STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115375	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE HEALTH CARE CENTER	5100 WEST ST NW COVINGTON, GA 30014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of the facility's infection control policies, the facility failed to: 1. ensure an effective Infection Prevention Control Program (IPCP) was implemented including timely and accurate COVID-19 testing for residents to be consistently aware of the COVID status of all residents to prevent the spread of [MEDICAL CONDITION] in the facility, 2. designate a single entrance to the facility to properly screen staff and contractors allowed inside the building to reduce the spread of COVID-19 within the facility, 3. provide and maintain adequate supplies of soap for proper hand hygiene for residents and staff, 4. properly don/doff and appropriately use Personal Protective Equipment (PPE) on the COVID-19 Unit, 5. appropriately quarantine and change PPE when providing care for Resident (R) #1, and R#6. quarantine and cohort newly admitted residents (R#3 and R#5) as Persons Under Investigation (PUIs) for 14 days to confirm their COVID-19 status. As a result of these facility failures the facility has had an ongoing COVID-19 outbreak with a cumulative 101 residents and 40 staff who have tested positive for COVID-19. Additionally, the facility reports 27 resident deaths from COVID-19. The sample was 27 residents. On August 17, 2020, in consultation with DCH, a determination was made that the facility's noncompliance had resulted in an Immediate Jeopardy. On August 18, 2020 and August 19, 2020, additional Immediate Jeopardy concerns were identified, and the facility was made aware. The Immediate Jeopardy was identified to exist on July 15, 2020. The facility's Administrator and Interim Director of Nursing (IDON) were informed of this Immediate Jeopardy on August 17, 2020 at 8:39 p.m. and was identified to have existed on August 11, 2020. On August 18, 2020 at 6:19 p.m. the facility's Administrator was informed of additional Immediate Jeopardy concerns and was identified to have existed on August 3, 2020. On August 19, 2020 at 6:18 p.m. further Immediate Jeopardy concerns were identified to have existed on July 15, 2020 and the facility's Acting Administrator/ Regional Director of Clinical Services and Vice President of Clinical Operations were informed. The immediate jeopardy situations are outlined as follows: 1. Medical record reviews revealed that 19 COVID-19 tests were rejected by the lab on July 15, 2020 and the facility failed to retest timely to confirm resident's COVID status for appropriate care and to reduce the spread of [MEDICAL CONDITION] until August 2, 2020. Of the 19 test that were repeated on August 2, 2020, one resident was not retested , one resident was hospitalized on [DATE] and found to be COVID-19 positive on admission, and eight additional residents tested positive on August 2, 2020. Poor infection prevention and control due to unknown COVID status for residents in the facility, increased the risks of illness from COVID-19 for residents and staff; and increased the potential risk of spreading [MEDICAL CONDITION] in the facility and the community. 2. The facility failed to designate an entrance/exit to the facility to ensure staff and visitors/surveyors were properly screened prior to entering the facility. 3. There were infection control/ PPE concerns on the positive COVID unit. Staff were not wearing the required PPE to include hair and shoe covers on the COVID unit. 4. Resident #1 was unnecessarily exposed to COVID-19 by facility staff failing to change PPE after treating COVID-19 positive residents. 5. It was discovered that all but two soap dispensers in the facility were empty. The serious concern regarding a lack of soap/hand hygiene supplies for staff and residents was relayed to the Administrator and Director of Nursing on August 18, 2020 at 11:00 a.m. after the tour and after confirming interviews with staff. 6. The facility failed to cohort and properly isolate newly admitted residents (Residents (R)#3 and R#5) who were considered Persons Under Investigation (PUI). These residents were admitted to the general population without quarantine for 14 days to determine COVID-19 status. R#5 was cohorted with R#8 (who was negative for COVID-19) putting R#8 at risk. The Immediate Jeopardy was identified on August 17, 2020, August 18, 2020 and August 19, 2020 and determined to exist on July 15, 2020 in the area of 42 CFR 483.80 infection control regulations, F880 which was cited at a Scope and Severity of L. At the time of exit on August 20, 2020, an acceptable Immediate Jeopardy Removal Plan had not been received therefore the Immediate Jeopardy remains ongoing. Findings include: 1. Review of the facility policy titled Laboratory Testing, dated September 1, 2018, revealed, Diagnostic test will be completed according to facility laboratory schedule and/or as ordered by the primary care physician, physician assistant, nurse practitioner .Any labs not obtained as scheduled will be rescheduled and the ordering physician will be notified . Review of the policy titled Covid19 Testing and Resident and Staffing Requirements dated 5/5/2020 revealed Definitions: Nasal and Oral-Pharyngeal samples will be collected by a licensed nurse after completion of training. Action: Step 1-a facility will require a Nasal and Oral-Pharyngeal test sample for COVID19. Step 2-Residents-COVID19 testing will be conducted per Physician Order. Medical record reviews, including Electronic Medical Records (EMR) and hard copy charts, revealed that 19 residents had COVID-19 tests ordered for July 15, 2020 and July 16, 2020. The specimens were collected and sent to the lab. Review of the lab results revealed that the specimens were rejected by the lab because the specimen tubes were not labeled. The lab reports stated, Rejection Reason: Tube was not labeled, will need to be recollected. Continued record reviews revealed no evidence that the specimens were recollected timely to execute the Physician's Order when the facility was notified that the initial specimens had not been properly processed. The EMR reviews revealed the next collection/test results available for the rejected specimens were as follows: R#7-8/2/2020 positive results R#9 -no retest documented R#10-8/2/2020 positive result R#11-8/7/2020 negative result R#12-8/2/2020 positive result R#13-8/2/2020 negative result R#14-8/6/2020 negative result R#15-8/2/2020 positive result R#16-8/2/2020 positive result R#17-8/2/2020 positive result R#18-8/2/2020 negative result R#19-8/2/2020 positive result R#20-8/2/2020 negative result R#21-8/2/2020 positive result R#22-8/2/2020 negative result R#23-8/2/2020 positive result R#24-8/2/2020 negative result R#25-7/24/2020 positive result when hospitalized R#26-8/2/2020 negative result In an interview with the Medical Director (MD) on 8/17/2020 at 2:22 p.m., the MD stated that he has had concerns with the facility not following Physician's Orders as written. The MD stated that he has received credible reports from his Nurse Practitioners (NPs) and facility nurses that the facility is aware of the MD's preference for nasopharyngeal specimen collection due to increased reliability of the test result. The nurses have reported to the NPs and to the MD that they were instructed by the Director of Nurses (DON) and the Administrator to collect and send oral samples instead. The MD also stated that due to sample collection and reporting concerns with the facility, the contracted provider of lab services had terminated their contract with the facility effective 8/14/2020. The named lab provider called the surveyor about lab results inquiries on 8/18/2020 at 4:49 p.m. and confirmed the named lab had terminated their contract with the facility on 8/14/2020. A call was placed to confirm the details of the contract termination with a lab representative and a voice mail was left requesting a return call on 8/20/2020 at 8:50 a.m. The call was not returned prior to exiting the survey. In a subsequent phone interview with the MD on 8/19/2020 at 12:10 p.m., the MD stated that if labs were ordered and not processed due to a facility error, then it was certainly his expectation that the sample be recollected that day. In an interview on 8/18/2020 at 10:40 a.m., RN II stated that she had been specifically instructed by her managers to collect oral specimens rather than nasopharyngeal specimens. RN II confirmed managers referred to the Administrator and DON. In an interview with the Interim DON (ID) and the Administrator on 8/18/2020 at 10:50 a.m., the Administrator stated she was aware that the MD wanted nasopharyngeal specimens for testing, but that corporate made a decision that oral specimens were less traumatic for the residents and confirmed that oral samples were collected When asked if the MD was notified that the

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) specimens were being collected orally and not by the nasopharyngeal method, the Administrator stated, I'm not sure . but we have to do what corporate says. In an interview with the Regional Director of Clinical Operations (RDCO) on 8/18/2020 at 11:50 a.m., the RDCO stated he was now the Acting Administrator. He stated he has been working with the facility on COVID issues for a couple of months. He was asked if a corporate directive should be followed instead of a Physician's Order and he stated . we have to do what corporate directs . When asked if he was aware of the MD's preference for nasopharyngeal specimens he said .yes, but the order says COVID test, so we are doing oral tests. When asked if the MD should have been notified that the lab specimens were oral and not nasopharyngeal, he stated, yes, he probably should have. In a phone interview with the former facility DON on 8/19/2020 at 12:30 p.m,, she confirmed that the facility did not recollect the specimens when the facility was notified the specimens had been rejected. In an interview with the Vice President of Clinical Operations (VPOC) on 8/19/2020 at 1:30 p.m., the VPOC confirmed the facility was aware the specimens had been rejected and not recollected. She confirmed the MD order had not been followed. When asked how the resident care should have been managed by the facility while the test results were unknown, and the VPOC said, they should have been treated as potentially positive or PUIs (Person Under Investigation) until we knew different. When asked if this had happened, she said no. In an interview with the RDCO on 8/19/2020 at 2:00 p.m., he was asked about the July 15, 2020 and July 16, 2020 testing errors and he confirmed he was aware the specimens had been rejected and were not recollected. The RDCO was asked if the Physician Orders had been followed and he replied, no, not in this case. The RDCO was asked to provide documentation that the MD had been notified of the rejected COVID tests although the documentation had not been presented by the survey exit on 8/20/2020. 2. Review of the facility's policy titled, Pandemic Event Emergency Procedure Coronavirus (COVID-19) Respiratory Disease Infection, revised 07/02/2020, revealed This facility has taken measures to prepare for a pandemic event. With the globally spreading of a new respiratory disease- Coronavirus Disease 2019 (COVID-19) . The facility will adhere to recommendation from the Center for Disease Control .All Employees-Screen all employees by obtaining temperatures and assessing for coughing, and sore throat symptoms, chest discomfort or shortness of breath . Observation on 8/17/20 at 8:43 a.m. revealed the receptionist came to the front door, used a temporal thermometer, and took two surveyors' temperatures and two Georgia Department of Public Health (GDPH) employees' temperatures. Continued observation revealed the receptionist did not screen any of the four visitors for signs and symptoms of COVID-19 and did not record any of the four visitors' names for contact tracing. Interview on 8/17/2020 at 9:30 a.m. with the receptionist revealed when we (surveyors and GDP) came into the facility she was supposed to ask screening questions and record our names. Observation on 8/17/2020 at 9:31 a.m. revealed Licensed Practical Nurse (LPN) AA preparing to enter R #1's room on the COVID positive unit. When asked if she had entered the unit through the designated entry/don/doff area she stated, No, I came in through that door, and pointed to an exit door at the other end of the hallway. When asked if she was screened prior to starting her shift LPN AA stated, I took my temperature. When asked to see where she logged her temperature LPN AA stated, I didn't write it down. The DON was present during this interview and confirmed the staff on the COVID unit are required to enter through the PPE don/doff area. An interview on 8/17/2020 at 2:05 p.m. with Certified Nursing Assistant (CNA) FF, revealed she was employed by agency staffing and had been assigned to this facility for two weeks. Continued interview revealed CNA FF confirmed she was not screened or had her temperature taken before starting her shift today. CNA FF stated she had not been screened or had her temperature taken since being assigned to the facility. Continued interview revealed she was assigned to Unit 2 today. An interview on 8/17/2020 at 2:34 p.m. with CNA GG, revealed she was an agency CNA and today was her first day. Continued interview revealed she had been in the building since approximately 6:55 a.m. and has not been screened or had her temperature taken. Review of the facility's COVID-19 screening form for Unit 2 titled, Riverside Healthcare Register, dated 08/17/2020, revealed no documented evidence CNA FF and CNA GG were screened for signs and symptoms of COVID-19 including having their temperature taken. Unit 2 was the designated unit for COVID-19 negative residents. Interview on 8/17/2020 at 3:20 p.m. with CNA HH revealed she did take her own temp when coming in the Unit 3 door this morning, but she did not document. Continued interview with CNA HH revealed she went to the Unit 3 nurses' station for screening and to have her temperature taken again; however, no one was at the nurses' station, no paper was there to sign, and she was in a rush to start her shift. CNA HH worked the 7:00 a.m. to 3:00 p.m. shift on 8/17/2020 without having been screened for signs and symptoms of COVID-19. Interview on 8/17/2020 at 9:46 a.m. with CNA DD revealed she entered the building from the outside side door of Unit 3, donned (put on) her PPE and then walked up to the nurses' station, through the unit's resident area, and was screened and her temperature was taken. Interview on 8/17/2020 at 9:48 a.m. with LPN EE revealed she was the nurse for Unit 3. Continued interview revealed the normal process for all staff who work on Unit 3 was to enter the side door at the end of the unit's hall, don PPE, and then come through the resident area to have her temperature taken and to be screened. LPN EE stated staff should take their own temperature when they don PPE and if no elevated temperature then they could come up to nurses' station where it was then confirmed the employee did not have a temperature. Review of the facility's COVID-19 screening form for Unit 3 titled, Riverside Healthcare Register, dated 8/17/2020, revealed no documented evidence CNA HH was screened for signs and symptoms of COVID-19 including having her temperature taken. Unit 3 was designated as the recovery unit where residents who previously had COVID-19 were monitored for additional signs or symptoms. Interview on 8/17/2020 at 2:54 p.m., the Medical Director revealed it was his expectation staff were screened upon entrance of the building and not after they have entered a resident area. In an interview on 08/17/2020 at 5:33 p.m., the Administrator stated there was no policy regarding designated entrances or exits for COVID screening. 3. Review of the facility policy titled Handwashing/Hand Hygiene dated November 2016, revealed, This facility considers hand hygiene the primary means to prevent infections .3. Hand hygiene products and supplies (sinks, soap, towels, alcohol- based hand rub, etc.) shall be readily accessible and convenient for staff use .6. Wash hands with soap .and water for the following situations: a. When hands are visibly soiled . Observations on 8/17/2020 and 8/18/2020 revealed the facility failed to ensure adequate handwashing supplies be available to residents and staff for proper hand hygiene during a pandemic. Observation 8/17/2020 at 4:10 p.m. revealed the restroom at the Unit 2 (designated as COVID negative hall) nurses' station had no soap in the bathroom for hand hygiene. The dispenser was empty and there was a bottle of (Brand) Shampoo & Bodywash on the sink. On 8/18/2020 at 10:10 a.m. at the Unit 2 nurses' station, a tour was initiated with the DON of all hand washing stations for staff use on each resident care areas/hallways. It was discovered that all but two soap dispensers in the staff handwashing areas were empty. At the Unit 2 nurses' station the restroom had no soap in the dispenser and had a scant amount of bodywash in a bottle on the sink. In the Unit 2 pantry there was no soap available, but there was a half full bottle of shampoo/bodywash. The DON stated that hand sanitizer was available for use in the facility. When asked what to do when hands were visibly soiled, or after using the rest room the DON stated .we have to do the best we can with what we have. On 8/18/2020 at 10:24 a.m. at the Unit 3 nurses' station, there was a pantry and an employee restroom with sinks for staff handwashing per the DON. There was neither soap nor bodywash available at either sink. There was no hand hygiene agent at all other than water. There was an 8 oz bottle of hand sanitizer on the nurse's station desk. The housekeeping closet on Unit 3 had no soap available at the sink. The DON confirmed the observations. Unit 3 was the recovery unit for the facility. On 8/18/2020 at 10:38 a.m., Registered Nurse (RN) II was interviewed and stated that she brings her own soap to work because it was not available in the facility. RN II stated that as a nurse she did not feel the shampoo/bodywash supplied by the facility was adequate for hand hygiene during resident care. On 8/18/2020 at 10:44 a.m., Unit 1, the COVID unit, was entered. In the donning/doffing area there was a bottle with a hand-written label hand sanitizer. There was no handwashing station at the entry/exit point to the COVID-19 unit. The restroom at the COVID unit nurses' station had no soap, only a bottle of shampoo/bodywash. In the COVID unit staff breakroom there was a sink but no hand hygiene agents available. Continued observation of the COVID unit revealed four of the 10 resident rooms were found to be without soap or any type of hand hygiene agent, only a sink. On 8/18/2020 at 11:21 a.m., CNA FF stated that soap had been unavailable in the facility for awhile. She stated that she brought her own soap to wash her hands. On 8/18/2020 at 11:45 a.m., CNA JJ was interviewed and stated that hand soap had not been available for staff or residents to use. On 8/18/2020 at 12:12 p.m., CNA KK also stated the facility had been out of soap for over a month. On 8/18/2020 at 12:45 p.m., the Infection Preventionist (IP) Registered Nurse was interviewed. She stated the soap dispenser refills had been on back order since before she was out of work for two weeks due to COVID-19 illness. On 8/18/2020 at 12:56 p.m. the Central Supply (CS) staff was interviewed. She confirmed that soap had been on back order for over a month. On 8/18/2020 at 1:00 p.m. the DON was interviewed about the soap shortages. The DON confirmed the tour with the surveyor and the empty soap dispensers. The DON confirmed that hand washing is key to infection control and the facility should have soap available for staff and resident use. The Acting Administrator (AA) was interviewed on 8/18/2020 at 1:16 p.m. revealed that he has been involved with this facility for a little over two months. He stated he was not aware that there was no actual soap available for staff and

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F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	(continued... from page 2) resident use. 4. Observation on 8/17/2020 at 9:09 a.m. revealed Restorative Certified Nurse Aid (RCNA) exiting the positive COVID unit in the PPE don/doffing area. The RCNA had ungloved hands as she removed her used/dirty gown. The RCNA then used her ungloved hands to place the used gown in a trash can and push the contents down with bare hands so the lid would close. The trash can that she used was clearly labeled No PPE. The RCNA was exiting the unit to work on Unit 3 that was not a positive COVID unit. Observation on 8/17/2020 at 9:31 a.m. revealed LPN AA preparing to enter R#1's room, on the positive COVID unit and LPN AA was not in full PPE. The PPE requirements on the COVID unit were mask, gloves, face shield, hair cover, gowns, and shoe covers. When questioned why she was not wearing the required hair and shoe covers, LPN AA stated, the hair net doesn't fit my hair, so I don't wear it, and I didn't put on shoe covers this morning. LPN AA stated she has worked in the facility for five days. When asked if she was aware full PPE was required on the COVID Unit LPN AA stated, yes. The DON was present during this interview and confirmed that the staff on the COVID unit are required to enter through the don/doff area and .staff are required to wear full PPE, at all times, on the COVID-19 hall inclusive of hair and shoe coverings, which is the facility's requirement. The DON stated that all residents on Unit 1 are positive for COVID-19. 5. Review of the Admission Criteria for COVID-19 policy, dated July 24, 2020, revealed the policy did not address residents admitted as PUI (Person Under Investigation) which are recommended infection control practices that include 14-day quarantine separated from residents negative for COVID-19 and from residents who are positive for COVID-19. This applies to PUI/newly admitted residents to determine COVID-19 status. In an interview on 8/17/2020 at 5:30 p.m., the Administrator stated that testing is the determining factor for determining Persons Under Investigation (PUI) versus COVID positive, but all hospital admits are considered PUIs, until testing confirmed positive or negative. Record review revealed that R#1 was admitted to the facility on [DATE] to a room on the COVID positive unit and remained so through the survey exit on 8/20/2020. Record review of the COVID Admission Criteria dated 08/10/2020 revealed R #1 tested negative for COVID-19 on 08/12/2020. The negative results are documented as received by the facility on 08/15/2020. On 8/17/2020 at 9:37 a.m., LPN AA was observed to enter the room of R#1. The LPN did not change PPE after caring for the resident next door to R#1 who is positive for COVID. An interview on 8/17/2020 at 11:10 a.m., LPN AA stated she was the nurse caring for R#1 and .up until 20 minutes ago I was not aware that I needed to change PPE between residents because (R#1) was PUI and not COVID positive. I thought they (residents on the unit) were all positive. Interview on 8/17/2020 at 11:15 a.m., CNA BB stated she was caring for R#1 and has worked with him since his admission last week. The CNA then stated that she has never changed PPE prior to entering R#1's room because until a few minutes ago she did not know R#1 was a PUI and not COVID positive. An interview with the ICP nurse on 08/17/2020 at 4:00 p.m. confirmed the negative resident (R#1) continues on the COVID positive unit, .but I'm going to move him. 6. Review of the facility's policy titled, Admission Criteria for COVID-19, dated 07/24/2020, revealed This facility shall admit and re-admit residents who are no longer acutely ill with the COVID-19 virus from acute care settings .COVID-19 testing is not required as a consideration for admission to the Skilled Nursing Facility .Practice Guidelines . 2. During a pandemic event all residents admitted or readmitted to the Skilled nursing Facility will be considered as having been exposed to Covid-19; therefore, transmission-based precaution will be initiated. They should be quarantined for 14 days . a. Review of R#3's undated Admission Record, located in the resident's electronic medical record (EMR) under the profile tab, revealed the resident was admitted to the facility on [DATE]. Continued review of the resident's EMR, specifically the census tab, revealed the resident was admitted to room [ROOM NUMBER]A and then on 8/12/2020 was moved to room [ROOM NUMBER]A. Unit 2 was designated as the negative unit meaning all residents on that unit are presumed to be negative for COVID-19. Review of R#3's Progress Note, dated 08/10/2020, located under the progress notes tab, revealed the Speech Therapist (ST) LL assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Interview on 8/18/2020 at 2:49 p.m. with R #3 revealed she was in room [ROOM NUMBER] when she was first admitted and then moved to room [ROOM NUMBER] a few days after she was admitted . Continued interview with the resident revealed she did not know if she was admitted as a PUI. The resident stated when she was in room [ROOM NUMBER] and room [ROOM NUMBER], the staff did sometimes have gowns on, but not all of the time. The resident also stated she had not been tested for COVID-19 since she was admitted to the facility. Interview on 8/18/2020 at 10:38 a.m. with Registered Nurse (RN) II revealed she did not find out that R#3 was supposed to be in quarantine until on 8/17/20. RN II stated she was not given a reason why the resident was now on Transmission Based Precautions (TBP). RN II stated R#3 had been in her current room since 8/12/20 and was not on any type of TBP for PUI. The RN also stated to her knowledge, the only PPE that had been worn in the resident's room for provided care was a mask and gloves. Further interview with RN II revealed when she left the facility last night (8/17/2020) R#3 was in room [ROOM NUMBER]; however, when she came on duty this morning, the resident had been moved to Unit 3 which was now the facility's PUI unit. Interview on 8/18/2020 at 11:21 a.m. with CNA FF revealed she was assigned to R#3 on 8/14/2020 and 8/17/2020 and was not told the resident was on any type of TBP. CNA FF stated she did wear a gown and face shield both days she was the resident's CNA; however, she wore the same PPE all day and did not change the PPE after providing care to R#3 and before providing care to other residents. The CNA also stated she had been told by the facility she did not have to wear any PPE while she was working on Unit 2 because it was a COVID-19 free unit, but she wore PPE because she felt more comfortable doing so. An interview on 8/18/2020 at 12:30 p.m. was held with the Infection Preventionist (IP).When asked if there was any potential for a negative outcome for the resident or other residents from staff providing care without PPE or wearing same PPE all day after providing care to R #3, the IP stated, Yes. It could have caused another outbreak. b. Review R#5's undated Admission Record, located in the resident's EMR under the profile tab, revealed the resident was readmitted to the facility on [DATE] to room [ROOM NUMBER]A and then on 8/12/2020 (nine days post admission) was moved to room [ROOM NUMBER]B. Interview on 8/18/2020 at 10:38 a.m. with RN II revealed R#5 was placed in room [ROOM NUMBER] when she was readmitted and then moved to room [ROOM NUMBER] (previous room prior to hospital stay) and had not been under any TBP or considered a PUI. Continued interview with RN II revealed the resident does currently have a roommate in room [ROOM NUMBER], R#8. Review of R#8's undated Admission Record, located in the resident's EMR under the profile tab, revealed the resident was readmitted to the facility on [DATE] to room [ROOM NUMBER]A. Review of R#8's COVID-19 lab results, with a report date of 07/09/2020 revealed a test result of Not Detected (negative). Interview on 8/18/2020 at 11:45 a.m. CNA JJ revealed she was familiar with R#5 and was regularly assigned to the resident. Continued interview revealed the resident had resided in rooms [ROOM NUMBERS] and there was never any signage or communication from the facility that the resident was on TBP. CNA JJ stated she would wear a gown when going into the resident's room to provide care; however, she would not change the gown before going to provide care to other residents. Interview on 8/18/2020 at 12:12 p.m. with CNA KK revealed she was frequently assigned to R#5 and revealed there has never been any signage on the resident's door to indicate the resident was ever on isolation or TBP. CNA KK stated she has not worn any PPE gowns when going into the resident's room to provide care. Interview 8/18/2020 at 12:30 p.m. with the IP revealed after reviewing R#5's record, the resident should have been readmitted to the facility from the hospital on [DATE] as a PUI on 14-day TBP. Continued interview revealed the resident should have never been moved back to her original room on 8/12/2020 with a roommate who was a confirmed negative resident. The IP stated, if R #5 had anything (COVID) the roommate would have been exposed. The IP also stated the resident not being quarantined as a PUI created a potential for an outbreak. Interview on 8/18/2020 at 1:01 p.m. with the DON revealed R#3 was never placed in quarantine when she was admitted to the facility and should have been considered a PUI. Continued interview revealed R#5 should have also been considered a PUI with 14-day TBP. The DON stated it was important both residents would have been considered a PUI because a resident could be negative for COVID one day and positive the next. Interview on 8/18/2020 at 1:10 p.m. with the Regional Director of Clinical Operations who was now the Interim Administrator revealed it was his expectation both R#3 and R#5 would have been admitted to the facility as PUIs with TBPs.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of the facility's policy, it was determined the facility failed to ensure residents, residents' representatives, and residents' families were notified after a single confirmed positive COVID-19 test result of residents and/or staff. Additionally, the facility failed to provide cumulative updates to residents, their representatives, and their families at least weekly. The facility had a cumulative total of 101 positive resident COVID-19 cases and 47 total staff COVID-19 cases. This failure had the potential to affect all residents of the facility. Findings include: Review of the facility's policy titled, Pandemic Event Emergency Procedure Coronavirus (COVID-19) Respirator Disease Infection Communication Plan (Communicable Disease Reporting), dated 4/20/20, revealed To reinforce this facility's

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	115375	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE HEALTH CARE CENTER	5100 WEST ST NW COVINGTON, GA 30014

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) existing procedures for the reporting of communicable diseases, healthcare associated infections, and potential outbreaks this facility will ensure that notifications for 42 CFR 483.30 for residents and staff with positive COVID-19 cases are reported .All practicable efforts to notify resident/resident representative of information related to the COVID-19 Pandemic will be made within 12 hours of the occurrence of a single confirmed infection. It is the intent of this facility to be transparent with residents and resident representatives regarding COVID-19 cases and on-going facility actions to prevent and reduce the transmission of the Coronavirus and respiratory illness . On 8/19/2020 at 9:00 a.m. a request was made to the Regional Director of Clinical Operations (RDCO) for verification of notifications to residents and their families/representatives weekly or after a positive resident and/or staff COVID result. Review of the provided documentation revealed documented evidence of only two notifications dated 7/15/2020 and 7/24/2020. Interview on 8/17/2020 at 9:50 a.m. with the Infection Preventionist (IP) revealed the facility's total number of positive resident COVID cases was 101 residents and the total number of staff COVID positive cases was 47. Interview on 8/19/2020 at 9:51 a.m. with the Social Services Director (SSD) revealed she was the person responsible for notifying all residents' families who had tested positive. Continued interview with the SSD revealed she would be given a list of residents who had tested positive and then only call those residents' families or representative on the list. The SSD stated she was not responsible for notifying other residents or residents' families after a resident or staff member tested positive for COVID-19, but only the families of residents who tested positive. Review R#5's undated Admission Record, located in the resident's electronic medical record (EMR) under the profile tab, revealed the resident was readmitted to the facility on [DATE]. Interview on 8/19/2020 at 10:10 a.m. with Family of R#5 revealed she had not received any notifications from the facility related to positive COVID residents and/or staff of the facility. Continued interview with the family member revealed she had found out that the facility did have positive cases from the Ombudsman after calling and texting the Ombudsman to inquire about the facility and COVID cases. Family of R#5 stated she has called the facility multiple times and either the phone was never answered, or she was told she could access a government website to find out how many cases the facility had. Family of R#5 also stated it was very important to her she would have been notified of any positive cases in the facility because she wanted to know if the cases in the facility were increasing because of her mother's health and other health concerns her mother has. Interview on 8/19/2020 at 10:42 a.m. with the Long-Term Care Ombudsman (LTCO) revealed Family of R#5 had called her and said that facility was not calling or communication with her to let her know of the facility's positive COVID cases. Continued interview with the LTCO revealed families of other residents had contacted her and reported that the facility would not answer the telephone. The LTCO stated the families of other residents of the facility also told her that the only way they had found out the facility had COVID-19 cases in the building was through the public health department's website or word of mouth. Further interview with the LTCO revealed she had spoken by telephone with the facility's SSD and was told she was notifying all families after a positive test result. Review of R#25's undated Admission Record, located in the resident's EMR under the profile tab, revealed the resident was admitted to the facility on [DATE]. Continued review of the admission record revealed the resident was listed as his own responsible party. Interview on 8/19/2020 at 11:18 a.m. with R#25, revealed he was his own decision maker. Continued interview revealed when asked had he ever been notified of any residents or staff of the facility had tested positive for COVID-19, the resident stated, No. I just know I don't got it. When the resident was asked if he would want to be informed if a person who resided at the facility or worked in the facility tested positive for COVID-19, the resident stated, Yes, because I want to make sure I do not get it. Interview on 8/19/2020 at 11:29 a.m. with the SSD revealed R#25 was his own decision maker. Continued interview with the SSD revealed she did remember speaking with the LTCO by telephone where she told her that she informed all families of residents who had tested positive. Interview on 8/19/2020 at 12:07 p.m. with the facility's former Director of Nursing (DON) stated from May 2020 (when the first resident tested positive) until her last day of employment on 8/10/2020 she only sent two messages out to all residents' families notifying them of positive COVID cases in the building per direction of the Regional Director of Clinical Operations (RDCO). Interview on 8/19/2020 2:00 p.m. with the RDCO who was also now the Interim Administrator revealed it was his expectation that residents and residents' families were notified within 24-hours after a positive test result of a resident and/or a staff member of the facility. The RDCO stated it did not appear that residents and residents' families were always notified by 5:00 p.m. the following day. The RDCO stated it was always important families are notified. Interview on 8/12/2020 at 2:11 p.m. with the Regional Vice President of Clinical Operations (RVPCO) revealed it was her expectation the facility would have followed regulatory requirements for COVID-19 reporting to residents and their representatives. Continued interview revealed from the medical record reviews she had completed the regulatory guidance was not met. The RVPCO stated it was very important residents and their families would have been notified of any COVID activity going on in the facility.