

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396137	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Athens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 200 South Main St Athens, PA 18810	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on a review of select facility policies and procedures, Centers for Disease Control (CDC) standards, clinical record review, review of personnel payroll records, and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of COVID-19 infection related to work exclusions for two of two employees reviewed (Employees 1 and 2), contact tracing for four of four residents reviewed (Sage nursing unit: Residents CR1, 1, 2, and 3), and transmission based precautions for two of four residents reviewed (Residents 1 and 3).</p> <p>Findings include:</p> <p>The facility policy entitled, Coronavirus Disease (COVID-19) Work Restrictions and Return to Work Criteria for Staff, last reviewed March 1, 2025, revealed that staff with mild to moderate illness who are not moderately to severely immunocompromised may return to work after the following criteria are met:</p> <p>At least seven 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 five to seven);</p> <p>Either a NAAT (molecular) or antigen (rapid) test may be used. If using an antigen test, staff should have a negative test obtained on day five and again 48 hours later; and</p> <p>At least 24 hours have passed since last fever without the use of fever-reducing medications; and</p> <p>Symptoms (e.g., cough, shortness of breath) have improved.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility policy entitled, Coronavirus (COVID-19) and COVID-19 Vaccine Policy, last reviewed March 1, 2025, revealed that the response to the current outbreak of the Coronavirus disease and all infection prevention and control measures are based on the most current national standards and recommendations from health policy officials, state agencies and the federal government. Staff will be subject to all applicable screening, guidance, and restriction criteria and asked to stay home or be sent home if they have symptoms of respiratory infections as per the most current CDC, federal, state, and/or local guidance. Educate and communicate with your staff on COVID-19 along with infection prevention practices such as handwashing, isolation practices/protocols, and proper personal protective equipment (PPE, isolation gowns, gloves, and eye protection) and usage. Stay current with federal, CDC, state, and local health department guidance and recommendations. Testing of staff and residents is to be completed as per the most current CDC, federal, state, or local guidance. Follow CDC, federal, local, and/or state guidance for reporting and documentation guidelines for testing and any possible COVID-19 illness in residents or staff.</p> <p>Current CDC Infection Control Guidance for SARS-CoV-2 (COVID-19), at https://www.cdc.gov/covid/hcp/infection-control/index.html, revealed that asymptomatic residents with close contact with someone with COVID-19 infection should have a series of three viral tests for COVID-19 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day one (where day of exposure is day zero), day three, and day five. Healthcare facilities should have a plan for how COVID-19 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. If healthcare-associated transmission is suspected or identified, facilities might consider expanded testing of HCP (health care personnel), and residents as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. The IPC (infection prevention and control) recommendations described below (e.g., resident placement, recommended PPE) also apply to residents with symptoms of COVID-19 (even before results of diagnostic testing) and asymptomatic residents who have met the criteria for TBP (TBP, a set of guidelines used in healthcare settings to prevent the spread of infections. The type of precautions required depends on the transmission route of the microorganism, which can be contact, droplet, or airborne. TBP for COVID-19 require the use of isolation gowns, gloves, and eye protection.) based on close contact with someone with COVID-19 infection. Examples of when TBP following close contact may be considered include:</p> <p>Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure</p> <p>Resident is residing on a unit experiencing ongoing COVID-19 transmission that is not controlled with initial interventions</p> <p>Residents placed in TBP based on close contact with someone with COVID-19 infection should be maintained in TBP for the following time periods.</p> <p>Residents can be removed from TBP after day seven following the exposure (count the day of exposure as day zero) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.</p> <p>If viral testing is not performed, residents can be removed from TBP after day 10 following the exposure (count the day of exposure as day zero) if they do not develop symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Duration of TBP for residents with COVID-19 infection with mild to moderate illness who are not moderately to severely immunocompromised:</p> <p>At least 10 days have passed since symptoms first appeared and</p> <p>At least 24 hours have passed since last fever without the use of fever-reducing medications and</p> <p>Symptoms (e.g., cough, shortness of breath) have improved</p> <p>When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority. A single new case of COVID-19 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area(s) of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.</p> <p>Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.</p> <p>Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day one (where day of exposure is day zero), day three, and day five.</p> <p>In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of TBP for residents and work restriction of HCP with higher-risk exposures. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every three to seven days until there are no new cases for 14 days.</p> <p>An exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol-generating procedure. For this guidance it is defined as:</p> <p>Being within six feet of a person with confirmed COVID-19 infection or</p> <p>Having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19 infection. Distances of more than six feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be two days before symptom onset through the time when the individual meets criteria for discontinuation of transmission-based precautions</p> <p>For individuals with confirmed COVID-19 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with COVID-19 infection may have been exposed could help inform the period when they were infectious.</p> <p>If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of two days prior to the positive test through the time when the individual meets criteria for discontinuation of TBP for contact tracing.</p> <p>Closed clinical record review for Resident CR1 (who resided on the Sage nursing unit) revealed nursing documentation dated April 1, 2025, at 9:09 AM that he had shortness of breath, low oxygen saturation while on supplemental oxygen, and received a respiratory treatment of his Duo medication (DuoNeb, a medication administered via an aerosol, that opens airways and reduces inflammation in the lungs). The certified registered nurse practitioner (CRNP) at his bedside ordered the facility to send Resident CR1 to the emergency room (ER) for evaluation. Emergency medical service (EMS) personnel arrived at the facility and transported Resident CR1 at 9:30 AM.</p> <p>Nursing documentation dated April 1, 2025, at 1:15 PM revealed that the ER admitted Resident CR1 to the hospital with diagnoses of hypoxia (low blood oxygen levels) and a COVID-19 positive test.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on April 23, 2025, at 11:05 AM revealed that the facility did not perform contact tracing to determine what staff (e.g., the nurse who administered Resident CR1's aerosol medication) or residents (e.g., residents cared for by the nurse who administered Resident CR1's aerosol medication) potentially had close contact with Resident CR1 before his confirmed diagnosis of COVID-19. The interview confirmed that the facility did not have universal source control measures (e.g., all individuals in the facility wearing tight-fitting masks) in place in the facility at the time of Resident CR1's illness and COVID-19 diagnosis.</p> <p>Clinical record review for Resident 2 (who resided on the Sage nursing unit) revealed nursing documentation dated April 8, 2025, at 8:07 AM that at 7:00 AM Resident 2 had, .respiratory issues, a high blood pressure (recorded as 188/84, normal 120/80 millimeters of mercury), a high heart rate (recorded as 109 beats per minute, normal 60 to 100 beats per minute), audible wheezing and rhonchi (low-pitched rattling sounds that resemble snoring) noted in her lungs, and a harsh cough, which was productive for blood-tinged sputum. Staff documented that they administered a nebulizer treatment (medication administered via an aerosol) that had no effect on Resident 2. Staff contacted the CRNP who agreed to send Resident 2 to the ER.</p> <p>Nursing documentation dated April 8, 2025, at 2:02 PM revealed that the hospital admitted Resident 2 with diagnoses of pneumonia (lung infection) and COVID-19.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Nursing Home Administrator and the Director of Nursing on April 23, 2025, at 11:05 AM revealed that the facility did not perform contact tracing to determine what residents (e.g., residents cared for by the nurse who administered Resident 2's aerosol medication) potentially had close contact with Resident 2 before her confirmed diagnosis of COVID-19. The interview confirmed that the facility did not have universal source control measures in place in the facility at the time of Resident 2's illness and COVID-19 diagnosis.</p> <p>Clinical record review for Resident 1 (who resided on the Sage nursing unit) revealed nursing documentation dated April 8, 2025, at 11:45 AM that therapy staff noted Resident 1 slumped over in her bed, presenting with convulsions. The nurse assessed Resident 1 as having a slightly elevated temperature of 99.4 degrees Fahrenheit (average normal is 98.6 degrees Fahrenheit) and a low oxygen saturation (recorded as 67 percent; normal range is greater than 90 percent) while wearing supplemental oxygen at two liters per minute. Staff increased Resident 1's supplemental oxygen to six liters per minute via a mask with minimal beneficial results (assessed as increased to 70 percent). Staff increased the supplemental oxygen again to 12 liters per minute via a specialized mask (non-rebreather mask that provides a high concentration of oxygen but does not allow the person to breathe in any room air) and assessed Resident 1's oxygen saturation as still low at 74 percent. Staff contacted EMS who transported Resident 1 to the ER.</p> <p>Nursing documentation dated April 8, 2025, at 2:02 PM revealed that the hospital admitted Resident 1 with diagnoses of pneumonia and COVID-19.</p> <p>Nursing documentation dated April 17, 2025, at 5:07 PM revealed that the facility readmitted Resident 1. Staff assessed Resident 1 as an oxygen saturation of 96 percent while wearing supplemental oxygen at four liters per minute, with diminished lung sounds, and a congested cough.</p> <p>Resident 1's clinical record did not contain evidence that staff maintained TBP for Resident 1 when she returned to the facility despite the facility admitted her day nine from her COVID-19 diagnosis without any evidence of negative COVID-19 testing.</p> <p>Interview with the Nursing Home Administrator and the Director of Nursing on April 23, 2025, at 11:05 AM revealed that the facility did not perform contact tracing to determine what individuals had close contact with Resident 1 (e.g., therapy staff or residents) before her confirmed diagnosis of COVID-19. The interview confirmed that the facility did not have universal source control measures in place in the facility at the time of Resident 1's illness and COVID-19 diagnosis. The interview confirmed that the facility had no physician order or evidence to substantiate the implementation of droplet isolation precautions (isolation gown, gloves, tight-fitting mask, and eye protection) for Resident 1 upon her readmission to the facility with the COVID-19 diagnosis.</p> <p>Clinical record review for Resident 3 revealed nursing documentation dated April 8, 2025, at 5:22 PM that in-house wound care staff assessed his right lateral heel ulcer.</p> <p>Nursing documentation dated April 10, 2025, at 10:34 AM revealed that Resident 3 tested positive for COVID-19. Resident 3 had complaints of, stuffiness, a dry cough, and shortness of breath.</p> <p>A physician's order dated April 11, 2025, instructed staff to implement droplet precautions for COVID-19 for 10 days (April 11 through 21, 2025).</p> <p>(continued on next page)</p>		

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