STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225538	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL CAPE COD NURSING & REHABILITATION CENTER	8 LEWIS POINT ROAD BUZZARDS BAY, MA 02532

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 record review and staff interviews, the facility failed during the Covid-19 pandemic, to ensure that staff followed the CDC (Centers for Disease Control and Prevention) Interim Infection Control Recommendations for Healthcare Personnel, dated 7/15/20, by not having personnel wear a face mask when entering the facility. Findings include: On 10/7/20, the facility identified having thirteen positive Covid-19 resident cases and one resident identified as PUI (Person Under Investigation)/Quarantine. The facility also identified seven healthcare personnel as Covid-19 positive and not working in the facility. When the survey team entered the facility on 10/7/20 at 6:50 A.M., the surveyors observed staff entering the facility with no face mask on. The surveyors observed six staff enter and walk around to the screening area and wait in line to be screened with no face coverings on. Each staff person, once his/her temperature was taken, they signed a screening assessment and then each staff member was given a face mask (N-95) for them to wear. One staff person with no face mask on did not wait in line but went to the time clock and than returned to get screened. Staff from the Rapid Response team who are not facility employee staff, entered with a face mask on and when screened changed to the offered N-95 masks. During interview on 10/7/20 at 7:14 A.M., the screener was asked to explain the screening process. She said that staff come in , they are to sanitize their hands then wait in line six feet apart at floor markings and then they have a temperature taken and complete a screen assessment and then they are given a N-95 face mask. The screener was asked about staff entering with no face mask on and she said,we know they aren't wearing a dirty mask that was changed in August. Before, we all wore a face mask when coming into the building. The CDC Interim Infection Control Recommendations for Healthcare Personnel, dated 7/15/20, For Implementing Universal Source Control measures indicates that patients and visitors should wear a their own cloth face coverings upon arrival to the facility. Healthcare personnel should wear a facemask at all times while they are in the healthcare facility. A review of the facility's policy for Screening Employees and Visitors, last modified July 16, 2020, had no information in the policy of what employees and visitors should be wearing when entering the facility. During interview with the Director of Nurses and the IPN (Infection Preventionist Nurse), they could not explain the lack of face masks when staff enter the building. The Director of Nurses said they were told they did not need one when coming in to the facility.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed during the Covid-19 pandemic, to follow the CMS (Centers for Medicare & Medicaid Services) published interim final rule, dated August 26, 2020, for Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents. For one sampled Resident (#3) there was no documentation in the medical record to reflect when the Covid-19 test was offered, when the test was administered and the results of the Covid-19 test. Additionally, the facility failed to obtain physician's orders for Covid-19 testing for all residents (Census of 56) in the facility that are currently being tested two times a week. Findings include: During the Covid-19 Focused survey completed on October 7, 2020, the facility identified having thirteen positive Covid-19 resident cases and one resident identified as PUI (Person Under Investigation)/Quarantine. The facility also identified seven healthcare personnel as Covid-19 positive and not working in the facility. The facility had no physician's orders for Covid-19 testing done and no documentation of when residents had the tests done and results of the Covid-19 testing were not documented in the residents medical records. The August 26, 2020 CMS (Centers for Medicare & Medicaid Services) published interim final rule for Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents indicates to document in the residents' records of the test being offered and the test results should be in the medical record of each resident. When conducting testing, the facility must obtain an order from a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes Covid-19 testing. Resident #3 was admitted in June 2020 with multiple [DIAGNOSES REDACTED]. The Resident's room is located on the designated Covid-19 positive unit. A review of the Resident's medical record, had no information in the record for the Resident being Covid-19 tested . A review of the interdisciplinary record progress notes written by the staff, dated 9/2/20 indicated the physician had been in to see the Resident and ordered laboratory work and to have the Resident tested for Covid-19. The medical record had no documentation of the Covid-19 test being done and no results of the test. The Resident was sent to the hospital on [DATE] due to abnormal laboratory results and returned on 9/4/20 after having had blood [MEDICAL CONDITION]. During interview and record review of the paper chart and electronic medical record on 10/7/20 at 10:10 A.M., Unit Manager (UM) #3 said after reviewing for Covid-19 testing, that the medical record had no documentation for testing but said,I have a separate book with laboratory Covid-19 results. At this time the Infection Preventionist Nurse (IPN) came onto the unit and the surveyor, along with the two nurses, found documentation that the Resident was Covid-19 tested on [DATE], 9/21/20 and 9/22/20 and all were negative results. The three Covid-19 tests were not documented in the Resident's medical record and there was no physician's order for ongoing Covid-19 testing. UM #3 said the Resident was again tested for Covid-19 on 9/29/20 and found to be positive for Covid-19. The medical record had no documentation of a physician's orders, no information of when the test was given and there were no results of the tests in the Resident's record. While the survey team was on the unit the UM said the Resident was being sent to the hospital due to a change in the Resident's change in condition of increase in lethargy and slow to respond to staff. The IPN explained that the laboratory company doing the Covid-19 testing cannot send test results directly into the electronic medical records but the results are sent separately to the facility. The other Covid-19 positive residents on the unit (13 residents) had no physician's orders for testing and laboratory results were not documented in the residents' records. During interview with the Director of Nursing and the IPN reviewed the requirements outlined in the CMS 8/26/20 Testing Requirements memo which the facility had in their policy book. The Director of Nurses said she wasn't aware of the CMS memorandum. The IPN said they were doing resident testing for all the residents twice a week and she said she was not aware of the memorandum.

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.