STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305087	A. BUILDING _____ B. WING _____	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW COMMUNITY	93 WATER VILLAGE ROAD OSSIPEE, NH 03864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control (FIC) survey was conducted on 4/7/23 through 4/10/23. Intake #44287 was investigated with deficiencies cited. Immediate Jeopardy (IJ) was identified on 4/10/23 for non-compliance with 42 CFR 483.80 at F880 Infection Prevention & Control. This deficiency resulted in IJ due to staff not following return to work policies after infection with COVID-19. Non-compliance at F880 could result in the potential transmission of COVID-19 to other residents and healthcare workers. The administrator was notified on 4/10/23 at 2:35 p.m. that IJ conditions existed under F880 Infection Prevention & Control. The IJ Template was provided at that time. The IJ at F880 Infection Prevention & Control was removed on 4/10/23 while onsite after the implementation of an immediate action plan on 4/10/23 that included education to the Infection Preventionist regarding return to work guidance and an audit of all current COVID-19 positive staff with return to work dates to ensure they were meeting the return to work guidance timeframe. Capacity: 103 Census: 87	F 000		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	Please see next page	

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

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F 880	Continued From page 1 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	Mountain View Community has taken the following steps to address the F-880 and the seriousness of the deficiency is imperative to make changes immediately to ensure nothing further has happened nor will it occur again. An audit took place reviewing April 9-15, 2023 to ensure there were no infractions occurring, **none found**. A three-person oversight committee was created with the following personnel: scheduling, Director of Nursing, and the Infection preventionist. They will ensure all persons with Covid will not be on the schedule nor allowed to work. A three-ring binder was created on April 18, 2023 to store audit, communication report and tracking forms. Policies and processes were reviewed and updated as necessary to address area of deficiency. Re-education was documented for those personnel who may potentially be involved in staffing decisions. All staff have received the **Return to Work policy and Staffing in Emergencies. This was initiated on April 19, 2023 via email, in person and on PCC.** QA meeting on April 25, 2023 also addressed these policies and corrective actions.	

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F 880	Continued From page 2 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80€ Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to follow the return to work guidelines for health care personnel who were positive for COVID-19 illness from working in the facility. 1 of 13 staff reviewed for COVID-19 infection returned to work the day after they tested positive for COVID-19. 12 of 13 staff reviewed for COVID-19 infection returned to work on day 4 or later. This failure increased the likelihood of exposure to pathogens for the facility's census of 87 residents, staff, and visitors (Staff identifiers are A, M, N, O, P, W, Q, R, S, G, T, U, and V). Findings include: Review on 4/10/23 of the facility COVID-19 line list of positive staff and the March 2023 and April 2023 nursing schedules revealed the following:	F 880	The two policies updated and educated on were the Return to Work after illness policy and the Staffing in Emergencies policy. We have started working with a QIO group IPRO and first meeting is Monday April 24, 2023. A site visit from the QIO group will take place on Wednesday May 3, 2023. The IP, DON and administrator met on numerous periods of time since receiving the survey report. April 24-28, 2023. The team discussed, problem solved and reviewed all policies to ensure this does not occur again. Part of this process was to complete a root cause analysis. This was completed on April April 19, 2023. Results from this root cause analysis will be discussed at QA meeting on April 25, 2023. However, we have identified the root cause as being Covid fatigue and human error. We believe all the systems we have put in place with policies, oversight and audits will address the issues. Communication log was created on April 24, 2023 to allow IP to share return to work information to supervisors, Department heads or anyone who may have authority to assign staff.	

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F 880	Continued From page 3 Staff A (Registered Nurse (RN)) tested positive for COVID-19 on 3/14/23 and returned to work on 3/20/23 (Day 6); Staff M (RN) tested positive for COVID-19 on 3/17/23 and returned to work on 3/24/23 (Day 7); Staff N (Licensed Nursing Assistant (LNA)) tested positive for COVID-19 on 3/28/23 and returned to work on 4/2/23 (Day 5); Staff O (LNA) tested positive for COVID-19 on 3/28/23 and returned to work on 4/4/23 (Day 7); Staff P (LNA) tested positive for COVID-19 on 3/28/23 and returned to work on 4/5/23 (Day 8); Staff W (Activities Aide) tested positive for COVID-19 on 3/28/23 and returned to work on 4/3/23 (Day 6); Staff Q (Licensed Practical Nurse (LPN)) tested positive for COVID-19 on 3/29/23 and returned to work on 4/5/23 (Day 7); Staff R (Medication Nursing Assistant (MNA)) tested positive for COVID-19 on 3/29/23 and returned to work on 4/4/23 (Day 6); Staff S (LPN) tested positive for COVID-19 on 3/29/23 and returned to work on 4/4/23 (Day 6); Staff G (LNA) tested positive for COVID-19 on 3/30/23 and returned to work on 4/5/23 (Day 6); Staff T (LNA) tested positive for COVID-19 on 3/30/23 and returned to work on 3/31/23 (Day 1); Staff U (LNA) tested positive for COVID-19 on 4/1/23 and returned to work on 4/5/23 (Day 4); Staff V (LNA/Activities Aide) tested positive for COVID-19 on 4/1/23 and returned to work on 4/6/23 (Day 5). Interview on 4/7/23 at approximately 10:00 a.m. with Staff A (RN) revealed that he/she had COVID-19 on 3/12/23 and had returned to work on 3/20/23. Staff A also revealed that he/she tested negative either on 4/3/23 or 4/5/23.	F 880	The two policies updated and educated on were the **Return to Work after illness policy and the Staffing in Emergencies policy.** **All forms etc are lettered and listed on the index form attached**	

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Interview on 4/7/23 at approximately 12:30 p.m. with Staff B (Infection Preventionist) confirmed that Staff A returned to work on Day 6 after they tested positive for COVID-19. Staff B stated the facility was using "contingency" staffing guidance at that time. Staff B stated they were following the return to work criteria for contingency staffing during the recent COVID-19 outbreak due to staff being out sick.

Interview on 4/10/23 at approximately 11:30 a.m. with Staff B confirmed that Staff T tested positive for COVID-19 on 3/30/23 and was working on the 11 p.m. to 7 a.m. shift performing direct resident care on 3/31/23, 4/1/23, 4/2/23, 4/3/23, 4/5/23, 4/6/23 and 4/7/23. Staff B stated that at the time the facility was following the "crisis" staffing guidelines.

Interview on 4/10/23 at approximately 1:30 p.m. with Staff X (Administrator) revealed that the process for changing to contingency or crisis staffing is done between the Infection Preventionist, Director of Nursing and the Administrator. Staff X stated that they were aware that Staff T was positive for COVID-19 and working while positive as they were informed that they had no other options due to low staffing and no one to replace Staff T. Staff X stated that if the facility cannot cover an open shift and staffing is needed they would utilize the MDS [Minimum Data Set] Nurse, Infection Preventionist and then the Director of Nursing to cover the shift as a last resort. Further interview with Staff X confirmed that no nurse managers were scheduled for the 6 days above that Staff T worked while COVID-19 positive and confirmed that 5 of those days they had more than minimal staffing to allow for Staff T to have the time off.

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F 880	Continued From page 5 Interview on 4/10/23 via phone call at approximately 2:30 p.m. with Staff Y (Director of Nursing) revealed that he/she did not realize that Staff T worked all 5 days after testing positive for COVID-19. Staff Y also revealed that the process for changing to contingency or crisis staffing is done by the Infection Preventionist, but should be completed by all of the management team. Review on 4/10/23 of the Centers for Disease Control (CDC) "Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 [Severe acute respiratory syndrome coronavirus 2] Infection or Exposed to SARS-CoV-2", updated September 23, 2022, revealed, "... Return to Work Criteria for HCP [Health Care Personnel] with SARS-CoV-2 Infection. The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions. After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen. If symptoms recur (e.g. [for example], rebound) these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the healthcare criteria below to return to work unless an alternative diagnosis is identified. HCP with mild to moderate illness who are not moderately to severely immunocompromised could return to work after the following criteria have been met: At least 7 days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), and at least 24 hours	F 880		

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have passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) have improved. *Either a NAAT [Nucleic Acid Amplification Test] (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later..."

Review on 4/10/23 of the CDC "Strategies to Mitigate Healthcare Personnel Staffing Shortages", updated September 23, 2022, "... Key Points... CDC's mitigation strategies offer a continuum of options for addressing staffing shortages. Contingency strategies followed by crisis strategies are provide to augment conventional strategies and are meant to be considered and implemented sequentially (i.e. [that is], implementing conventional strategies followed by contingency strategies followed by crisis strategies. Introduction ... CDC's mitigation strategies offer a continuum of options for addressing staffing shortages. Contingency, followed by crisis capacity strategies, augment conventional strategies and are meant to be considered and implemented sequentially (i.e., implementing contingency strategies before crisis strategies)... Allowing HCP with SARS-CoV-2 infection to return to work before meeting the conventional criteria could result in healthcare-associated SARS-CoV-2 transmission. Healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is utilizing these strategies, specify the changes in practice that should be expected, and describe the actions that will be taken to protect patients and HCP from exposure to SARS-CoV-2 if HCP with suspected or confirmed SARS-CoV-2 infection are requested to work to fulfill staffing

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needs. As part of conventional strategies, it is recommended that healthcare facilities: Ensure any COVID-19 vaccine requirements for HCP are followed, and where none are applicable, encourage HCP to remain up to date with all recommended COVID-19 vaccine doses. Understand their normal staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care under normal circumstances. Understand the local epistemology of COVID-19-related indicators (e.g., community transmission levels). Communicate with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed... When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. These include: Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities. Cancel all non-essential procedures and visits. Shift HCP who work in these areas to support other patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation and training to work in these areas that are new to them. Attempt to address social factors that might prevent HCP from reporting to work, such as need for transportation or housing that allows for physical distancing, particularly if HCP live with individuals with underlying medical conditions or older adults. Consider that these social factors disproportionately affect persons

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from some racial and ethnic groups, who are also disproportionally affected by COVID-19 (e.g., African Americans, Hispanics and Latinos, and American Indians and Alaska Natives). Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP. As appropriate, request that HCP postpone elective time off from work. However, there should be consideration for the mental health benefits of time off and that care-taking responsibilities may differ substantially among staff. Developing regional plans to identify designated healthcare facilities or alternate care sites with adequate staffing to care for patients with SARS-CoV-2 infection. Allowing HCP with SARS-CoV-2 infection who are well enough and willing to work to return to work as follows: HCP with mild to moderate illness who are not moderately to severely immunocompromised: At least 5 days have passed since symptoms first appeared (day 0), and at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) have improved. Healthcare facilities may choose to confirm resolution of infection with a negative nucleic acid amplification test (NAAT) or a series of 2 negative antigen tests taken 48 hours apart*. HCP who were asymptomatic throughout their infection and are not moderately to severely immunocompromised: At least 5 days have passed since the date of their first positive viral test (day 0)..."

Review on 4/10/23 of the facility's policy titled "A Staffing in Emergencies" updated 4/15/22, revealed "... Most of our staff work 8 hr [hour] shifts. If we got in to an emergency situation, we

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F 880	Continued From page 9 could switch to 12 hour shifts 3 days on and 3 days off...With administrators approval incentive can be offered for staff to work extra...There may be times when we need to use discretion and weigh the benefits and risks of a staff member entering the building and performing their department tasks. Departments with staff shortages: If a department has 50% [percent] of their staff out because of illness related to the pandemic we will use the contingency category for work restrictions from the CDC..."	F 880	Despite our efforts to notify all of Covid cases impacting the residents or visitors. We were deficient in documenting the notification in the electronic records. We have utilized Facebook, group emails and telephone calls. We did not tell our residents that have advanced dementia as we did not to upset or agitate them. We notified DPOA. However, as of April 10, 2023, we have established a process to have recreation complete notifications on their designated activities unit. They will then provide a list of who was told to Recreation Director who will then enter a note into the resident electronic records. The 3- person team will audit and monitor our COVID communication process and adherence to policies for 4 consecutive weeks then continue monthly for 6 months in accordance with required reporting regulations. This was initiated on 4/24/23.	
F 885 SS=B	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (iii) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with	F 885		

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F 885	Continued From page 10 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to notify resident representatives and families of those residing in the facility by 5:00 p.m. the next calendar day following the occurrence of a single confirmed COVID-19 infection for 8 out of 14 days reviewed from 3/14/23 to 4/5/23 when there were newly identified positive COVID-19 cases. Findings include: Review on 3/7/23 of the facility's COVID-19 line list revealed that the facility had positive COVID-19 rapid test results on the following dates: 3/14/23 (1 staff); 3/17/23 (1 staff); 3/20/23 (1 staff); 3/25/23 (1 resident residing on Mount Shaw); 3/27/23 (1 resident residing on Mount Shaw); 3/28/23 (6 staff); 3/29/23 (4 staff, 4 residents residing on Mount Shaw North); 3/30/23 (1 staff); 3/31/23 (3 staff, 1 resident Mount Shaw); 4/1/23 (2 staff); 4/2/23 (1 staff, 1 resident residing on Mount Whittier); 4/3/23 (1 staff); 4/4/23 (2 staff); 4/5/23 (1 resident residing on Mount Whittier). Interview on 4/7/23 at approximately 10:00 a.m. with Staff B (Infection Preventionist) revealed that the facility uses social media updates, emails, and phone calls to notify individuals that do not	F 885	A new form was created on April 24, 2023 as a tool to use during the admission process to identify how the resident, family and DPOA wish to be contacted in non-emergency or emergency situations. This will be completed upon admission to MVC.	

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MOUNTAIN VIEW COMMUNITY	93 WATER VILLAGE ROAD OSSIPEE, NH 03864

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F 885	Continued From page 11 have access to the social media or email and that if a call is made it is noted in the resident chart. Review on 4/7/23 of all social media posts and emails provided by the facility that were utilized to notify residents representatives and families revealed the following: Social media updates were done on 3/27/23, 3/28/23, 3/29/23, 3/31/23, 4/3/23, and 4/5/23 and only discussed residents that were identified as positive; Email notifications were done on 3/27/23, 3/28/23, 3/29/23, 3/31/23, 4/3/23 and 4/6/23. Review on 4/7/23 of March 2023 and April 1-7, 2023 progress notes revealed: -Resident #1 residing on Mount Shaw, Durable Power of Attorney for Healthcare (DPOA-HC) (not activated), no documentation of notifications; -Resident #2 residing on Mount Shaw, DPOA-HC activated, documented notification on 3/27/23; -Resident #3 residing on Green Mountain, DPOA-HC not activated, no documentation of notifications; -Resident #4 residing on Green Mountain, DPOA-HC activated, no documentation of notifications; -Resident #5 residing on Mount Whittier, with a Guardian, documentation of notification on 4/3/23 and 4/6/23; -Resident #6 residing on Mount Whittier, DPOA-HC not activated, no documentation of notifications; -Resident #7 residing on Mount Chocurua, DPOA-HC not activated, no documentation of notifications; -Resident #8 residing on Mount Chocurua, DPOA-HC not activated, no documentation of notifications.	F 885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305087	A. BUILDING _____ B. WING _____	04/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW COMMUNITY	**93 WATER VILLAGE ROAD OSSIPEE, NH 03864**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 12 Interview on 4/7/23 at approximately 2:30 p.m. with Staff B confirmed the above information and that the facility did not notify residents, representatives and families throughout the facility of all resident and staff COVID-19 positives identified. Staff B stated that the facility was only notifying the resident and/or representatives for only the residents that resided on the unit where a positive COVID-19 resident was identified.	F 885		