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

PRINTED: 01/13/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555114	A. BUILDING _____ B. WING _____	C 12/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DRIFTWOOD HEALTHCARE CENTER	4109 EMERALD ST TORRANCE, CA 90503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a COVID-19 FOCUSED SURVEY FOR INFECTION CONTROL and a Complaint. Complaint #: CA00818100 A COVID-19 Focused Infection Control Survey was conducted by the California Department of Public Health on behalf of the Centers for Medicare & Medicaid Services (CMS) on 12/29/2022 through 12/30/2022. The facility was found not to be in compliance with 42 CFR §483.80 Infection control regulations and has/has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total residents: Representing the California Department of Public Health: Health Facility Evaluator Nurse ID: 44634, RN, HFEN Health Facility Evaluator Nurse ID:41699, RN, HFEN Health Facility Evaluator Nurse ID:44088, RN, HFEN The inspection was limited to the COVID-19 COVID-19 FOCUSED SURVEY FOR INFECTION CONTROL and a Complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was written for the COVID-19	F 000	Driftwood Healthcare and Wellness Center submits this response and plan of correction as part of the requirements under the state and federal law. The Plan of Correction is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider or its employee, agents, officers, director, or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. The facility desires that this plan of correction be considered the facility's allegation of compliance. "Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of federal and state law." F- 880 Infection Prevention & Control Plan of Correction How corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	1/20/23

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

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F 000	Continued From page 1 FOCUSED SURVEY FOR INFECTION CONTROL and Complaint CA00818100 On 12/29/22, at 4:25 p.m., in the presence of the Administrator in Training (AIT) and the Director of Nursing (DON), an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had caused, or is likely to cause serious injury, harm, impairment, or death to a resident), was identified, and declared. On 12/30/22, at 3:50 p.m., the Administrator submitted an acceptable IJ Removal Plan ([IJRP] a plan with interventions to immediately correct the deficient practices). The Department of Public Health removed the IJ while onsite after the surveyors verified the facility implemented the facility's IJRP by observations, interviews, and record reviews. The DON and DSD were informed.	F 000	1.a) On 12/29/22, Resident 9 was remained cohorted with other COVID- 19 positive residents in isolation. Care plan for COVID- 19 for Resident 9 was updated on 12/30/22 per the most current guidelines by providing isolation room or cohorting of multiple residents with known or suspected COVID- 19 infections. b) On 12/29/22, Resident 15 was remained cohorted with other COVID- 19 positive residents in isolation. Care plan for COVID- 19 for Resident 15 was updated on 12/29/22 per the most current guidelines by providing isolation room or cohorting of multiple residents with known or suspected COVID- 19 infections. Registered Nurse 1, Licensed Vocational Nurse 1 and Licensed Vocational Nurse 3 were provided with re-education training by Regional Quality Management Consultant on 12/30/22 on Policy and Procedure on Management of COVID- 19 and facility's Mitigation Plan for COVID- 19 with emphasis on cohorting of positive residents and designation of space. The Director of Nursing and Director of Staff Development were provided with re-education training by Regional Quality Management Consultant on 12/30/22 on Policy and Procedure on Management of COVID- 19 and facility's COVID- 19 Mitigation Plan with emphasis on cohorting of positive residents, designation of areas and response testing for staff and residents immediately after the knowledge of the first positive test result of COVID- 19.	
F 880 SS=L	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:	F 880		

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F 880	Continued From page 2 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	On 12/29/22, Resident 24 was cohorted in the isolation area. Resident 11 was monitored every shift for signs and symptoms of COVID- 19. MD 2 was educated by Medical Director on 12/30/22 on Infection Control, with emphasis on disinfecting and sanitizing of equipment before and after each resident use to prevent the spread of COVID- 19 infection. On 12/30/22, the Regional Quality Management Consultant provided the Director of Nursing and Director of Staff Development on notifying the Department of Public Health on facility's positive results to seek further guidance and recommendation on cohort management. Certified Nurse Assistant 3 was immediately provided an in-service training by Director of Staff Development on 12/30/22 on facility's Infection and Control Policy and Procedure and COVID- 19 Mitigation Plan, with emphasis on donning and doffing of PPE and hand washing when entering isolation room and serving meal trays. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this deficient practice; therefore, on 12/29/22: • The Director of Nursing and Director of Staff Development reviewed current COVID- 19 positive residents to ensure	

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F 880	Continued From page 3 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 implement infection control practices to prevent the spread and transmission of coronavirus (COVID 19, a potentially severe respiratory illness caused by a virus and characterized by fever, coughing, and shortness of breath) for four of eight sampled residents (Residents 9, 11, 15, and 24). The facility failed to: 1. Separate COVID 19 positive residents (Resident 16 and 17) from COVID 19 negative resident (Resident 9) and COVID 19 positive residents (Resident 13 and 14) from COVID 19 negative resident (Resident 15). Resident 9 and 15 who were COVID 19 negative on 12/22/22 were sharing rooms with COVID 19 confirmed positive residents and tested positive on 12/29/22. 2. Initiate COVID 19 facility wide testing (testing all residents and staff) for facility staff exposed to COVID 19. The facility first identified COVID19 case on 12/23/22, and staff testing was conducted on 12/28/22.	F 880	that no other COVID- 19 positives are cohorted with COVID- 19 negative residents. No other resident had been affected with the same deficient practice. • The Director of Nursing and designee reviewed the staff response testing results to ensure all staff were tested for COVID- 19. No other staff was affected. • The Director of Nursing/designee-initiated observation of staff and visitor to ensure they adhere to proper donning and doffing of PPE in isolation and disinfecting/sanitizing equipment before and after resident use. No other staff or visitor was affected with this deficient practice. **What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:** The Director of Nursing, Director of Staff Development and Regional Quality Management Consultant and Infection Preventionist consultant provided an in – service education to the staff regarding the facility's COVID-19 Mitigation Plan and Policies & Procedures on 12/29/22, 12/30/22, 1/5/23, 1/17/23 and 1/18/23, with emphasis on: • Response to Test Results and Cohorting of Residents • Required PPE for Each Area of the Facility • Disinfection of Equipment before and after each resident use • Designation of Areas	

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F 880	Continued From page 4 3. Ensure Medical Doctor (MD) 2 who was examining residents in isolation (COVID 19 positive residents) area sanitized her personal stethoscope (medical instrument for listening to the action of someone's heart or breathing,) before and after used with Residents 11 and 24. Resident 11 was COVID 19 confirmed negative, and Resident 24 was COVID 19 confirmed positive resident. 4. Ensure Director of Staff Development/Infection Preventionist Nurse (DSD/IPN) and Director of Nursing (DON) were aware of infection control guideline and the facility's Infection Control Policies and Procedure (P&P) requiring confirmed COVID 19 positive residents be isolated from confirmed COVID 19 negative residents to mitigate (lessen) the transmission of COVID 19. 5. Ensure Certified Nurse Assistant (CNA) 3 donned (put on) gown and gloves when entering resident's rooms in the red zone (designated area for residents who have confirmed COVID 19)/isolation area to deliver and setup food trays. These deficient practices resulted in the spread of COVID-19 infection to Resident 9 and 15 and placed other residents, staff, visitors, and the community at a high risk for cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and increased the spread COVID-19 infection. On 12/29/22, at 4:25 p.m., in the presence of the Administrator in Training (AIT) and the Director of Nursing (DON), an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had	F 880	During Daily Clinical Meeting on Mondays to Fridays, the IDT will review Covid-19 positive residents' room placements to ensure that no positive residents are cohorted in the same room as negative residents. Facility will conduct response testing to all staff and resident immediately after the knowledge of the first positive test result of COVID- 19. Designated screener will provide education to outside vendors and physicians adhere to proper PPE use and disinfecting equipment before and after each resident use. **How facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficient practice will not recur:** The DON/Designee will conduct rounds and observations bi-weekly until COVID-19 Outbreak has cleared, to ensure that: • COVID – 19 Positive Residents are not cohorted in the same room as COVID-19 negative residents. • Staff, outside vendors, and physicians adhere to required PPEs in each area of the facility, and disinfection of equipment in between resident use; and • The Infection Preventionist/Designee will conduct random observation audits on all shifts in all department to ensure that staff are adhering to proper PPE donning and doffing in Transmission	

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F 880	Continued From page 5 caused, or is likely to cause serious injury, harm, impairment, or death to a resident), was identified, and declared due to the facility's failure to separate COVID 19 positive residents (Resident 16 and 17) from COVID 19 negative resident (Resident 9) and COVID19 positive residents (Resident 13 and 14) from COVID 19 negative resident (Resident 15). Resident 9 and 15 who were COVID 19 negative on 12/22/22 were sharing a room with COVID 19 confirmed positive residents and tested positive on 12/29/22. Failure to initiate COVID 19 facility wide testing for facility staff exposed to COVID. The facility first identified COVID 19 case on 12/23/22, and staff testing was conducted on 12/28/22. Failure to ensure MD 2 who examined residents in isolation area sanitized her personal stethoscope before and after used with Residents 11 and 24. Resident 24 was confirmed COVID 19 positive residents. Failure to ensure DSD/IPN and DON were aware of infection control guideline and the facility's P&P requiring confirmed COVID 19 positive residents be isolated from confirmed COVID19 negative residents to mitigate transmission of COVID 19. Failure to ensure CNA 3 donned gown and gloves when entering resident's rooms in the isolation area to deliver and setup food trays. On 12/30/22, at 3:50 p.m., the Administrator submitted an acceptable IJ Removal Plan ([IJRP] a plan with interventions to immediately correct the deficient practices). The acceptable IJRP included the following corrective actions: 1.On 12/29/22, the licensed nurses conducted COVID 19 antigen tests (test designed for the	F 880	Based Precautions zones. Re-education will be provided to staff, as applicable, who are identified as non-compliant. Findings will be reported to the DON and Administrator for further correction action and resolution. The Director of Nursing will present the results of the Infection Control Audits to the Quality Assurance and Performance Improvement Committee for review monthly for the next 3 months and quarterly thereafter. Completion date: 1/23/23	

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rapid diagnoses of active infection) to COVID 19 negative residents who were cohorted (group together) with COVID 19 positive residents. DON and designee reviewed all COVID 19 positive residents to ensure that no other COVID-19 positive residents were cohorted with COVID 19 negative residents.

2. On 12/29/22, the DON immediately provided in - service education to all CNAs on site regarding the facility's Infection control P&P with emphasis on personal protective equipment ([PPE] equipment worn to minimize exposure to infection) use and will continue with all three shifts. The DON/Designee initiated an Inservice education to facility staff regarding facility's Infection Control P&P with emphasis on response to test results, cohorting of residents, required PPE for each area of the facility, disinfection of equipment before and after resident use and designation of space.

3.On 12/29/22, the Administrator immediately notified the Medical Director to provide education to MD 2 regarding infection control, with emphasis on sanitizing equipment before and after each resident use.

4.On 12/29/22, the Regional Quality Management Consultant (RQMC) provided immediate remote education to the Administrator, DON, and DSD, regarding the facility's infection control P&P, with emphasis on cohorts/designation of space to prevent the spread of the virus. RQMC also provided education on response testing.

5.The licensed nurses-initiated point of care ([POC] tests produce rapid, reliable results that aid in identification and monitoring of acute

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Infections) testing to 27 residents who have had high risk exposure to COVID19 positive residents.

6. The DON/Designee initiated observation of staff to ensure facility staff provided care to COVID 19 negative residents first before COVID 19 positive residents (clean to dirty), the proper use of PPE, and equipment sanitation in between resident use.

7.During daily clinical meeting on Mondays to Fridays, the Interdisciplinary ([IDT] health professionals from different disciplines, along with the patient, working collaboratively as a team) will review COVID 19 positive residents' room placements to ensure that no positive residents are cohorted in the same room as COVID 19 negative residents.

8.The DON/Designee will conduct rounds and observations bi-weekly until COVID 19 outbreak has cleared, to ensure that COVID -19 positive residents were not cohorted in the same room as COVID 19 negative residents. Facility staff, outside vendors, and physicians adhere to required PPEs in each area of the facility, and disinfection of equipment in between resident use. Staff will provide care to COVID-19 negative residents first before COVID 19 positive residents if there are no designated staff for each cohort.

9. The Administrator and DON will be responsible in monitoring and sustaining compliance.

10.The Director of Nursing will present the results of the Infection Control Audits to the Quality Assurance ([QA] identification, assessment, correction and monitoring of important aspects of patient care) and Performance Improvement

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(focuses on performance within a healthcare organization) committee for review monthly for the next three months and quarterly thereafter.

On 12/30/22, at 3:50 p.m., the Department of Public Health removed the IJ while onsite after the surveyors verified the facility implemented the facility's IJRP by observations, interviews, and record reviews. The DON and DSD were informed.

Findings:

1. a) During a review of facility's census on 12/28/22, Resident 9 shared a room with Resident 16 and 17.

During a review of Resident 9's "Admission Record" (AR), the AR indicated Resident 9 was admitted to the facility on 10/26/18 and was readmitted on 6/17/21 with diagnoses that included dementia (a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities), and epilepsy (seizure disorder - sudden, uncontrolled electrical activity in the brain that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness).

During a review of Resident 9's Minimum Data Set ([MDS], a comprehensive assessment and care-screening tool), dated 11/17/22, the MDS indicated Resident 9 had severely impaired cognitive (ability to learn, remember, understand, and make decision) skills for daily decision making. The MDS indicated Resident 9 was totally dependent with bed mobility, transfers, dressing, eating, toilet use, personal hygiene, and

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bathing.

During a review of Resident 9's laboratory (lab) report dated, 12/23/22, the lab report indicated COVID 19 test result was negative.

During a review of Resident 9's COVID 19 Resident Testing Record dated, 12/29/22 indicated Resident 9 test result was positive for COVID 19.

During a review of Resident 9's care plan titled, Residents with COVID 19 or suspected COVID 19, dated, 12/29/22, the care plan indicated Resident 9 was positive for COVID 19. Goals included ensure implementation of guidelines regarding the care of all residents during the COVID 19 outbreak and be updated with most current guidelines. Interventions included place resident in a private room with own bathroom, room sharing might be necessary if there are multiple residents with known or suspected COVID 19, and keep door closed.

During a review of Resident 16's MDS, dated 12/20/22, the MDS indicated Resident 16 had intact cognitive skills for daily decision making, was totally dependent on staff for bed mobility, transfers, toileting, personal hygiene, bathing, and required extensive assistance with dressing and eating.

During a review of Resident 16's lab report dated, 12/23/22, the lab report indicated COVID 19 test result was positive.

During a review of Resident 17's MDS dated 10/31/22, the MDS indicated Resident 17 had intact cognitive skills for daily decision making,

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F 880	Continued From page 10 was totally dependent for toilet use, required extensive assistance with bed mobility, transfers, dressing, personal hygiene, bathing, and required limited assistance with eating. During a review of Resident 17's lab report dated, 12/23/22, the lab report indicated COVID 19 test result was positive. b). During a review of facility's census on 12/28/22, Resident 15 shared a room with Resident 13 and 14. During a review of Resident 15's AR, the AR indicated Resident 15 was admitted to the facility on 1/23/20 and was readmitted on 3/22/21 with diagnoses that included multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves) and type 2 diabetes (a condition in which the body fails to metabolize (process) glucose (sugar) correctly). During a review of Resident 15's MDS, dated 10/21/22, the MDS indicated Resident 15 had intact cognitive skills for daily decision making, was totally dependent on staff for bed mobility, transfers, toileting, personal hygiene, and bathing, required extensive assistance with eating, and supervision with eating. During a review of Resident 15's lab report dated, 12/23/22, the lab report indicated COVID 19 test result was negative. During a review of Resident 15's COVID 19 Coronavirus Resident Testing Record dated, 12/29/22 indicated Resident 15 test result was positive for COVID 19.	F 880		

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During a review of Resident 15's Care Plan titled, Residents with COVID 19 or suspected Covid-19, dated, 12/27/22, the care plan indicated resident 15 was positive for Covid 19. Goals included ensure implementation of guidelines regarding the care of all residents during the COVID 19 outbreak and be updated with most current guidelines. Interventions included place resident in a private room with own bathroom, room sharing might be necessary if there are multiple residents with known or suspected COVID 19, and keep door closed.

During a review of Resident 13's MDS dated 9/23/22, the MDS indicated Resident 13 had severely impaired cognitive skills for daily decision making, and was totally dependent with bed mobility, transfers, dressing, eating, toilet use, personal hygiene, and bathing.
During a review of Resident 13's lab report dated, 12/23/22, the lab report indicated COVID 19 test result was positive.

During a review of Resident 14's MDS, dated 11/19/22, the MDS indicated Resident 14 had severely impaired cognitive skills for daily decision making, and was totally dependent for toilet use, personal hygiene, bathing, required extensive assistance with bed mobility, transfers, dressing, and required limited assistance with eating.

During a review of Resident 14's lab report dated, 12/23/22, the lab report indicated COVID 19 test result was positive.

During an interview on 12/29/22 at 8:25 a.m. with Registered Nurse (RN) 1, RN 1 stated the entire facility was changed to red zone/isolation with

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COVID 19 positive and COVID 19 negative residents cohorting in the same rooms together. RN 1 stated she does not know who made the decision to transition the entire facility to a red zone and she does not know the date the isolation began.

During an interview on 12/29/22 at 9:07 a.m., with Licensed Vocational Nurse (LVN) 1, at Nursing Station 2, LVN 1 stated the entire facility was transitioned into a red zone and she was taking care of both COVID 19 negative and COVID 19 positive residents. LVN 1 stated her assignment included two rooms that have COVID 19 negative and COVID 19 positive residents cohorting together in the same rooms. LVN 1 stated the red zone should be designated for COVID 19 positive residents and with designated staff. LVN 1 stated having COVID 19 positive resident in the same room with COVID 19 negative residents will lead to all residents becoming infected with the COVID 19 virus and can lead to severe respiratory illness for residents with lots of medical problems. LVN 1 stated best practice was to have COVID 19 positive resident isolated in the red zone away from COVID 19 negative residents.

During a concurrent observation and interview on 12/29/22 at 10:25 a.m., with LVN 3, in the east hall, LVN 3 stated she was taking care of Residents 13 and 14 who are confirmed COVID 19 positive, and isolated in a room with Resident 15 who was confirmed COVID 19 negative. LVN 3 stated she was also caring for Residents 16 and 17 who were COVID 19 positive and was isolated in a room with Resident 9 who was confirmed COVID 19 negative. Residents 13, 14, and 15 were observed isolated in the same room, and Residents 9, 16, and 17 were observed

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isolated in the same room. LVN 3 stated the red zone was for residents that are positive for COVID 19 and residents who were COVID 19 negative are at a higher risk of developing COVID 19 when the residents are in the same room with COVID 19 positive residents.

During an interview on 12/29/22 at 3:39 p.m., with DON, DON stated the facility follows Center for Disease Prevention and Control (CDC), California Department of Public Health (CDPH), and Los Angeles County Department of Public Health (LAC-DPH) COVID 19 infection control guidance which indicate the red zone is designated for COVID 19 positive residents. DON stated COVID 19 positive resident must be isolated in the red zone to contain the virus and prevent other residents and staff from becoming infected. DON stated even after receiving negative COVID 19 test results for residents who were exposed to virus she made the decision to isolate all resident in place causing COVID 19 negative and COVID 19 positive resident to be in the same room. DON stated best practice was isolate COVID 19 positive residents in red zone only.

During an interview on 12/30/2022 at 11:40 a.m. with DSD, the DSD stated Resident 9 and Resident 15 were initially confirmed negative with COVID 19 on 12/23/22 and was in the same room with COVID 19 positive residents. DSD stated Resident 9 and Resident 15 tested positive with COVID 19 on 12/29/22.

2. During an interview on 12/29/22 at 10:50 a.m., with CNA 5, CNA 5 stated she was informed by the DSD/Infection Preventionist Nurse (IPN) the facility was in a COVID 19 outbreak starting on 12/26/2022. CNA 5 stated the first time she was

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F 880	Continued From page 14 tested during the current outbreak was on 12/28/22. During an interview on 12/29/22 at 11:40 a.m., with DSD/IPN, DSD/IPN stated the facility covid outbreak was confirmed on 12/23/22 after 14 residents and five (5) staff tested positive for COVID 19. DSD/IPN stated facility wide testing was conducted for staff on 12/28/22, five (5) days after the outbreak began. DSD/IPN stated she was not aware of the facility's P&P for initial outbreak testing for staff during a covid outbreak. During an interview on 12/29/22 at 3:39 p.m., with the DON, the DON stated a COVID 19 outbreak is when 2 or more resident tested positive for COVID 19. DON stated response testing for staff and residents should start immediately after knowledge of an outbreak. The DON stated she does not know why there was a delay in testing staff. The DON stated any delay in testing put residents, visitors, and staff at risk for developing and spreading the COVID 19 virus. 3. During a review of Resident 11's AR, the AR indicated Resident 11 was admitted to the facility on 12/17/22 with diagnoses that included hypothyroidism (underactive thyroid [small, butterfly-shaped gland located at the base of the neck]) and anemia (low number of red blood cells). During a review of Resident 11's COVID 19 resident testing record dated, 12/29/22, the lab report indicated COVID 19 test result was negative. During a review of Resident 24's AR, the AR indicated Resident 24 was admitted to the facility on 12/11/18 diagnoses that included dementia	F 880		

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F 880	Continued From page 15 and hypertension (HTN - high blood pressure). During a review of Resident 24's lab report dated, 12/23/22, the lab report indicated COVID 19 test result was positive. During a concurrent observation and interview on 12/29/22 at 9:55 a.m., in the east hall and middle halls in the red zone, MD 2 was observed going into Resident 11's room and used her personal stethoscope to listen to Resident 11's chest. MD 2 placed her personal stethoscope on a belt hook/holder, removed her gown and gloves, exited the room and sanitized her hands. MD 2 did not sanitize personal stethoscope. MD 2 put on a gown and gloves, entered Resident 24's room and used her personal stethoscope and listen to Resident 24's chest. MD 2 removed her gown and gloves sanitized her hands and exited the room. MD 2 stated she was aware the facility was in a COVID 19 outbreak, and she know she should sanitize her stethoscope before and after using it on a resident in an isolation area. MD 2 stated she did not know facility had wipes to sanitize the stethoscope. During an interview on 12/29/22 at 3:39 p.m., with the DON, the DON stated it is the facility's policy that disposable stethoscope should be used in isolation rooms. The DON stated if personal stethoscope was used it must be sanitized before and after use on a resident to prevent cross contamination and to prevent the spread of COVID 19. 4. During an interview on 12/29/22 at 11:40 a.m., with DSD/IPN, DSD/IPN stated she did not receive guidance for the Department of Public Health (DPH) on converting the entire facility to a	F 880		

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red zone. DSD/IPN stated the red zone should be designated for COVID 19 positive residents. DSD/IPN stated the decision was made by DSD/IPN and DON to not move the COVID 19 positive resident into the red zone and isolate away from COVID 19 negative residents, instead DSD/IPN and DON decided to isolate all residents in place which led to COVID 19 positive resident being in the same room with covid negative resident.

During an interview on 12/29/22 at 3:39 p.m., with the DON, the DON stated RN 1 conducted room changes initially and cohorting was done without the guidance of DON/DSD/IPN. DON stated male COVID 19 positive residents were isolated in one room and female COVID 19 positive residents in another room. The DON stated after receiving negative and positive COVID 19 lab results on 12/26/22 the decision was made not to move any residents, so the entire facility was declared a red zone and COVID 19 negative resident were isolated in the same rooms with COVID 19 positive resident.

5. During an observation on 12/29/22 at 12:26 p.m., CNA 3 entered room 34 that was occupied by two COVID 19 confirmed positive residents and one COVID 19 confirmed negative resident and delivered lunch tray without wearing gloves and gown, exited the room, went back to the tray cart and took another lunch tray into the room without hand washing.
During an observation on 12/29/22 at 12:28 p.m., CNA 3 entered room 33 that was occupied by two COVID 19 confirmed positive residents and delivered lunch tray without wearing gloves and gown, exited the room, went back to the tray cart and took another lunch tray into the room without

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hand washing.

During an interview on 12/29/22 at 2:39 p.m. with CNA 3, CNA 3 stated she was not aware which residents were COVID 19 positive and which residents were COVID 19 negative. CNA 3 stated she was not aware she needs to don a gown and gloves when delivering lunch tray to the resident. CNA 3 stated she did not wash her hands in between residents.

During an interview on 12/29/22 at 4:01 p.m. with the DON, the DON stated room 34 and 33 were red cohort/isolation, all staff must follow the infection control practices and all staff must use all the necessary PPE required to contain the COVID 19 outbreak and prevent the spread of the COVID 19 virus.

During an interview on 12/30/22 at 8:06 a.m., with the RN 2, the RN 2 stated all staff must wear all required PPE (gown and gloves) when entering room in the isolation area to prevent cross contamination and transmit COVID 19 infection from staff to resident and vice versa.

During a review of the facility's policies and procedures (P&P) titled Designation of Areas to Contain the Spread of COVID 19 dated 5/20/2020, the P&P indicated "To minimize the risk of transmission of COVID 19, the facility will keep separate residents who are infected with COVID 19, residents who are suspected or potentially infected and residents who are low risk or free from COVID 19 infection."

During a review of the facility's COVID-19 Mitigation Plan (MP), revised on 10/2/22, the MP indicated "The facility has policies in place for

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designated spaces within the facility to ensure separation of infected residents from non-infected residents. Isolation is only for residents who have laboratory confirmed COVID 19 with or without symptoms - regardless of vaccination status. Residents who test positive will be isolated in the designated COVID19 positive area of the facility. Gowns and gloves are worn for every resident encounter in an isolation cohort. All healthcare providers who have had a high-risk exposure and residents who have had close contacts, regardless of vaccination status, will be tested promptly (not earlier than 24 hours after exposure, with day of exposure counted as day zero (0) and if negative again at three (3) days and again at five (5) days after exposure."

During a review of the facility's P&P, titled Management of COVID 19, dated, 10/11/22, the P&P indicated "Standard (minimum infection prevention and control practices) and transmission-based precaution (a set of practices specific for patients with known or suspected infectious agents that require additional control measures to prevent spread) will be implemented for patients suspected or confirmed to have COVID 19 based on the Center for Disease Prevention and Control (CDC) guidance. For the purpose of this policy, transmission based precautions may include wearing N95 (respiratory protective device) upon entry into the patient's room or while in a designated area for isolation or quarantine, in addition to the recommended PPE and keeping the door to the patient's room closed."