STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. Building B. Wing	07/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harnett Woods Nursing and Rehabilitation Center	604 Lucas Road Dunn, NC 28334

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on observation, record review, staff interview, and physician interview the facility failed to update their policy regarding transmission-based precautions for COVID-19 prevention and thereby failed to place three (Resident # 1, #7, and #9) out of eight sampled residents reviewed for COVID-19 prevention on transmission-based precautions. This occurred during a coronavirus pandemic. The findings included. The facility's policy entitled, Guidelines for Quarantine Considerations for Community Visits and Close Contact, dated as last revised on [DATE], read in part, Residents, who are fully vaccinated that leave the facility for more than 24 hours or who have close contact with a COVID-19 positive individual in the facility, do not require quarantine. However, these residents must: wear a mask, socially distance, be tested two days after exposure and again at ,d+[DATE] days after exposure to confirm they are negative. Review of CDC (Center for Disease Control) guidance revealed CDC's guidelines had been updated again on [DATE]; which was after the facility's last policy update. The [DATE] CDC guidelines read in part as follows: Roommates of residents with SARS-CoV-2 infection should be managed as described in Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection. Empiric use of Transmission-Based Precautions (quarantine) is recommended for residents who are newly admitted to the facility and for residents who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses. In general, all residents who are not up to date with all recommended COVID-19 vaccine doses and are new admissions and readmissions should be placed in quarantine, even if they have a negative test upon admission, and should be tested as described in the testing section; Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which of these residents require quarantine upon admission. Review of CDC's COVID transmission rates for the facility's county revealed for all the dates on which data was recorded between [DATE] and [DATE], the county's transmission rate was marked as high. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] a review of the facility's COVID case tracking information revealed the facility was currently in outbreak status. As of [DATE] one resident currently had COVID and was on TBP (transmission- based precautions). As of [DATE] one staff member currently was out of work due to testing positive for COVID. The facility's documentation showed they had been using contact tracing during the outbreak to identify high risk exposures. 1a. Resident # 9 was admitted to the facility on [DATE]. Review of documentation provided by the facility regarding COVID vaccine and case tracking information revealed Resident # 9 was fully vaccinated but not up to date with her COVID vaccinations. Resident # 9 was documented to reside with Resident # 8 prior to the date of [DATE]. According to the facility logs, Resident #8 tested positive for COVID on [DATE]. Resident # 9 tested positive for COVID on [DATE]. Resident #9's nursing notes on [DATE] at 10:37 AM, [DATE] at 12:55 PM, and [DATE] at 11:05 AM revealed the resident had non labored breathing, was afebrile, and had an occasional non-productive cough after being diagnosed with COVID. 1b. Resident # 7 was originally admitted on [DATE]. Review of documentation provided by the facility regarding COVID vaccine and case tracking information revealed Resident # 7 was fully vaccinated but not up to date. Resident # 7 was documented as residing with Resident # 6 prior to the date of [DATE]. Resident # 6 tested positive for COVID on [DATE]. Resident # 7 tested positive for COVID on [DATE]. Resident # 7's nursing notes on [DATE] at 2:24 AM, [DATE] at 1:47 PM, [DATE] at 10:54 AM and [DATE] at 1:22 PM revealed Resident #7 had no shortness of breath after being diagnosed with COVID. The note of [DATE] at 1:22 PM noted the resident continues to only have runny stuffiness to nose. 1 c. Resident # 1 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE]. According to Resident # 1's record, he was fully vaccinated for COVID but not up to date. Resident # 1 tested negative for COVID upon readmission to the facility on [DATE]. Resident # 1 was observed on [DATE] at 10:00 AM in a room residing with another resident. There was no signage on the door indicating Resident # 1 was on transmission- based precautions. Nurse # 1 was observed in Resident # 1's room at this time without full PPE (personal protective equipment). Nurse # 1 had eye protection and a N95 mask but no gown. Upon exiting Nurse # 1 was interviewed regarding whether the resident was on TBP and stated she had just returned to work and did not know. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was interviewed on [DATE] at 1 PM and reported the following. They had not updated their facility policy since the CDC updates on [DATE]. They had not been placing new admissions or readmissions on TBP if they were not up to date with COVID vaccines because they were going by the former guidance which referenced vaccinated admission/ readmissions did not have to be placed on TBP. They had not been taking many admissions in the past month and therefore this would not have affected many residents. They also had not been placing roommates of residents who tested positive for COVID on TBP. They did restrict the roommate to their room while the facility tested the roommate on days 1,2, 3, 5 and 7 to determine if they would contract COVID. All staff, even if the facility was not in outbreak status, were required to wear N95 masks while providing care to residents. All the staff also were required to wear eye protection while caring for residents. The facility was also using plasma filters within their heating and air system in addition to using an electrostatic sprayer for disinfectant application in targeted areas to control cases. At the current time of [DATE], the facility only had one resident who was COVID positive. The Administrator reported none of the residents who had been COVID positive in the facility's current outbreak had been very sick. None had been hospitalized or expired from COVID illness. The facility's Medical Director was interviewed on [DATE] at 1:45 PM and reported the following. During the facility's current outbreak status, none of the residents had any severe illness. Some residents, who had contracted the illness during the current outbreak, had both been vaccinated and historically had COVID before. This had boosted their immunity and therefore even if some of the residents had not been placed on TBP, it was his opinion that this had not significantly impacted the outcome of who had gotten sick. The Medical Director also stated that when the outbreak occurred, he had placed all residents on a prophylactic COVID cocktail of Vitamin D, Vitamin C, Zinc, and Pepcid.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on record review and staff interview the facility failed to assure two (Residents # 4 and # 5) of five residents reviewed for immunizations had either received their pneumococcal immunization (Resident # 5) or that staff followed up to determine if a resident was eligible to receive one (Resident # 4). The findings included: 1. Resident # 5 was admitted to the facility on [DATE] and was over [AGE] years of age. The resident's quarterly Minimum Data Set Assessment, dated 7/4/22, coded the resident as cognitively impaired. A review of Resident # 5's record revealed Resident # 5's RP (Responsible Party) had signed consent that Resident # 5 could have the pneumonia vaccine. A review of Resident # 5's record on 7/22/22 revealed Resident # 5 had been immunized with the Pre-var 13 (one of the recommended pneumonia vaccines) on 11/14/20 but had never received the PPSV23 vaccine (a second Pneumonia Vaccine recommended for those over the age of 65.). It was validated with the Administrator on 7/23/22 at 1 PM that Resident # 5 had never had the PPSV23 and the staff should have followed up about the lack of immunization. According to the interview with the Administrator on 7/23/22 at 1 PM, the unit managers were responsible for assuring vaccines were given. 2. Resident # 4 was admitted to the facility on [DATE]. The resident's Admission Minimum Data Set assessment, dated 7/4/22, coded Resident # 4 as cognitively impaired. On 7/22/22 a review of Resident # 4's record revealed no history of pneumococcal vaccine administration. The Administrator was interviewed on 7/23/22 at 1:00 PM and again at 3:45 PM. The Administrator reported that the staff were supposed to be following up on whether Resident # 4 had had her pneumococcal vaccines prior to coming to the facility by the resident's outside medical practice, and there still had not been any verification by her staff. According to the Administrator, this should have been verified by the date of 7/23/22 in order that the staff know whether they should offer the vaccination to the resident by way of her responsible party.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Perform COVID19 testing on residents and staff. 13289 Based on observation, record review, and staff interview the facility failed to assure testing was done per CDC (Center for Disease Control) guidelines to assure the accuracy of the results for two of six staff members reviewed for COVID testing. The facility failed to assure a staff member, who was testing for COVID, was knowledgeable about the practice of testing. The facility also failed to wait at least 24 hours prior to testing a staff member who had been exposed to another COVID positive staff member per current CDC guidelines. The findings included: 1. On 7/22/22 at 11:25 AM dietary employee (DE) # 1 was observed to enter the facility's conference room, where COVID testing materials were located. DE # 1 gathered COVID testing supplies and began testing herself for COVID. DE # 1 asked the surveyor if the surveyor knew how long she was supposed to wait to get a result and commented that they had told her to come and test and if the test was positive it would turn positive in just a few minutes. DE # 1 stated her nose was stuffy and she just wanted to make sure she did not have COVID. DE # 1 did not know if there was supposed to be someone who was to be helping her with the test. Immediately following the observation, Nurse Consultant # 1 was located in a different part of the facility by the surveyor. Nurse Consultant # 1 was informed that DE # 1 was testing herself for COVID and was unsure how long she was to wait for the results. Nurse Consultant # 1 responded that someone would help DE # 1. On 7/22/22 at 4:40 PM the facility's Infection Preventionist (IP) was interviewed and reported the following. DE # 1 had been retested by her and the Director of Nursing (DON) that day to make sure it was done correctly and DE # 1 tested negative. She and the DON had talked to DE # 1 after the surveyor had observed DE # 1 testing herself and learned that no one in a supervisory position had told DE # 1 to test herself. DE # 1 had been talking to the other dietary staff members earlier that day and let them know she did not feel all that great. The other staff members had told her she could go test herself and that it only takes a minute or two. The IP reported it was the facility's system that any employee who had COVID symptoms was to go directly to a nurse. The nurses were trained in the correct testing procedures and would have made sure it was done correctly. The IP stated there was a nursing station right outside the dietary department and DE # 1 should have gone there to report to a nurse she was not feeling well. The Medical Director was interviewed on 7/23/22 at 1:45 PM and reported he felt that there should only be a few people, who were trained in correct testing, to be designated as the staff members to conduct COVID testing. 2. Review of the Center for Disease Control guidelines for testing, updated on 1/21/22, revealed the following information. All HCP (health care personnel) who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested as described in the testing section. For those who have not recovered from SARS-CoV-2 infection in the prior 90 days, perform SARS-CoV-2 testing immediately (but generally not earlier than 24 hours after the exposure) and, if negative, again 5-7 days after the exposure. (continued on next page)

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility tracking information for COVID positive employees revealed Nurse # 2 tested COVID positive on 6/27/22. According to the contract tracing records, Nurse # 3 had ridden to work with Nurse # 2 on 6/27/22. Review of testing results revealed the facility tested Nurse # 3 on 6/27/22; the day she was exposed while riding to work with Nurse # 2. Interview with the Administrator on 7/23/22 at 3:45 PM revealed the facility did not wait to test Nurse # 3 for 24 hours after her initial exposure (which was her car ride on 6/27/22). Interview with the Administrator and review of facility records revealed Nurse # 3 never contracted COVID from the exposure.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on record review and staff interview the facility failed to assure one (Resident # 4) of two sampled residents who were not vaccinated for COVID received their COVID vaccine per their responsible party's choice to follow guidelines and have the vaccine administered. The findings included: 1. Resident # 4 was admitted to the facility on [DATE]. The resident's Admission Minimum Data Set assessment, dated 7/4/22, coded Resident # 4 as cognitively impaired. A review of the record revealed Resident # 4's RP (responsible party) had signed consent for Resident # 4 to have the COVID vaccine on 6/28/22 when the resident was admitted . On 7/22/22 a review of Resident # 4's record revealed no history of COVID vaccine administration. According to the record, the resident had not tested positive for COVID while residing at the facility. The Administrator was interviewed on 7/23/22 at 1:00 PM and again at 3:45 PM. The Administrator reported that their pharmacy comes to the facility and administers the COVID vaccine when residents or their responsible parties give permission. The Administrator reported the pharmacy could respond within a few days to administer the vaccine when contacted but verified that Resident # 4 had never received her COVID vaccine since her RP signed permission for it on 6/28/22. According to the Administrator she kept track of the residents who wanted to have the COVID vaccine and the reason Resident # 4 was not vaccinated was because she had not yet followed up with the pharmacy to alert them there was a need to come and administer the vaccine.