STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	05/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, interviews with local health-department staff, review of facility documents, and clinical record review, it was determined, that the facility staff failed to ensure the implementation of infection control practices and precautions, to prevent the spread of infection, and communicable disease during an identified outbreak of Coronavirus (COVID 19), on one of two facility units, (South unit), and for five of 15 sampled residents, (Residents #3, #13, #2, #5, and #14). The facility staff was not observed implementing standard and droplet precautions to prevent the spread of COVID 19 while providing care and services to COVID positive and negative residents, on the South unit. The facility staff failed to pull privacy curtains the full length of the bed in five of ten resident rooms in which COVID positive and negative residents resided together in the same room, resident room numbers, #220, #210, #206, #225, and #224. The director of nursing, ASM (administrative staff member) #2 failed to implement droplet precautions when caring for a COVID-19 positive and a COVID-19 negative resident. ASM #2 failed to wear gloves and a gown when putting an arm around Resident #3, who was COVID-19 positive. ASM #2 then sanitized her hands with alcohol gel and, without donning gloves or a gown, walked over to Resident #13, who was COVID-19 negative, put an arm around Resident #13, and assisted Resident #13 down the hall. The facility failed to implement droplet precautions by failing prevent Resident #3 and Resident #2, both COVID positive residents from wandering on the South unit without masks or PPE (personal protective equipment) (2). Resident #3, who was COVID-19 positive, was observed sitting at a table in common area accessible to both COVID 19 positive and negative residents. In the hallway, Resident #2 was observed self-propelling in her wheelchair, within three feet of Resident #13, who was COVID-19 negative and not wearing a mask. In the common area, Resident #2 sat within three feet of Resident #5, who was COVID-19 negative. As, a result of this failure, it was likely other residents were at risk of continued exposure and contracting COVID-19, which had already resulted in a COVID-19 positive status for over 60% (59 residents) of the current 109 resident population at the time of the survey, with one resident death, (Resident #8), attributed to COVID-19. This failure resulted in Immediate Jeopardy. On [DATE], at approximately 2:00 p.m., the facility failed to prevent Resident #14 from wandering from a COVID-19 positive area on the South Unit, through a set of fire doors, and to a nurses' station located directly across from a room housing COVID-19 negative residents, resulting in a situation of continued Immediate Jeopardy. In addition, the facility staff failed to implement infection control practice during incontinence care for one of 15 sampled residents, (Resident #15). The facility staff member failed to change gloves and to sanitize hands after cleansing Resident #15's perineal area (3) and handling the resident's soiled incontinence brief during incontinence care. Without cleaning hands or changing gloves, the staff member applied the resident's clean brief, helped pull the resident up in bed, and cleaned the resident's face with a wipe. The State Agency informed the facility on [DATE] at 10:42 a.m. of the Immediate Jeopardy situation. On [DATE] at 1:18 p.m., the Immediate Jeopardy was abated and lowered to a level II Isolated. The findings include: 1. On [DATE], the survey team began an abbreviated, remote FICS (focused infection control survey) at the facility. As a part of the remote survey process, the survey team contacted and interviewed staff members from both the local and central health department. On [DATE] at 11:21 a.m., OSM (other staff member) #1 was interviewed. She stated that, to her knowledge, no member of the local or central VDH (Virginia Department of Health) had been inside the facility. She stated that when she was first informed of COVID-19 positive residents at the facility; she sent them copies of the state health department guidance for long-term care facilities. OSM #1 stated that she made a phone call to connect with ASM (administrative staff member) #3, the administrator, and ASM #2, the director of nursing. At that time, ASM #2 and ASM #3 described the facility's layout, and stated that in addition to one resident who had been hospitalized and tested positive for COVID-19, the facility had identified four additional residents as symptomatic. OSM #1 stated the facility staff told her they had begun to implement a plan to make the facility's dining room the COVID-19 ward. OSM #1 stated it was the next day that the facility-wide and staff-wide testing for COVID-19 was performed, and then the results started coming back over the next few days. OSM #1 stated that on Thursday, [DATE], most all of the testing results had come back, indicating that over half the residents were COVID-19 positive, and 18 staff members were COVID-19 positive. She stated the facility then transferred 10 residents to the local hospital in an effort to, basically isolate them. OSM #1 stated the facility transferred the residents to the hospital to get them out of the facility and to stop the transmission inside the nursing facility. OSM #1 stated that she recommended, at that time, that the facility not try to do mass cohorting, as there were a significant number of COVID-19 positive residents on both units of the facility. When asked her professional response to the lack of mass cohorting of like residents, OSM #1 stated she had mixed feelings. She stated that moving residents can be disruptive to them, and that there is a risk of exposure to other residents during a move. OSM #1 stated there was some thinking that COVID-19 negative residents had already been exposed to [MEDICAL CONDITION] if their roommate was COVID-positive. OSM #1 stated, But I wonder how it is working in practice. I don't know the best way to assess if it is effective. She stated the best scenario would have been for COVID-19 positive residents to be placed with other positive residents, and vice versa for COVID-19 negative residents, but she was aware of staff limitations to implement fully the best scenario. OSM #1 stated the next best scenario would be to have the curtain pulled between residents, and for the staff to use different PPE (personal protective equipment) between residents. OSM #1 stated that her current understanding was that the facility was treating all residents as if they were COVID-19 positive. On [DATE], at 12:36 p.m., OSM #2, the director of the local health department, was interviewed. He stated that neither he nor any member of his staff had been inside the facility. OSM #2 stated one of his staff members had been up to the front door, but no further. When asked if he had any concerns about the way the facility was handling the outbreak, OSM #2 stated his concerns were about maintaining the staff and the quality of care they are giving. OSM #2 stated, I would not be horrified if you (State Survey Agency) made a site visit. But things seem to be better now than they were. On [DATE], at 12:47 p.m., OSM #3, a nurse epidemiologist from the state health department was interviewed. When asked about any concerns that she had for the facility, OSM #3 stated, They have a lot of COVID-19 there. OSM #3 stated the facility initially had a plan to use the dining room for COVID-19 positive patients, but she had expressed concerns to the facility staff about having adequate handwashing and toileting options available. OSM #3 stated the facility staff abandoned that plan because there were not enough staff members to do it. OSM #3 stated that once all facility residents had been tested and the results had come back, it was a situation where you found a lot of asymptomatic, positive residents. She stated this created a concern about how to move residents and about how to staff the move. OSM #3 stated, I can understand why they did not move or cohort residents. The staff was scared to come to work. OSM #3 stated, We backed off and let the facility take the lead. It was safer for the situation they were in. OSM #3 stated she had emphasized to the facility the need to change gown and gloves between negative and positive patients. On [DATE] at 1:10 p.m., a phone interview was conducted with ASM #4, a nurse supervisor for the local health department. She stated she had been in the facility parking lot during the previous week, and had observed staff wearing PPE outside in the parking lot. She stated her concerns about the facility, were primarily related to PPE usage, and about what kind of infection control

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) is happening there. On [DATE] at 1:30 p.m., after the survey team entered the facility, ASM (administrative staff member) #1, the acting administrator, was interviewed about rooms, which housed both COVID-19 positive and COVID-19 negative residents. When asked how the staff knew which residents in a room were positive, and which residents, were negative for COVID-19, ASM #1 stated that resident nameplates had colored stickers. A pink sticker meant a resident was positive for [MEDICAL CONDITION]; a yellow sticker meant a resident was negative for [MEDICAL CONDITION]. On [DATE] at 1:40 p.m., an initial tour of the facility's South Wing was completed. The following room nameplates indicated that both a COVID-19 positive and a COVID-19 negative resident were housed in the same room: 220, 217, 214, 213, 210, 209, 206, 225, 224, and 223. In room [ROOM NUMBER], the curtain between the resident beds, was only pulled approximately ,[DATE] of way down the length of the beds. In rooms [ROOM NUMBER], the curtain between resident beds was pulled approximately ,[DATE] way down the length of the beds. In room [ROOM NUMBER], the curtain between resident beds was not pulled at all. On [DATE], ASM (administrative staff member) #2, the director of nursing, was observed walking in hallway of the South Unit. ASM #2 was wearing a mask, but no gloves or gown. ASM #2 approached Resident #3, who was not wearing a mask, and who was walking down the hall. ASM #2 put her right arm around Resident #3's shoulders, and guided Resident #3 back towards her room. ASM #2 sanitized her hands with alcohol gel. Still without gloves or gown, ASM #2 approached Resident #13, who was not wearing a mask, and who was standing still in the hallway near the nurses' station. ASM #2 put her right arm around Resident #13's shoulders, and walked with Resident #13 all the way to the resident's room. On [DATE] at 3:45 p.m., Resident #3 was observed sitting alone at a table in the common area. She was not wearing a mask. While no other residents were observed in the area at this time, this common area was accessible to any resident on the South Unit. On [DATE] at 4:00 p.m., LPN (licensed practical nurse) #1 walked into the common area where Resident #3 was sitting. LPN #1 was wearing mask, gown, and gloves. She approached Resident #3, and invited the resident to walk with her down the hall and to return to her room. When asked why she was inviting the resident to go back to her room, LPN #1 stated, She is one of the ones that is hard to keep in her room. LPN #1 stated the resident had been pretty compliant that day, and had three masks in her room. When asked why it was important for Resident #3 to wear a mask and to remain in her room, she stated the resident was at risk of spreading the COVID-19 virus. Review of the clinical records for Resident #3 and #13, remotely, revealed Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of [DATE], the resident was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as being independent for walking in her room and moving around on the unit. A review of Resident #3's nurse notes revealed a note on [DATE] stating that she tested positive for COVID-19. A review of Resident #3's care plan dated [DATE] and updated [DATE] revealed, in part: Droplet isolation precautions (6) from COVID-19 .Keep resident in room .Staff to wear PPE (personal protective equipment) at all times and maintain good hand hygiene .Behavior wandering - The resident is an elopement risk/wanderer r/t disoriented to place, impaired safety awareness, wanders aimlessly due to dementia .distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Further review of Resident #3's clinical record revealed the following nurse note dated [DATE]: Resident was given a mask for protection. Resident is confused and may take off and refuse mask. Further review of Resident #3's clinical record revealed the following nurse note dated [DATE]: Resident was given a mask for protection. At this time resident has mask on, but resident has advanced dementia and may take it off. Resident #13 was admitted to the facility on [DATE]; [DIAGNOSES REDACTED]. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of [DATE], Resident #13 was coded as having severe impairment for making daily decisions, having scored only six out of 15 on the BIMS. She was coded as being independent for walking in the room moving around the unit. A review of Resident #13's laboratory test results received by the facility on [DATE] revealed that she tested negative for COVID-19. A review of Resident #13's care plan, dated [DATE] and updated [DATE] revealed, in part: BEHAVIORS (Resident #13) was in a physical altercation with another resident. Potential for further altercations with others and staff due to dementia with behaviors .provide redirection or distraction to minimize frequency or duration of behavior .Resident at risk for cross infection r/t (related to) actual/potential exposure to COVID-19 .Droplet isolation precautions from COVID-19 .Initiate social distance of 6 feet away from resident unless giving care .Keep resident in room .Staff to wear PPE at all times and maintain good hand hygiene .BEHAVIOR/WANDERING - The resident is an elopement risk/wanderer related to [MEDICAL CONDITION], known to wander when she was home .Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book .[MEDICAL CONDITION] - The resident has dementia causing impaired thought process r/t Alzheimer's .Cue, reorient, and supervise as needed .The resident needs supervision and assistance with all decision making. On [DATE] at 2:54 p.m., Resident #2 was observed sitting in a wheelchair in the common area watching television. Resident #2 was not wearing a mask. Resident #5 was observed sitting in a brown recliner watching television, and was within three feet of Resident #2. Resident #5 was wearing a mask. Resident #5 was asked his name and the location of the room. He answered the surveyor appropriately. When asked how often he watched television in the common area, he stated that he watched television right much. When asked if he always wore a mask, Resident #5 stated, Yes. An observation of this common area again at 3:05 p.m., revealed Resident #5 was no longer in the common area. Resident #2 remained there in her wheelchair, wearing no mask. On [DATE] at 3:12 p.m., Resident #2, who was COVID-19 positive and not wearing a mask, was observed self-propelling in her wheelchair, from the common area down the hall towards the nurses' station. As Resident #2 traveled down the hall, she passed within three feet of Resident #13, who was COVID-19 negative and not wearing a mask. Review of the clinical records for Resident #2 and Resident #5 completed remotely, revealed Resident #2 was admitted to the facility on [DATE], and most recently readmitted on [DATE], with [DIAGNOSES REDACTED]. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of [DATE], Resident #2 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as being independently mobile with supervision and the use of a wheelchair. A review of Resident #2's nurse notes revealed a note on [DATE] stating that she tested positive for COVID-19. Resident #2's comprehensive care plan, dated [DATE] and updated on [DATE], revealed, in part the following: Resident exhibits signs of alteration in respiratory status and at risk for cross infection due to positive test for COVID 29 (sic) .Droplet isolation precautions for COVID-19 .Keep resident in room .Staff to wear PPE at all times and maintain good hand hygiene .The resident is able to propel herself independently in wheelchair at times, and other times requires supervision with occasional assistance .BEHAVIOR Noted with increased confusion. Resident refuses to wear face mask .Continue to encourage to wear face mask .Identify pattern of wandering: Is wandering purposeful, aimless or escapist? Is resident looking for something? Does it indicate the need for more assistance? .Cue, reorient, and supervise as needed. Resident #5 was admitted to the facility on [DATE], and was readmitted on [DATE]; [DIAGNOSES REDACTED]. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of [DATE], Resident #5 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS. Resident #5 was coded as requiring the help of one staff member for moving around the unit. He was coded as using a walker for mobility. A review of Resident #5's nurse notes revealed a note dated [DATE] documenting that Resident #5 tested negative for COVID-19. Review of Resident #5's comprehensive care plan, dated [DATE] and updated on [DATE], revealed, in part the following: Resident is at risk for cross infection r/t (related to)actual/potential exposure to COVID-19 .Droplet precautions from COVID-19 .Initiate social distance of 6 ft (feet) away from resident unless during care .Keep resident in room .THOUGHT PROCESS Potential for thought processes impaired d/t (due to) prior stroke .Cue, reorient and supervise as needed. On [DATE] at 4:02 p.m., ASM #1 was interviewed about the process staff followed for the decision to leave COVID-19 positive residents in the same rooms with COVID-19 negative residents. She stated that the facility had undergone testing for all residents and staff. ASM #1 stated that when the results of the testing came back, the results indicated, Everyone had been exposed. She stated that at that time, the decision was made to leave all residents where they were, as more than 49 residents would have needed room changes to separate COVID-19 positive from COVID-19 negative residents. ASM #1 stated one of the facility's strategies of isolating COVID-19 positive from COVID-19 negative residents was to keep the curtain pulled between residents. She stated a staff member from the health department had instructed the facility to do this to maintain a barrier between COVID-19 positive and COVID-19 negative residents. When asked what it meant if the curtains were not pulled completely between COVID-19 positive and COVID-19 resident beds, ASM #1 stated the curtains should be pulled if both a COVID-19 positive and a COVID-19 negative resident were housed in the same room. When informed that interviews with the local health department had yielded information indicating that there was not enough staff to make resident room moves in order to separate COVID-19 positive and COVID-19 negative residents after the all-resident testing, ASM #1 stated, That is true - with 49 room moves and we had staff calling out. ASM #1 was informed

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) that Residents #2 and #3, who were positive for COVID-19, were observed wandering the halls and common areas without a mask. ASM #1 stated, Yes, we have given them masks. It is hard to keep them in their rooms, though. When asked the facility was still responsible to implement infection control precautions to prevent the spread of COVID-19 from positive to negative residents, ASM #1 stated, Yes, they should stay in their room, and we keep giving them masks to use. Review of the Line List for COVID-19 Outbreaks, submitted by the facility for review by fax on [DATE], revealed, the following documented entry for Resident #8: - Name of resident (Resident #8), Unit or Room, N (no), Onset Date, ,[DATE], Cough (Y/N), N, Fever (Y/N), N, Shortness of Breath (Y/N), N, [DIAGNOSES REDACTED] (severe acute respiratory syndrome) COV-2 test result (+/-), + (positive), Respiratory Panel Test Result (+/-), - (dash), hospitalized (Y/N), N (no), died (Y/N), ,[DATE]. Under the section titled Notes: a + sign that was circled and handwritten note beside this documented, COVID-19, with staff initials. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On the most recent MDS (minimum data set), an annual assessment with an assessment reference date of [DATE], Resident #8 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). A review of Resident #8's clinical record revealed a nurse note dated [DATE] documenting that the resident had tested positive for COVID-19. Further review revealed a nurse note dated [DATE] documenting notification to the sons of the resident that the resident's condition had worsened. Further review revealed a nurse note dated [DATE] documenting the resident's death at 2:37 p.m. A review of the facility policy, Isolation - Categories of Transmission-Based Precautions, revealed, in part: Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others .Droplet Precautions .In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets (larger than 5 microns in size) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning) .Resident Placement (1) Place the resident in a private room if possible .When a private room is not available, residents with the same infection with the same microorganism but with no other infection may be cohorted. When a private room is not available and cohorting is not achievable, use a curtain and maintain at least 3 feet of space between the infected resident and other residents and visitors. A review of the facility policy, Outbreak of Communicable Diseases, revealed, in part: Outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled .The nursing staff will be responsible for initiating isolation precautions as directed or as necessary; and confining symptomatic residents to their rooms as much as feasible, when indicated. A review of the facility policy, Topic: Caring for the Resident with a Suspected or Confirmed Case of COVID-19, revealed, in part: Residents with confirmed or suspected cases of COVID-19 will be cared for in accordance with guidelines as stipulated by the CDC. All efforts will be made to prevent transmission, treat symptoms, and provide necessary psychosocial support for infected resident (sic) .Patients with known or suspected COVID-19 will be transferred to the designated unit, and when feasible provided with a private room .Residents that have a confirmed case of COVID-19 can cohort with other residents who have a confirmed COVID-19 .The following measures will be implemented for residents with known or suspected COVID-19: a facemask will be placed on the resident and worn as tolerated, transmission based precautions will be instituted to include placement of isolation cart at entrance of room and signage on the door, caregivers will don appropriate personal protective equipment (PPE) - gown, mask, face/eye shield, gloves. A review of the facility's corporate document, Rapid Response Plans in Event of Confirmed Infection, revealed, in part: 1. Triggering the Risk Management Team to coordinate response. Key Goals: Reduce morbidity and mortality, minimize disease transmission, protect healthcare personnel, preserve healthcare system functioning. 2. Activate COVID-19/Observation Unit Assessment for affected patient. Isolate patient .Facility works with local DOH (department of health) on federal recommendations. A review of the facility's policy, COVID-19 (Coronavirus) revealed, in part: This guidance is based on the currently available understanding of COVID-19-nCOV related to disease severity, transmission efficiency, and shedding duration which is crucial in understanding [MEDICAL CONDITION] transmission and control .[MEDICAL CONDITION]' main means of spreading is thought to be person-to-person transmission. This includes, but is not limited to: people who are within about six feet of each other, respiratory droplets produced when an infected person coughs or sneezes. It can also be spread from contact with infected surfaces or objects .Preventative Measures .Patient Placement: Residents identified to have COVID-19 should be placed in an AIIR (Airborne Infection Isolation Room) or isolation room until transferred to a hospital or healthcare facility equipped with treating such infections and reported to local Board of Health. On [DATE] at 4:30 p.m., after the onsite visit was completed, the long-term care supervisor was notified of the survey team's observations and a conference call was completed with two additional supervisors and the survey team. On [DATE] at 6:49 p.m., it was determined that the facility's failure to implement infection control practices to prevent the spread of a communicable disease (COVID-19), resulted in a situation of IJ (immediate jeopardy). On [DATE] at 7:02 p.m., the survey team attempted to contact the acting administrator of the facility, ASM #1. The survey team was informed that the administrator had left for the day. On [DATE] at 8:25 a.m., 8:44 a.m., 9:21 a.m., and 9:23 a.m., the survey team attempted to contact ASM #1, the acting administrator. On [DATE] at 10:42 a.m., the administrator was reached by phone, and was informed of the concern for IJ. ASM #1 stated, I knew it was going to be this. She stated, the only way to fix this is to cohort the patients and round up the bodies to do this. ASM #1 was instructed to not begin moving residents or take any other action until the facility had submitted a POC (plan of correction), and the POC had been approved by the survey team and Long Term Care Supervisor. On [DATE] at 11:36 a.m., the surveyor received a call from OSM (other staff member) #1, the director of the local health department. OSM #1 stated he had received a most disturbing phone call from the CEO (chief executive officer) of the company that owns the facility. OSM #1 stated the CEO is very upset that they have received notification of some, sort of very bad, punitive measures that have financial implications. OSM #1 stated, I thought we were clear about all of this. He stated, I want to know what is going on, and asked what the facility CEO had been told. OSM #1 was informed that the only correspondence by the survey team, had been with ASM (administrative staff member) #1, a corporate staff member who is acting as the facility administrator and that ASM #1 had been informed of a concern for the facility's failure to implement infection control practices to prevent the spread of a communicable disease COVID-19. OSM #1 asked if the survey team was concerned because COVID-19 positive residents are in the same rooms with COVID-19 negative residents. OSM #1 was informed that observations made onsite on [DATE] raised concerns. OSM #1 then asked to be informed of those concerns, and was informed of the findings of curtains not closed between positive and negative residents, of positive residents roaming freely without PPE and coming into close contact with negative residents. OSM #1 was informed of the facility staff member without PPE in direct contact with a COVID-19 positive resident, with subsequent direct contact with a COVID-19 negative resident. OSM #1 stated that the CEO had not told him these things, and that there seemed to be more to this story. OSM #1 stated, Those things can be fixed. From [DATE] through [DATE], a review of the facility presented several POC (plan of correction) drafts, which were reviewed and declined, due to not meeting all the requirements. On [DATE], the facility presented the following plan of correction. 1. On [DATE], Resident #1 was redirected to her room by staff when observed outside of her room. Resident refuses to leave facemask in place. On [DATE], Resident #2 was redirected to her room by staff when observed outside of her room. Resident refuses to leave a facemask in place. On [DATE], Resident #3 was redirected by staff when observed outside of her room. Resident refuses to leave facemask in place. All care plans reflect refusal to wear facemask. On [DATE], curtains were not pulled between resident beds in cohorted rooms, room # 220, 216, 210, 216, and 225. Rounds on [DATE] showed privacy curtains pulled appropriately in room [ROOM NUMBER], 216, 210, 216, and 225 On [DATE], Nurse #1 observed having direct contact with two positive COVID 19 residents wearing only a facemask, no other PPE. Rounds on [DATE] completed by VP (vice president) of Clinical Services showed all staff wearing appropriate PPE while interacting with residents. Any negative resident has potential to be at risk for contracting [MEDICAL CONDITION] pathogens due to cohorting of positive and negative residents in the same areas within the facility 2. Room changes implemented to move residents to designated positive and negative areas within the facility. On North Unit, the unit will be divided into positive and negative zones, separated by a fire door. Two positive rooms will be outside the doors but will house non wandering residents that stay in their rooms. COVID positive Residents noted to wander will be housed behind the closed fire doors to prevent wandering into negative areas. South Unit will be divided by the hallway in front of the nurses' station with negatives and positives on either side of the unit. COVID positive Residents noted to wander will be housed behind the closed fire doors to prevent wandering into negative areas. Any positive rooms outside of fire door will house non wandering residents that stay in their rooms. Negatives with symptoms will be cohorted together. When optimal staffing present, Staff working with positive residents will only be assigned to the COVID zone with use of full PPE: One designated nurse on ,[DATE] and ,[DATE], and half of the scheduled CNA's. One nurse ,[DATE] and ,[DATE], one half of scheduled CNA's

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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 -** Some	(continued... from page 3) will be designated to the negative zone. ,[DATE] has only one nurse per unit, so that nurse will provide medications and complete assessments to negative residents first, and then complete same tasks on the COVID unit wearing appropriate PPE, half of CNA's will be assigned to COVID positive zone. This applies to both North and South Unit. Medication carts will be designated to the positive and negative areas, and will remain in their designated area. When staffing is less than optimal and staff must have assignments which include residents with both positive and negative test results, staff will attempt to provide care to negative residents first, using standard precautions and face mask. When leaving negative zone, must remove surgical facemask, and wash their hands. When entering positive zone, must don full PPE, including N95 mask pri