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	535042	A. BUILDING _____ B. WING _____	C 11/06/2020

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SHEPHERD OF THE VALLEY REHABILITION AND WELLNESS	**60 MAGNOLIA CASPER, WY 82604**

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F 000	INITIAL COMMENTS A complaint survey was conducted by Healthcare Licensing and Surveys from 10/28/20 through 11/6/20. The survey was prompted by complaint intakes WY000003142, WY000003146, and WY000003148. In addition, a COVID-19 focused infection control survey, which included a review of emergency preparedness requirements, was conducted by Healthcare Licensing and Surveys. The following common abbreviations are used throughout this document: CNA: Certified Nurse Aide DON: Director of Nursing Services LPN: Licensed Practical Nurse MDS: Minimum Data Set PPE: Personal Protective Equipment RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to	F 563		11/30/20

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

Electronically Signed | 11/23/2020

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F 563	Continued From page 1 a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: . Based on family and staff interview, review of the facility's infection line listing, medical record review, and review of facility policy and procedures, the facility failed to ensure compassionate care visits were offered to 2 of 6 sample residents (#1, #9) who would have benefitted from such visits. The findings were: 1. Review of the facility infection line listing provided by the assistant administrator on 11/2/20 showed resident #9 tested positive for COVID-19 on 10/26/20. Review of a progress note dated 11/1/20 and timed 1:43 PM showed the resident was placed on comfort care related to declining status and spouse request. Review of a progress note dated 11/3/20 at 11:19 PM showed the resident's spouse was notified the resident had	F 563	1)Identified resident #1 and #9, no longer reside in the facility. 2)Audit completed by Social Services to ensure families are aware that compassion visits may occur within the facility. 3)Education provided by DNS/Designee on 11/11/20 to current staff related to compassion care visits being allowed and offered to families. 4)Social Service Director/Designee will randomly audit residents/families for three months to ensure residents are provided choice in compassion care visits. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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F 563	Continued From page 2	F 563		

passed away. The following concerns were identified:

a. Interview with the resident's spouse on 11/4/20 at 10:54 AM revealed the spouse was able to visit the resident through the window only and was not offered visits inside the facility due to COVID-19 restrictions. Further interview revealed s/he would have entered the facility to visit the resident if it were offered and s/he was provided appropriate PPE to protect him/herself from COVID-19.

b. Interview with the administrator, assistant administrator, and unit manager #1 on 11/5/20 at 1:14 PM revealed the administrator had contacted the resident's spouse and s/he reported a compassionate care visit had not been offered.

2. Review of the facility infection line lisiting provided by the assistant administrator on 11/2/20 showed resident #1 tested positive for COVID-19 on 10/26/20. Review of a progress note dated 10/30/20 and timed 7:41 AM showed the resident was checked hourly related to deteriorating health and had an absence of vital signs at 4:35 AM. The following concerns were identified:

a. Interview with the resident's daughter on 11/6/20 at 10:27 AM revealed she was not able to visit the resident, except through the window, due to COVID-19. Further interview revealed the facility did not offer a compassionate care visit and she did not understand why she couldn't visit the resident inside if she wore protective clothing.

3. Review of the facility policy titled "COVID-19 Policy and Procedure" last revised on 9/26/20 showed "...H. Managing Visitor Access and Movement within the Facility during Community Transmission or Active Outbreak of COVID-19 in

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F 563	Continued From page 3 the Center...2. Restriction of visitation will be implemented by the center for reasonable and clinical safety reasons (i.e., community based spread of COVID-19 is occurring, or the center has an increase rate of symptoms of an influenza-likeillness). a. Restricting means the individual should not be allowed in the facility, except for in certain situations, such as end of life or when a visitor is essential for the resident's emotional well-being and care. Visits will be restricted to the resident's room and proper PPE provided by the center as appropriate..." .	F 563		
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, staff interview, medical record review, and policy and procedure review, the facility failed to ensure residents received care and services to promote wound healing for 1 of 4 sample residents (#10) with non-pressure wounds. The findings were:	F 684	1)Resident #10 is receiving care and services to promote wound healing for non-pressure wound. 2)Audit performed by AED and Nurse Management starting on 11/6/20, of entire facility to check on any wound and/or skin issues of any residents in the facility. 3)Staff educated on wound documentation for residents #10.	11/30/20

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F 684	Continued From page 4 1. Observation on 11/3/20 at 1:50 PM showed resident #10 had wounds located on his/her right wrist and right lower extremity. The resident's right wrist had an area above the palm which had a wound that appeared dark brown or black in color with visible redness to the surrounding tissue. The resident's lower extremity had 3 wounds which appeared dark brown or black near the resident's ankle, mid shin, and calf. RN #1 cleansed the wounds and applied xeroform petroleum based dressings, cut to size, and secured with a gauze wrap. No measurements were obtained during the dressing change. Interview with RN at that time revealed she was unsure how the facility communicated the wound status or treatment effectiveness to the physician. Review of the admission orders dated 9/9/20 and timed 12:09 PM showed the resident had diagnoses which included peripheral vascular disease and s/he was ordered Xeroform gauze for a venous stasis ulcer on his/her right leg. Review of the care plan last revised on 9/18/20 showed the resident had a right lower extremity venous/stasis ulcer and interventions included give pain medication as ordered,elevate legs as much as possible for edema, monitor/document/report signs and symptoms of infection, and provide wound care per physician orders and facility protocol. The following concerns were identified: a. Interview with the resident's physician on 11/5/20 at 3:24 PM revealed the resident was admitted with the lower extremity wounds and had a surgical consult; however, the resident was not a surgical candidate. The physician stated the wounds are slow to heal, she has not been in the facility due to COVID-19, and she monitors the wound status in the electronic medical record. b. Interview with the wound nurse on 11/5/20	F 684	Education done with staff by Asst. ED on 11/11/20, related to importance of wound care and documentation of such, to include wound measurement and treatment of wounds. 4)DNS/Designee will randomly audit wound care and documentation of such for three months. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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F 684	Continued From page 5 at 12:54 PM revealed she has been out with symptoms of COVID-19 and her last day in the facility was 10/23/20. Further interview revealed the nurses on each unit were in charge of monitoring wounds due to cohorting of staff to prevent the spread of the illness. The facility's process for monitoring wounds and treatments is to take a picture of the wound and load it into the electronic medical record which takes measurements of the area and determines if the area has gotten larger or smaller. c. Review of electronic medical record showed no evidence of measurements or routine monitoring of the right wrist or right lower extremity wounds. 2. Review of the policy titled "Skin Integrity" last revised on 5/2019 showed "...6. For skin impairment identified with admission (abrasion, bruise, burn, excoriation, pressure sore, rash, skin tear, surgical wound, etc.), the LN [licensed nurse] completes the following: a. Documents skin impairment that includes measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on Weekly Wound Evaluation. b. Notifies the physician and, if needed, obtains Treatment Order and documents on the Treatment Administration Record (TAR) after order is implemented...d. Evaluates environment, mobility equipment, functional and cognitive ability, medications, and labs to identify interventions to promote healing/resolution of skin impairment. e. Implements interventions and document on the resident's care plan and Care Directive. 7. If skin impairment is noted after admission (in addition to the above steps), the LN :...d. Implements new interventions as needed. Documents on the	F 684		

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F 684	Continued From page 6 resident's care plan and Care Directive...9. Wounds are evaluated weekly by Center clinicians. Arterial, Pressure, Stasis, and Venous Ulcers, significant surgical wounds, and burns are evaluated, measured, and findings documented in the medical record. If a wound condition fails to improve after 2 weeks of treatment or the condition of the wound deteriorates, the Physician and Resident's Representative are notified. If a new treatment is obtained the LN: a. Re-evaluates POC and resident's condition (e.g. off-loading pressure from skin impairment area, nutritional intake, blood sugars, and lab values)...11. Evaluate resident's compliance with POC. When the resident chooses to not have specified treatments or interventions implemented, the Center discusses the following with the resident and documents in the medical record:...h. Update the comprehensive care plan to include resident's choice to decline treatments..."	F 684		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	F 725		11/30/20

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F 725	Continued From page 7 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, medical record review, and review of the facility line listing of infections, the facility failed to provide sufficient staffing to ensure residents received needed care and services. The census was 128. The findings were: 1. Interview with resident #17 on 10/28/20 at 1:30 PM revealed the facility did not have enough staff and bathing had not been completed in over a week. Review of the resident's bathing record dated 10/29/20 showed the resident had a bed bath documented on 10/22/20, no other bathing was documented since that time. Review of the resident's bathing care plan last revised on 12/6/20 showed "I prefer to take a bath at least 2 x [times] weekly..." 2. Interview with resident #12 on 10/28/20 at 1:50 PM revealed the facility did not have enough staff and residents were not getting care such as baths. Review of the resident's bathing record dated 10/29/20 showed the resident had a bath documented on 10/21/20, no other bathing was	F 725	1)No immediate intervention can be done to fix missing ADL documentation for residents #17, #12, #13, #3, and #2. Residents #17, #12, #13, #3, and #2 are being provided sufficient staff to receive the needed cares and services. 2)Audit completed by DNS/Designee to ensure adequate staffing is available to provide resident needs in relation to care plans. 3)Education provide to Nursing/CNA staff by Asst. ED, on 11/25/20. Education was related to adequate staff being provided, to ensure needs of the residents are met. Education provided to nursing leadership regarding appropriate assignments related to meeting goals of residents 4)DNS/Designee will randomly audit for three months to ensure staff is adequate to meet the needs of the residents. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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documented since that time. Review of the resident's bathing care plan last revised on 9/12/20 showed "Bathing/Showering: I would like a shower 1x/week [1 time per week] and as needed..."

3. Interview with resident #13 on 10/28/20 at 1:50 PM revealed s/he "can't get help" because staff were sick with COVID-19 and the facility "needs more staff." Review of the resident's bathing record dated 10/29/20 showed the resident had a bed bath documented on 10/22/20, no other bathing was documented since that time. Review of the resident's ADL care plan last revised on 10/8/20 showed "...I would like a shower twice weekly and as needed."

4. Interview with resident #3 on 11/3/20 at 1:20 PM revealed the facility did not have enough staff, it took a long time to answer call lights, sometimes there were only 2 staff members on the east unit during the day and night, the normal staffing was 3 at night and 4 during the day, and s/he has not received any type of bathing in "2 1/2" weeks. Review of the resident's bathing record dated 10/29/20 showed the resident had a bath documented on 10/20/20, no other bathing was documented since that time. Review of the resident's bathing care plan provided by the facility on 11/3/20 showed "I prefer a shower at least 2 times a week."

5. Review of the bathing record dated 10/29/20 showed resident #2 had a shower on 10/19/20, no other bath was documented since that time. Review of the resident's bathing care plan last revised on 12/22/19 showed "I prefer a shower at least 2 times per week.

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6. Interview with staff member #1 on 10/29/20 at 9:42 AM revealed "a lot" of staff members had to pick up extra shifts because residents and staff were sick with COVID-19 and the decreased staff made it difficult to get things done for the residents.

7. Interview with staff member #2 on 10/29/20 at 9:54 AM revealed staffing was really "short" and the east unit had 2 CNAs on days and night shift to care for 50 residents. Further interview revealed staff were unable to give the residents the care they needed; it was difficult to answer lights and pass meals, showers weren't being done, and staff were unable to give bed baths.

8. Interview with staff member #3 on 10/29/20 at 11:13 AM revealed some staff were taken off the COVID positive unit and sent to the east unit, where there were no positive resident cases, because there was not enough staff. Further interview revealed residents did not receive all the care they need and they did not receive showers.

9. Interview with staff member #4 on 10/29/20 at 3:34 PM revealed the facility did not have enough staff to assist residents, "especially with meals."

10. Interview with staff member #5 on 10/29/20 at 3:40 PM revealed it was "tough" to get care done with staffing because there was not enough people. Further interview revealed the residents needed more help than staff could provide.

11. Interview with staff member #6 on 10/29/20 at 3:49 PM revealed s/he had "major concerns" about staffing because so many people were "out" and the facility was "super short-handed."

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F 725	Continued From page 10 12. Interview with staff member #7 on 10/29/20 at 4:01 PM revealed staffing was a "nightmare" and it was difficult to find people to work. 13. Review of the line list of infections provided by the facility on 10/30/20 showed the facility had 20 staff members who were on quarantine due to positive COVID-19 results which included 5 CNAs, 2 nurses, and 2 medication aides. Further review showed all 9 of those staff members were cleared to return to work on 10/31/20. 14. Interview with the DON and assistant administrator on 10/28/20 at 6:08 PM revealed they did not feel staffing was a concern and the facility could utilize "agency" staff if necessary.	F 725		
F 880 SS=H	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. 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	F 880		11/30/20

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F 880	Continued From page 11 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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	F 880		

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F 880	Continued From page 12 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, resident and staff interview, medical record review, review of the facility infection line listing, policy and procedure review, and review of the Centers for Disease Control (CDC) guidelines, the facility failed to ensure staff who were symptomatic for COVID-19 infection did not work, and further did not ensure appropriate use of PPE and social distancing to protect residents and staff from COVID-19. This pattern of infection control breaches contributed to the continuation of the COVID-19 outbreak at the facility, resulting in harm to residents as COVID-19 infections continued to rise. The census was 128. The findings were: Regarding staff working while symptomatic for COVID-19: 1. Review of the facility's COVID-19 surveillance form dated 10/21/20 showed CNA #1 reported symptoms which included a new headache, sudden loss of taste or smell, and nausea or vomiting. Review of the facility's COVID-19 surveillance form dated 10/22/20 showed the same CNA reported symptoms which included a cough, sore throat, muscle pain, a new headache, sudden loss of taste or smell, nausea or vomiting, diarrhea, and contact with a COVID positive individual in the last 14 days. The following concerns were identified: a. Interview with the employee on 10/29/20 at	F 880	1)C.N.A. #1, LPN #1, C.N.A. #2, LPN #2, were educated that they cannot work with symptoms. Because all of these staff have been positive, there is no immediate corrective action that can be done. Plexiglas barriers were placed in the middle of dining tables in dining rooms. RN #2 immediately educated on PPE and policy of expectations with PPE as well as social distancing. A large X will be utilized on the floor in common areas and dining rooms to help as a visual aid to residents and staff to show what 6 feet distance looks like. 2)Audit performed by AED, on staff symptoms sheets for month of October. Audit will be done daily by IC nurse to ensure staff with multiple symptoms are not working. Abbott machine will now be used which sends a text message to IC nurse and administration anytime someone clocks in and answers yes to any symptom questions. Audit performed by AED on 11/6/20, of entire facility to ensure residents are displaying social distancing and staff are utilizing PPE. 3)Nurse management educated by Asst. ED on 11/11/20, on how to decide if symptoms of staff justify ability to work. Education also included use of rapid test device should employees show symptoms	

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F 880	Continued From page 13 3:49 PM revealed she reported her symptoms to the facility screening staff member and the manager on duty. The CNA revealed she was told since she was not running a fever, she should work. Further interview revealed the CNA had been tested for COVID-19 on 10/20/20 as part of the facility's routine screening and the result was still pending on 10/22/20. The CNA was also tested for COVID-19 on 10/22/20 with a rapid screen, which resulted in a positive result. The sample collected on 10/20/20 also resulted in a positive result on 10/24/20. b. Review of time card data provided by the facility showed the CNA worked for 6 hours and 37 minutes on 10/21/20, and 2 hours and 25 minutes on 10/22/20, despite reporting symptoms of COVID-19. 2. Review of the facility's COVID-19 surveillance form dated 10/19/20 showed LPN #1 reported symptoms which included cough, fever, shortness of breath, sore throat, chills or repeated shaking with chills, and new muscle pain. Further review showed a comment which said "okay by management unit coverage found." Review of the facility's COVID-19 surveillance form dated 10/20/20 showed the same LPN reported symptoms which included cough, sore throat, chill or repeated shaking with chills, new muscle pain, and recent diarrhea. Further review showed a comment which said "ok to work" and was signed by an RN (name illegible).The following concerns were identified: a. Review of the line list of infections provided by the facility on 11/2/20 showed the LPN's last date of work was 10/20/20 and the LPN left with signs and symptoms of COVID. Further review showed the LPN was tested for COVID-19 on 10/20/20 and the facility received the positive	F 880	of any kind. Education done with staff by Asst. ED on 11/11/20, related to importance of and policy on PPE and social distancing. 4)ED/Designee will audit staff check in/symptom sheets daily for three months to ensure staff with multiple symptoms are not working. DNS/Designee will randomly audit common areas and dining rooms to ensure social distancing 3 times per week for three months. Results of initial as well as ongoing audits will be reviewed via the monthly QAPI process with recommendations made as necessary.	

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results on 10/23/20.

b. Review of time card data provided by the facility showed the LPN worked for 12 hourse and 23 minutes on 10/19/20, and 11 hurs and 19 minutes on 10/20/20, despite reporting symptoms of COVID-19.

3. Review of the facility's COVID-19 surveillance form dated 10/18/20 showed LPN #2 reported symptoms which included a cough, new headache, and nausea or vomiting. Further review showed a comment which said "Ok to work per nurse manager." The following concerns were identified:

a. Interview with the LPN on 10/29/20 at 4:01 PM revealed symptoms started on 10/15/20 and she notified the facility's screening staff of symptoms which included nausea, headaches, and cough on 10/18/20. Further interview revealed the screening staff member notified the "on-call" nurse who told the LPN she could work since she didn't have a fever. The LPN revealed she monitored her temperature throughout the shift and when she detected an elevated temperature, the nurse manager obtained the 10/18/20 specimen and sent the LPN home. The following concerns were identified:

b. Review of the line list of infections provided by the facility on 11/2/20 showed the LPN was tested for COVID-19 on 10/18/20 and the facility received the positive result on 10/22/20.

c. Review of time card data provided by the facility showed the LPN worked for 11 hours and 27 minutes on 10/18/20, despite reporting symptoms of COVID-19.

4. Review of the facility's COVID-19 surveillance form dated 10/10/20 showed CNA #2 reported symptoms which included cough, sore throat,

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new headache, and contact with a COVID-19 positive individual. The following concerns were identified:

a. Interview with the CNA on 10/29/20 at 11:13 AM revealed he worked with COVID-19 symptoms for "2 1/2 days" and he reported the symptoms to the nurses as well as the facility screening staff member. Further interview revealed on his second day with symptoms, the facility did not have anyone at the entrance to screen employees and employees screened themselves.

b. Review of the facility's line list of infections provided by the facility on 11/2/20 showed the employee was tested for COVID-19 on 10/11/20 and the facility received the positive result on 10/18/20.

c. Review of the time card data provided by the facility showed the CNA worked 12 hours and 2 minutes on 10/10/20, and 5 hours and 27 minutes on 10/11/20, despite reporting symptoms of COVID-19.

5. Interview with the facility screening staff member on 10/29/20 at 4:10 PM revealed when staff report symptoms they have to step out of the building and are screened by a nurse manager to determine if they can work. Further interview revealed some staff members who report symptoms were allowed to work.

6. Interview with the infection preventionist on 10/29/20 at 4:17 PM revealed anyone reporting symptoms which are not related to a chronic illness should be sent home and should not be allowed to work.

7. Interview with unit manager #1 on 11/2/20 at 5:40 PM revealed staff who reported symptoms

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were sent home for mandatory quarantine if the symptoms were new onset and not chronic. The only staff who worked with COVID-19 symptoms had symptoms which were identified as chronic.

8. Interview with the wound nurse on 11/5/20 at 12:54 PM revealed when staff members report symptoms a visual assessment was performed and if the employee did not have "visible symptoms" and was not running a fever, they were allowed to work.

9. Interview with the assistant administrator on 10/29/20 at 6:20 PM revealed if staff had symptoms, they were not allowed to work. The facility implemented rapid screening "last week" in an attempt to prevent staff from working with symptoms.

10. Review of the line list of infections provided by the facility on 11/2/20 showed the facility had 70 residents and 49 staff members who had tested positive for COVID-19. Further review showed the facility had 10 COVID-19 positive resident deaths.

Regarding PPE use and social distancing:

11. Observation on 10/28/20 at 1:35 PM showed 14 residents were seated in the east dining room. Three round tables in the dining room had 2 residents seated at each table, within arm's reach, and none of the residents were wearing face masks or face coverings.

12. Observation on 10/28/20 at 1:57 PM showed 3 residents were seated at a long table in the east activity area near the pool table. All 3 residents were seated at the same end of the table, within arm's reach, and none of the residents were

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F 880	Continued From page 17 wearing face masks or face coverings. 13. Observation on 11/3/20 at 11:46 PM showed 15 residents were seated in the dining room. Four tables had 2 residents seated at the tables, within arm's reach, and the residents were not wearing face masks or face covering. At that time, there were 4 tables with no residents seated at them. Observation at 12:01 PM showed 5 tables had 2 residents seated at the tables, within arm's reach, and no face masks or face coverings were worn. At that time, there were 4 tables with no residents seated at them. 14. Observation on 11/4/20 at 9 AM showed RN #2 was seated at the Rapid Recovery nurse's station and was not wearing a face mask. 15. Interview with the DON on 10/28/20 revealed all staff should wear face masks and goggles at all times while at the facility and all residents on the Rapid Recovery unit were positive for COVID-19. 16. Interview with the infection preventionist on 10/29/20 at 4:17 PM revealed residents should be encouraged to wear masks when they were out of their rooms and they should be placed 6 feet away from each other during meals. If a table is not big enough to ensure 6 feet of distance between residents, there should only be 1 resident at each table. Further interview revealed staff should wear a mask prior to entering the facility. 17. Review of the policy titled "COVID-19 Policy and Procedure" last revised on 9/26/20 showed "...D. Personal Protective Equipment...a. The PPE [personal protective equipment]	F 880		

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recommended when caring for a patient with known or suspected COVID-19 includes an N95 respirator facemask...G. Interventions During an Active COVID-19 Outbreak in the Center...8. All care staff will wear an N95..."

18. Review of the CDC guidance titled "Preparing for COVID-19 in Nursing Homes" (found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, retrieved on 11/6/20) last updated 6/25/20 showed "...Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance...Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene...Considerations when restrictions are being relaxed include: Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate...Implement Source Control Measures. HCP [Healthcare Personnel] should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required...""

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