STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525598	A. BUILDING _____ B. WING _____	10/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHEBOYGAN SENIOR COMMUNITY INC	3505 COUNTY ROAD Y SHEBOYGAN, WI 53083

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** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on prevention and control program to help prevent transmission of COVID-19. This had the potential to affect all 50 residents (R) residing in the faciliy and all staff members. The facility does not require residents to wear cloth face coverings or face masks while outside of their room and inside of the facility. Findings: According to the CDC (Centers for Disease Control and Prevention), Preparing for COVID-19 in Nursing Homes dated 6/25/2020 states, Residents should wear a cloth face covering or face mask (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. According to the CMS (Centers for Medicare and Medicaid Services) docuement titled COVID-19 Focused Survey for Nursing Homes; Infection Control; Critical Element #1; Standard and Transmission-Based Precautions (TBPs); Personal Protective Equipment (PPE); Source Control, states, Are residents, visitors, and others at the facility donning (wearing) a cloth face covering or facemask while in the facility or around others outside? Critical Element #2; Resident Care, states, When residents not on Transmission-Based Precautions are outside of their room, are they wearing a cloth face covering or facemask as part of source control? On 10/20/20 at 8:30 AM, Surveyor conducted the entrance conference with DON/IP (Director of Nursing, Infection Preventionist)-B. Surveyor requested all policy and procedures pertaining to COVID-19. At 8:55 AM, Surveyor entered nursing unit Maple Creek with six residents eating breakfast, socially distanced. Surveyor observed CNA (Certified Nursing Assistant)-C bringing a resident who was not wearing a mask to sit by a window in the nursing unit. At 8:58 AM, Surveyor interviewed CNA-C who stated there are eighteen residents on the unit and that residents do not wear masks outside of their room. CNA-C stated the residents do have masks in their rooms. CNA-C stated R4 leaves R4's room without a mask to eat all three meals per day with R4's spouse who resided in the attached Assisted Living facility. At 9:10 AM, Surveyor entered nursing unit Oak. Residents were observed outside of thier rooms without wearing masks. At 9:15 AM, Surveyor interviewed R1 who stated residents do not wear their masks outside of their rooms and are not encouraged by staff to wear their masks when they leave their room. R1 stated the only time residents are required to wear their mask is when they have face to face visits outdoors. At 9:20 AM, Surveyor interviewed CNA-D who stated residents are not required to wear a mask unless they are outdoors for a visit. CNA-D stated new admissions or residents who leave the facility for a wedding are educated to wear a mask for fourteen days. CNA-D stated almost all residents have a mask in their room and the facility supplies them to residents when needed. At 10:10 AM, Surveyor interviewed DON/IP-B who stated the facility does not have a policy and procedure requiring residents to wear a mask while in the building and not in the resident's room. DON/IP-B stated in the facility's policy and procedure regarding visitation, residents are required to wear masks during outdoor visitations. The Surveyor reviewed the facility's policy and procedure titled COVID-19 In Person Visits dated 6/10/20, which did not include guidance indicating residents need to wear cloth face coverings during outdoor visitations.
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	Based on observations and interviews, the facility did not designate an individual as the infection preventionist. This has the potential to affect all 50 residents (R) residing in the facility and all staff who work in the facility. The facility's DON (Director of Nursing) is the facility's designated IP (Infection Preventionist), performing both roles that require designating an individual to each role of DON and IP. 42 CFR (Code of Federal Regulations) 483, Requirements for Long Term Care Facilities, F727; 483.35(b)(2) requires the facility to designate a registered nurse to serve as a the director of nursing on a full time basis. DON/IP-B is responsible as the designated person to perform both roles. On 10/20/2020 at 8:30 AM, Surveyor interviewed DON/IP-B. DON/IP-B stated DON/IP-B performs both the DON and IP role for the facility. At 11:00 AM, Surveyor interviewed DON/IP-B who indicated DON/IP-B does not have an officially designated infection prevention assistant or ADON (Assistant Director of Nursing). DON/IP-B stated the facility has two Unit Managers; one RN (Registered Nurse) and one LPN (Licensed Practical Nurse) who DON/IP-B could ask for assistance from. Surveyor asked DON/IP-B if DON/IP-B works at least full time in the facility, DON/IP-B nodded DON/IP-B's head suggesting DON/IP-B works more than full time in both designated roles. At 2:45 PM, Surveyor met with NHA-A and DON/IP-B for the exit conference. NHA-A stated it is financially unreasonable to hire a designated IP staff member part time. NHA-A stated NHA-A does not feel the additional IP staff member would be able to keep up with the existing and frequently changing regulatory guidance that nursing homes need to be in compliance with.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on interviews and record review, the facility did not test residents for COVID-19 based on parameters set forth by the Secretary, including testing frequency, testing of asymptomatic individuals during an outbreak, and did not have procedures for addressing residents and staff who refuse testing or are unable to be tested . This had the potential to affect all 50 residents residing in the facility and all staff. The facility did not test all residents every three to seven days from the date of the most recent positive COVID-19 result on 10/9/2020, during an active COVID-19 outbreak in the facility. Findings: CMS (Centers for Medicare and Medicaid Services) Memo QSO-20-38-NH dated 8/26/2020, provides guidance for COVID-19 testing of nursing home staff and residents stating, To enhance efforts to keep COVID-19 from entering and spreading through nursing homes, facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS (Health and Human Services) Secretary .For outbreak testing, all staff and residents should be tested , and all staff that tested negative should be retested every 3 to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of 14 days since the most recent positive result An outbreak is defined as a new COVID-19 infection in any helathcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. On 10/20/2020, Surveyor reviewed the facility's policy and procedures related to COVID-19. The facility did not supply policy and procedures related to COVID-19 testing of staff and residents. On 10/20/2020, Surveyor reviewed COVID-19 testing documentation provided by NHA/IP (Director of Nursing/Infection Preventionist)-B. The docuements indicated on 10/9/2020 the facility tested the residents on two of three nursing units, Maple and Hickory. Two resident's, R2 and R5, had positive results. DON/IP-B tested Maple and Hickory based on one staff's, CNA (Certified Nursing Assistant)-H, positive COVID-19 result who was documented to have worked on Maple and Hickory. On 10/13/2020, the facility tested the residents only on Hickory. One resident had positive results, R3. One staff, CNA-I, tested positive for COVID-19 on 10/15/2020. One staff, LPN (Licensed Practical Nurse)-J, tested positive for COVID-19 on 10/16/2020. At 10:30 AM, Surveyor interviewed DON/IP-B who stated the facility will test residents if they are symptomatic with signs and symptoms consistent with COVID-19. DON/IP-B stated the facility would be retesting the residents on Hickory on 10/27/20 due to the last positive COVID-19 test result being on 10/13/2020. DON/IP-B stated they are testing on 10/27/2020 because that is fourteen days from the last positive COVID-19 case from Hickory. DON/IP-B stated the guidance DON/IP-B used to make the decision to test fourteen days after the last COVID-19 positive result is from the DHS (Department of Health Services) website titled COVID-19: Nursing Homes. DON/IP-B provided the DHS resource in paper format and Surveyor and DON/IP-B

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

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 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) reviewed the guidance from the DHS website DON/IP-B printed the docuement from. DON/IP-B pointed out where in the online document DON/IP-B read the guidance the facility uses for testing frequency. DON/IP-B did not refer to the portion of the document that stated, Retest all residents on a regular basis in accordance with CMS guidance. DON/IP-B stated DON/IP-B misinterpreted the guidance and acknowledged the facility needs to test all residents every three to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of 14 days since the most recent positive result. At 2:27 PM DON/IP-B informed Surveyor the facility tested all staff and residents and were all negative for COVID-19 minus the three residents who currently are positive for COVID-19.