility on 12/5/21 with diagnoses that included, in part: Type II diabetes, hemiplegia, kidney transplant and acute	F0677	Residents #801 was discharged from the facility on 2/2/2022. Resident #817 was provided a bath/shower per schedule and incontinence care. All residents have the potential to be affected. An audit was completed to ensure residents are receiving baths/showers as scheduled and timely incontinence care. All residents who reside in the facility are at risk for a similar occurrence. Like residents have been visually assessed to determine if additional ADL care was needed, additional ADL care was provided to any residents requiring it. The master shower schedule has been entered into the electronic medical record so that missed showers will trigger on the dashboard and can be reviewed daily to ensure that the process and system is being followed to prevent recurrence. By 2/21/2022, CNAs and licensed nurses will be educated on providing toileting and ADL cares, and documentation of ADL care to ensure that the policy is being followed for continued compliance. Facility DON/designee will be providing focused oversight, observation, and guidance to the nursing staff to follow the facility policy to ensure that the inservices on incontinence care and showers are being followed as	12/6/2021

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

Electronically Signed | 02/16/2022

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	respiratory failure. The resident's Minimum Data Set (MDS) revealed R801 had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact) and required extensive one to two person assist for most ADLs. R801's care plan for ADLs documented, in part, "The resident prefers showers and requires assistance by 1 staff twice a week and as necessary. If refuse offer bed bath." (Initiated 12/7/21). A review of the shower/bath record for the past 30 days showed the resident was to receive weekly showers on Monday and Thursdays on the afternoon unit, as well as PRN (as needed). Electronic notes as well as paper Skin Observation and Shower sheets showed the resident received showers on the following dates: 12/30/21, 1/5/22, 1/11/22, 1/19/22 and 1/22/22, which accounted for only 5 of the eight showers R801 should have recieved in this time span. A facility "Grievance and Satisfaction Form" (dated 12-16-21) documented, in part, "Name (R801)... (name redacted) voiced the concern of the resident (R801) being left in a soiled brief for a long period of time and then having to push off therapy until cleaned up...". R817 On 1/24/22 at approximately 10:30 AM, R817 was observed lying in bed with a gown on. The resident was alert and able to answer questions asked. R817 reported that they were sitting in a wet brief and had been for several hours and indicated over the past weekend they waited almost 10 hours to be changed. R817 reported that staff take forever to respond to call light request and noted that they were not receiving their showers twice per week. They further stated		scheduled/needed. The DON/designee will conduct random ADL and toileting audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure adherence to the ADL Care & Toileting Policy. The results of ADL and toileting audit By 2/21/2022, nursing staff will be educated by the DON/designee on ensuring residents are receiving showers per shower schedule and timely incontinence care. DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained by ensuring all residents are receiving baths/showers per shower schedule and timely incontinence care. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator and DON will be responsible for assuring substantial compliance is attained through this plan of correction by 2/21/2022 and for sustained compliance thereafter.	

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	it was hard to get them out of bed as there was not wheelchair in their room. A review of R817's clinical record was conducted and revealed they were re-admitted to the facility on 5/11/21 with diagnoses that included, in part: hemiplegia, generalized anxiety disorder and chronic kidney disease. A review of R817's most recent MDS assessment indicated the resident was cognitively intact and required extensive one to two person assist for most ADLs. An electronic and paper review of showers/bed baths provided to R817 the past 30 days revealed the resident was to receive showers on Wednesdays and Saturdays. Electronic records indicated showers/bed baths given on 1/10/22 and 1/17/22. Paper Skin Observation Shower sheets indicated the resident had received showers on 1/13/22 and 1/21/22, which accounted for only 4 of the eight showers R817 should have recieved in this time span. On 1/26/22 at approximately 12:10 PM, an interview was conducted with the Administrator. The Administrator was queried about staffing and the possible impact on residents, including R801 and R817. The Administrator confirmed that staffing has been a problem and thus impedes on resident's getting timely and needed care, including brief changes and showers. A facility policy titled Nursing Clinical (Adopted 7/11/18) documented, in part: "...Subject: Bath Shower...Policy: it is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation...".			
F0867 SS= F	QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F0867	No specific residents were identified in 2567. All residents have the potential to be affected.	2/21/2022

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	(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement effective plans of action to correct identified quality deficiencies related to infection control, COVID-19 testing, and activities of daily living (ADLs) resulting in the continuation of deficient practices. This had the potential to affect all residents who resided in the facility. Findings include: On 1/24/22 through 1/27/22, a revisit survey was conducted to determine compliance with deficiencies identified during an abbreviated survey conducted on 11/4/21. According to a CMS (Center for Medicare and Medicaid) 2567 form dated 11/4/21, the facility was found to be noncompliant with regulatory requirements related to infection control, COVID-19 testing, and ADLs. Review of the facility's Plan of Correction (POC) with an alleged compliance date of 12/6/21 revealed the facility would do the following to correct the deficient practice related to the failure to properly use Personal Protective Equipment (PPE) for residents on transmission based precautions: "...The DON (Director of Nursing)/designee will conduct random audits on 5 staff members weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure proper infection control practices are being followed by staff related to hand hygiene, donning/doffing PPE, and wearing full PPE including a NIOSH approved N95 or equivalent or higher level		By 2/21/2022, the Regional Director of Operations and Regional Nurse Consultant completed an in-service with the facility Quality Assessment and Assurance (QA&A) Committee regarding an effective QA&A Committee and Process which included but was not limited to a QAPI Overview, Perceptions of Quality, Six Step Process, Data Collection, Root Cause Analysis, Outcomes, Leadership Oversight, Quality Assessment and Assurance Committee (Purpose, Membership, Roles, Expectations of the Committee, communication, Confidentiality of the Committee, Conducting a Meeting, Monthly Meeting, QA&A Committee Meeting Minutes, QAA Subcommittee, Subcommittee Planning and Development, QA&A AD HOC Committee, Celebrate Success,) Quality Assurance Performance Improvement, QAPI Annual Reporting Schedule, Quality Assurance Performance Improvement Action Plan, Quality Assurance Summary Report and Federal Regulatory Groups for Long Term Care Facilities. The QA&A Program guidelines will be followed to address identified facility issues. Oversight will be provided by Regional Director of Operations and Regional Nurse Consultant monthly for 3 monthly to ensure the implementation of the revised QA&A Program and the QA&A Committee□s performance in identifying and addressing compliance issues to ensure that effective plans of actions to correct identified quality deficiencies are corrected and maintained. Any discrepancies identified in the audits will be documented, investigated, and corrected immediately by Administrator.	

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	respirator, eye protection (eye goggles or a face shield that covers the front and sides of the face, gloves and gown use specifically to residents with Transmission Based Precautions. The results will be presented to the QAA (Quality Assurance and Assessment) committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 12/6/21 and for sustained compliance thereafter." The facility's POC documented the following would be done to correct the deficient practice related to the failure to COVID-19 testing according to current guidelines: "..The DON/designee will conduct random audits on 5 staff weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the facility conducts COVID 19 test per the CMS guidelines and documents the test accordingly. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 12/6/2021 and for sustained compliance thereafter." The facility's POC documented the following would be done to correct the deficient practice related to the failure to ensure residents were provided showers and/or baths on a regular basis: "..The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained by ensuring all residents are receiving showers as preferred and per shower schedule. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring		As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. If trends or discrepancies are noted this QA&A process will be revised by the QA&A Committee. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 2/21/2022 and for sustained compliance thereafter.	

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	substantial compliance is attained through this plan of correction by 12/6/2021 and for sustained compliance thereafter." On 1/27/22, it was identified by observations, interview and record review that the facility was not in compliance with infection control practices, including multiple staff not wearing masks that covered their mouth and nose, staff reheating food items brought from a room of a resident on transmission based precautions in a microwave used by the general population of the facility, and staff not wearing the proper PPE for a resident on transmission based precautions due to exposure to COVID-19. It was also identified that two staff members reviewed for COVID-19 testing were not tested according to the facility's outbreak testing protocol (all staff regardless of vaccination status were tested two times per week according to the Regional Nurse Consultant (RNC "A) who was covering for the Infection Control Preventionist.(ICP "H"). Review of the facility provided material related to their POC revealed random audits were conducted. However, no deficiencies were identified according to what was documented. On 1/24/22 at 12:17 PM, the Regional Nurse Consultant (RNC) "A" was interviewed. RNC "A" was appointed to act in place of the DON who was out of the facility at that time and unavailable for interview. At that time, RNC "A" was asked who was responsible for auditing staff for proper infection control procedures and RNC "A" was not sure. On 1/27/22 at 2:13 PM, the Administrator was interviewed. When queried about any concerns identified through audits that were brought to the QAA committee, the Administrator reported there were several clinical staff members that were not			

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	working the day of the last QA meeting and therefore they went through the QA process with the exception of the clinical care areas. The Administrator reported he was not aware there were concerns with infection control practices, COVID-19, or ADLs and that nothing was brought forth through the QA process. On 1/27/22 at 3:00 PM, an interview with the DON was conducted. When queried about who was responsible for conducting audits and ensuring the facility was in compliance with infection control procedures such as PPE use and following transmission based precautions, as well as ensuring staff were being testing according to the current guidance, the DON reported the Infection Control Preventionist (ICP) was conducting audits for infection control and monitoring for COVID testing and managers were conducting rounds to ensure staff were wearing proper PPE. The DON reported they did not identify any concerns with either area. When queried about any concerns identified with showers, the DON reported they were not aware there were any concerns with showers. Review of a facility policy titled, "Quality Assessment & Assurance Program" revised on 9/18/19 revealed, in part, the following: "Quality Assurance is a continuous process toward quality management...The Quality Assessment and Assurance (QAA) Committee provides leadership and guidance for ongoing continuous quality and performance improvement...The process provides a structured methodology to analyze the problem, strategize possible solutions, determine actions required, develop plans, implement approaches, and evaluate effectiveness...The six-step process analysis cycle includes the following steps:...Gather and review date...Determine any issue...Discuss potential solutions...Determine priorities and goals...Implement changes...Evaluate			

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	outcome...OUTCOMES...When a QAPI Action Plan is final, audits are completed to monitor for continued compliance. Audits are evaluated and trends identified by the project champion or committee chair prior to the QAA meeting...Quality Assurance and Performance Improvement is facilitated through leadership oversight..."			
F0880 SS= E	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but	F0880	Resident #809 was discharged from the facility on 2/3/2022. Resident #818 was discharged from the facility on 1/26/2022. All facility residents have the potential to be affected. By 2/21/2022, All Staff will be educated on the Guidance- COVID-19 Core Practices policy as it relates to proper use of PPE and infection control practices for residents in isolation. Education will specifically include proper handling of food/beverages in isolation area, hand hygiene, properly wearing N95 to cover nose and mouth, donning/doffing PPE, staff wearing full PPE including a NIOSH approved N95 or equivalent or higher-level respirator, eye protection (eye goggles or a face shield that covers the front and sides of the face), gloves and gown use specifically to residents with Transmission Based Precautions. Director of Nursing/designee will conduct random audits on 5 residents on Transmission Based Precaution weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance for infection control practices has been maintained to ensure proper protocol are followed in regards to wearing proper use of Personal Protective Equipment (PPE), hand hygiene and food handling for residents on transmission based precautions.	12/6/2021

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	not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure infection control practices in accordance with the Centers for Disease Control (CDC) protocol were followed, in regard to the proper usage of Personal Protective Equipment (PPE) for residents on transmission based precautions and to prevent the spread of COVID-19. This involved residents R809 and R818 and has the potential to affect all residents who reside in the facility. Findings include: On 1/24/22 at 8:10 AM, during an entrance conference with the Administrator, it was		The results will be presented to the QAA committee for review and consideration of further corrective actions and maintaining a clean urinary drainage system. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 2/21/2022 and for sustained compliance thereafter. Directed Plan of Correction: Directed Plan of Correction- Infection Control Consultant Infection control consultant responsibilities must include, but are not limited to, the following: " Exercise independent judgement in the performance of all duties under the consultant contract. " Meet the independent judgement requirement if the consultant is not presently, and has not within a five (5) year period immediately preceding June 1, 2020, directly or indirectly affiliated with the facility, facility's owner(s), agent(s), or employee(s). " Have completed infection prevention and control training from a recognized source, such as the Centers for Disease Control and Prevention or American Health Care Association. " Will be contracted to work with the facility for a minimum of three (3) months of which must include onsite facility hours. " Assist the facility in completing the CMS infection control self-assessment. If this assessment was completed prior to the June 4, 2020 survey, the assessment should be reviewed to determine if it is an accurate reflection of the facility□s infection control program. The self-assessment can be found	

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	explained by the Administrator that there were currently five residents positive for COVID-19 who resided in the building and were placed on the COVID-19 unit. The Administrator further reported there was an observation unit for residents who were unvaccinated and who were readmitted or newly admitted from the hospital. To enter the observation unit, the Administrator explained that an N95 respirator mask, gown, gloves and goggles or a face shield were required to enter each residents room and should be removed prior to exiting the room. It was further explained by the Administrator that a surgical mask was required covering the mouth and nose in all other areas of the facility. When queried about who the Infection Control Preventionist was, the Administrator reported it was Nurse "H", but she was not in the facility. The Administrator also reported the Director of Nursing (DON) was out and not available for interview and that Regional Nurse Consultant (RNC) "A" would cover for both of them. On 1/24/22 at approximately 9:00 AM, an interview was conducted with RNC "A". When queried about the facility's current COVID-19 status, RNC "A" reported the facility was currently in "outbreak status" with five residents in the facility who were positive for COVID-19. RNC "A" reported if a resident tested positive for COVID-19, they were isolated on transmission based precautions on the designated COVID-19 unit. If a resident was unvaccinated against COVID-19 and exposed to the virus, they would be placed on transmission based precautions regardless of signs and symptoms. Review of R818's clinical record revealed R818 was admitted into the facility on 1/11/22 with diagnoses that included: urinary tract infection, and chronic obstructive pulmonary disease. Review of physician's orders revealed R818 had an order for "droplet precautions" beginning on		at the following link: https://www.cms.gov/files/document/qso-20-20-all.pdf " Review all relevant facility infection control policies and procedures and make recommendations for revisions based on the RCA. " Work with the facility□s Quality Assessment and Assurance (QAA) Committee to conduct a Root Cause Analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop an intervention or corrective action plan to prevent recurrence, as a part of the Quality Assurance and Performance Improvement (QAPI) program. Information about how to perform RCA can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf " The QAA Committee must report the results of RCA and the plans for corrective action to the Governing Body. " The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies may be helpful at completing the RCA and can be found at https://qioprogram.org/covid-19. The facility□s Infection Preventionist, Quality Assessment and Assurance (QAA) Committee must conduct Root Cause Analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop an intervention or corrective action plan to prevent recurrence, as a part of the Quality Assurance and Performance Improvement (QAPI) program. Information about how to	

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	1/12/22 "for COVID 19 observation monitoring for 14 days". During an observation on 1/24/22 at 10:54 AM Certified Nursing Assistant (CNA) "E" was observed to enter R818's room wearing an N95 mask, face shield, gown, and gloves. CNA "E" exited R818's room not wearing the gown and gloves but carrying a Styrofoam food container and a Styrofoam cup with a lid. No hand hygiene was performed as CNA "E" was carrying the container and cup. CNA "E" proceeded to open the double doors and exited the observation unit and then exited out the closed double doors that exited into the main hallway. On 1/24/22 at approximately 11:10 AM, CNA "E" was observed to exit the nourishment room that contained a microwave. CNA "E" was carrying a Styrofoam food container and Styrofoam cup with a lid. When queried about the facility's protocols for residents who were on isolation precautions on the observation unit, CNA "E" reported R818 "wouldn't take no for an answer" and insisted that her food and coffee be warmed up. On 1/24/22 at approximately 11:15 AM, RCN "A" was interviewed. When queried about protocols for disposable food containers of residents on isolation for observation of COVID-19 signs and symptoms and whether they should leave the unit uncontained and heated up in the microwave, RCN "A" reported that should not have happened and the microwave would need to be sanitized. On 1/25/22 at 8:59 AM, CNA "B" was observed on the second floor wearing a surgical mask below their nose. On 1/25/22 at 9:00 AM, Registered Nurse (RN)		perform RCA can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf " The QAA Committee must report the results of RCA and the plans for corrective action to the Governing Body. " The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies may be helpful at completing the RCA and can be found at https://qioprogram.org/covid-19. The facility must take immediate action to implement an infection prevention plan consistent with the requirements at 42 CFR ¿ 483.80 that includes corrective action for the affected residents identified in the CMS-2567, identification of other residents that may have been impacted by the noncompliant practices, and implementation of systemic changes. This plan must include but is not limited to implementation of the following: " Staff have the tools and abilities to ensure residents practice appropriate social distancing; " Staff are provided with and use Personal Protective Equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines; " Required staff will receive instruction before they begin their next work shift. The instructions will include demonstration; " The facility will develop a plan for monitoring the progress of the corrective action plan and tracking performance improvement. This plan will include requiring facility supervisors to	

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	"I" was observed wearing a surgical mask underneath their chin which exposed their nose and mouth. On 1/25/22 at 9:26 AM, Housekeeping Staff "L" was observed to enter the second floor from the elevator and walk down the hallway with a surgical mask underneath their chin which exposed their nose and mouth. A review of R809's clinical record documented the resident was admitted to the facility on 12/20/20 with diagnoses that included: schizophrenia-bipolar disease, Type II diabetes. The resident Minimum Data Set was reviewed and noted the resident was cognitively intact. An order dated 1/18/22 noted the resident was to be placed on droplet precautions for 14 days. On 1/25/22 at approximately 11:46 AM, Nurse "N" was observed entering R809's room wearing only a surgical mask. On R809's door were instructions noting the resident was on precautions and that entry into the resident's room required PPE (N95 mask, face shield, gown and gloves) to be worn. Nurse "N" exited the room and was interviewed as to whether R809's was on precautions. Nurse "N" stated the resident was on droplet precautions as they believed the resident had been exposed to a staff member that tested positive for COVID-19. Nurse "N" further stated that they should have worn proper PPE upon entry into the room. On 1/25/22 at approximately 3:00 PM, RNC "A" was interviewed about appropriate use of masks in the facility. RNC "A" reported all staff should wear a mask that covered their nose and mouth. When queried about R809 and what PPE was required to enter their room, RNC "A" reported she would look into it. RNC "A" followed up and reported that R809 was on isolation precautions		conduct scheduled and objective rounds throughout the facility to ensure appropriate infection control procedures are followed. During these round, ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. As a part of the corrective action plan, the facility must provide training to all staff, including the Director of Nursing, Infection Preventionist, all staff that provide direct resident care, as well as staff that enter into resident rooms to provide for dietary needs or to perform therapy, social worker, activities, housekeeping, laundry, or maintenance services, to ensure staff are fully trained on infection prevention and control. The training must cover the following topics, in addition to training needs identified by facility□s completed the RCA: " Nursing Home Infection Preventionist Training Course - https://www.train.org/cdctrain/training_plan/3814 " Targeted COVID-19 Training for Nursing Homes □ https://qsep.cms.gov/ProvidersAndOthers/home.aspx " Sparkling Surfaces - https://youtu.be/t7OH8ORr5Ig " Clean Hands - https://youtu.be/xmYMUly7qiE " Closely Monitor Residents - https://youtu.be/1ZbT1Njv6xA " Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw " Lessons - https://youtu.be/YYTATw9yav4 " Standard Infection Control Practices " Transmission-Based Precautions " Isolation " Hand Hygiene	

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	due to exposure to COVID-19 and N95 mask, face shield, gown, and gloves were required. Review of a facility policy titled, "COVID-19 Core Practices" updated 9/20/21, revealed, in part, the following: "...The facility will implement source control measures and physical distancing measures...Source control refers to use of well-fitting cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing...Staff members will wear well-fitting source control at all times while they are in the facility, including in breakrooms or other spaces where they might encounter co-workers...The facility will ensure proper use, handling and implementation of Personal Protective Equipment...Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an NIOSH approved N95 or equivalent or higher-level respirator, eye protection (eye goggles or a face shield that covers the front and sides of the face), gloves, and gown...Unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative...Residents in quarantine should be placed in a single-person room...Staff members should wear an NIOSH approved N95 or equivalent or higher-level respirator, eye protection (eye goggles or a face shield that covers the front and sides of the face), gloves, and gown..."		" Appropriate use of PPE More trainings and updates are available on the CDC YouTube channel https://www.youtube.com/c/CDC/. Trainings can be completed by staff directly or by train the trainer (Director of Nursing, Infection Preventionist, Medical Director, or Infection Control Consultant). The facility should use training resources made available by the Centers for Disease Control and Prevention or a program developed by well-established centers of geriatric health services education, such as schools of medicine or nursing, centers for aging, and area health education centers with established programs in geriatrics. If the facility employs or contracts staff with limited English proficiency (LEP), the facility will ensure education is provided in a language that the LEP staff member(s) can understand. Upon completion of the training, the facility must validate staff competency using a post-training test.	
F0886 SS= D	COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19.	F0886	All Staff had the potential to be affected. By 2/21/2022, All Staff will be educated on the Guidance- COVID 19 CMS Facility Testing Requirements. The Administrator/Designee	12/6/2021

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	At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health		will review the staff log for COVID 19 test to ensure all staff are tested per the CMS/Facility Testing Requirements Director of Nursing/designee will conduct random audits on 5 staff weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the facility conducts COVID 19 test per the CMS guidelines and documents the test accordingly. The results will be presented to the QAA committee for review and consideration of further corrective actions and maintaining a clean urinary drainage system. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 2/21/2022 and for sustained compliance thereafter.	

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	departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct COVID-19 testing per it's policy and current guidelines for two staff members (Certified Nursing Assistant-CNA "B" and Registered Nurse - RN "J") of five staff reviewed for COVID-19 testing. Findings include: On 1/24/22 at 8:10 AM, during an entrance conference with the Administrator, it was explained by the Administrator that there were currently five residents positive for COVID-19 who resided in the building who were placed on the COVID-19 unit. When queried about who the Infection Control Preventionist was, the Administrator reported it was Nurse "H", but she was not in the facility. The Administrator reported the Director of Nursing (DON) was out and not available for interview and that Regional Nurse Consultant (RNC) "A" would cover for both of them in their absence. On 1/24/22 at approximately 9:00 AM, an interview was conducted with RNC "A". When queried about the facility's current COVID-19 status, RNC "A" reported the facility was currently in "outbreak status" with five residents in the facility who were positive for COVID-19. RNC "A" explained that all staff and residents were tested for COVID-19 twice a week on Tuesdays and Thursdays due to being in outbreak status. are testing days. When queried about individuals that provide care and services in the facility that are contracted through a staffing agency, RNC "A" reported those individuals were required to provide a COVID-19 test taken within			

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	the past 48 hours and if they did not have that, they were required to have a rapid test performed in the facility prior to beginning their shift. A list of five staff members was provided and their test results were requested, including CNA "B" and RN "J" who was a nurse contracted to work at the facility through a staffing agency. Review of CNA "B"'s COVID tests revealed no tests on 12/7/21, 12/9/21, 12/28/21, 12/30/21, and 1/4/22. No test results were provided for RN "J". On 1/25/22 at approximately 3:00 PM, RNC "A" reported they would reach out to the agency to see if they had tests for RN "J", but the facility should have been verifying the tests per protocol. Review of a facility policy titled, "COVID-19 Core Practices" updated 9/20/21 revealed, in part, the following: "...The facility will follow local, state and federal guidance for testing residents, staff members, outside consultant, contractor, volunteer, vendors, students and caregivers who provide care and services to residents on behalf of the facility for SARS-CoV-2- refer to Guidance-COVID19 CMS Facility Testing Requirements A Centers for Medicare & Medicaid Services (CMS) Memorandum- Ref: QSO-20-38-NH (revised 9/10/21) documented in part, " ... Routine testing of unvaccinated staff should be based on the extent of the virus in the community ... Facilities should use their community transmission level ... High (red) ... Minimum testing frequency of unvaccinated staff ... twice a week ..." This Memorandum further states that in response to an outbreak, if the "Testing Trigger: Newly identified COVID 19 positive staff or resident in a facility that can identify close contacts Test all staff, vaccinated and unvaccinated, that had a higher-risk exposure			

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	with a COVID-19 positive individual." Or if the "Testing Trigger: Newly identified COVID19 positive staff or resident in a facility that is unable to identify close contacts Test all staff, vaccinated and unvaccinated, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility)..."			