STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365729	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRAEVIEW MANOR	**20611 EUCLID AVE EUCLID, OH 44117**

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 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on record review, interview and review of the facility assessment, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to ensure comprehensive and effective infection control policies and practices were developed and implemented to prevent the spread of COVID-19 within the facility and failed to ensure services of the medical director who was responsible for the implementation of care policies and coordination of the overall medical care in the facility. In addition, a situation of Actual Harm was identified under the area of Administration when the facility rapidly relocated residents without taking assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident. The facility also failed to have policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure. This had the potential to affect all 40 residents residing in the facility. Findings include: 1. Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, review of the facility's Coronavirus (COVID-19) policy, review of the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH (revised 3/13/20), review of the World Health Organization (WHO) hand hygiene brochure, and review of the Centers for Disease Control and Prevention (CDC) guidelines, observations, interviews, and record review the facility failed to implement appropriate infection control practices related to visitor screening, appropriate use of PPE for residents on COVID-19 quarantine precautions, use of recommended face coverings and proper hand hygiene. This resulted in Immediate Jeopardy on 09/21/20 when the facility COVID-19 screening policy was not followed, and the facility used vented N95 respirators in quarantined residents' rooms who were on droplet precautions. In addition, the facility failed to ensure staff members donned appropriate PPE when entering quarantined residents' rooms on droplet precautions and failed to ensure surgical masks and hand hygiene was consistently implemented to prevent the spread of Covid-19 infections. The lack of effective infection control practices placed all residents at the facility at risk for serious life-threatening harm, complications and/or death related to the facility's failed practice of infection control. Cross reference F880. 2. Based on observation, interview and record review, the facility administration failed to provide a written 60-day notice of facility closure to the residents, physicians and the facility residents/representatives as required. Actual harm occurred when the facility rapidly relocated residents without taking assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident. This affected all 39 residents residing in the facility at the time the facility closure was announced. Cross reference F845. 3. Based on observations, record reviews and interviews, the facility failed to ensure the services of the medical director who was responsible for the implementation of care policies and coordination of the overall medical care in the facility to ensure all residents maintained their highest practicable physical and mental well-being. The facility failed to effectively and efficiently ensure comprehensive and effective infection control policies and practices were developed and implemented to prevent the spread of COVID-19 within the facility. Cross reference F841. 4. Based on record review and interviews, the facility failed to have written policies regarding facility closure and appropriate notifications. Cross reference F846. 5. Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable environment for the residents. Cross reference F921.
F 0841 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility.** Based on observations, record reviews and interviews, the facility failed to ensure the services of the medical director who was responsible for the implementation of care policies and coordination of the overall medical care in the facility to ensure all residents maintained their highest practicable physical and mental well-being. The facility failed to effectively and efficiently ensure comprehensive and effective infection control policies and practices were developed and implemented to prevent the spread of COVID-19 within the facility. This had the potential to affect the 40 residents residing in the facility. Findings include: The following concern of Immediate Jeopardy was identified at the time of the Covid-19 Focused Infection Control Survey: Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, review of the facility's Coronavirus (COVID-19) policy, review of the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH (revised 3/13/20), review of the World Health Organization (WHO) hand hygiene brochure, and review of the Centers for Disease Control and Prevention (CDC) guidelines, observations, interviews, and record review the facility failed to implement appropriate infection control practices related to visitor screening, appropriate use of PPE for residents on COVID-19 quarantine precautions, use of recommended face coverings and proper hand hygiene. This resulted in Immediate Jeopardy on 09/21/20 when the facility COVID-19 screening policy was not followed, and the facility used vented N95 respirators in quarantined residents' rooms who were on droplet precautions. In addition, the facility failed to ensure staff members donned appropriate PPE when entering quarantined residents' rooms on droplet precautions and failed to ensure surgical masks and hand hygiene was consistently implemented to prevent the spread of Covid-19 infections. The lack of effective infection control practices placed all residents at the facility at risk for serious life-threatening harm, complications and/or death related to the facility's failed practice of infection control. Cross reference F880.
F 0845 **Level of harm** - Actual harm **Residents Affected** - Many	**Submit a timely, acceptable plan for facility closure, including notification of the appropriate entities and ensuring residents are transferred in a safe and orderly manner.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility administration failed to provide a written 60-day notice of facility closure to the residents, physicians and the facility residents/representatives as required. Actual harm occurred when the facility rapidly relocated residents without taking assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident. This affected all 39 residents residing in the facility at the time the

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 0845 **Level of harm -** Actual harm **Residents Affected -** Many	(continued... from page 1) facility closure was announced. Findings include: Interview on 09/30/20 at 1:26 P.M. with the Administrator revealed another corporation had acquired the facility, and the facility was closing. Several residents were discharged on [DATE] to other facilities A certified letter was sent on 09/30/20 to residents, resident's families, Power of Attorneys, and legal guardians giving a 90-day notice of closure. Observation on 10/01/20 at 3:05 P.M. of the facility parking lot revealed most parking spots were filled with cars, sport utility vehicles and there were three vans with different facility names printed on them parked in front of the main entrance. Boxes were being loaded into the facility vans and one resident was in a wheelchair being assisted into a van by a van driver. Observation on 10/01/20 at 3:10 P.M. of the facility lobby inside the main entrance revealed approximately six residents sitting on couches, upholstered chairs, and in wheelchairs with many large boxes stacked up along the walls. Furniture was observed with the boxes and had resident names on them. Interview on 10/01/20 at 3:13 P.M. with Resident #42 who was sitting in a wheelchair in the lobby revealed he was moving to a different facility and was interviewed and shown a three-minute video two hours ago by a representative from the facility. Resident #42 further stated the Administrator told him the facility was closing in three weeks, and he was not given a 90-day notice or a letter. Interview on 10/01/20 at 3:26 P.M. with Resident #22 who was sitting very still on a couch in the lobby with a concerned look on his face revealed he was told today the facility was closing, and he was being moved to a different facility today. Resident #22 further stated he was not given a choice or shown a list of facilities to choose from. He stated all of my stuff was packed up, and I was given a letter stating the facility was closing. Interview on 10/01/20 at 3:33 P.M. with the Director of Nursing (DON) revealed Resident #22 was very worried if he would be accepted at his new facility because he identified as a male but wore women's clothing much of the time. Interview on 10/01/20 at 3:30 P.M. with Social Worker (SW)/Admission Director (AD) #87 revealed phone calls were made on 09/30/20, and closure letters were mailed to residents families, Power of Attorneys and legal representatives. The new owners provided a list of facilities, and told the residents and families they could pick the facility they wanted. Interview 10/01/20 at 3:45 P.M. with Ombudsman #103 revealed there were 28 residents in the facility this morning and now there were 18 residents. The Administrator told him things were changing by the hour. Ombudsman #103 further stated he definitely thought the residents were being rushed out of the facility, and there had not been time to have meaningful conversations, to look at other facilities and make educated decisions for the placement of the residents. Interview on 10/01/20 at 3:50 P.M. with the Regional Director of Operations (RDO) #102 revealed she and about eight others present in the facility worked for the new owners and were hired as consultants by the current owners to assist with the closure of the facility. They entered the building on 09/30/20 when the consulting agreement was in place. RDO #102 stated the residents have 90 days to transfer, and the new owners take possession in 91 days. Observation and interview on 10/01/20 at 4:06 P.M. with Resident #3 revealed the resident sitting in a wheelchair in the main lobby with an anxious look on his face. Resident #3 could not speak, but shook his head yes or no to questions. Resident #3 shook his head yes when asked if he was moving out of facility today. Resident #3 also emphatically shook his head yes when asked if he was upset about leaving, and shook his head no when asked if he was given a choice of facilities he could go to. Interview on 10/01/20 at 4:10 P.M. with Ombudsman #103 revealed Resident #1 was very anxious about moving out of the facility, and she needed a private room. Ombudsman #103 was told the closure notices were sent out 09/30/20, but Resident #1's guardian did not receive a written notice of the facility closure. Residents were being moved to different facilities and had not received their closure notice. Ombudsman #103 stated he informed SW/AD #87 residents had not received their closure notice. Interview on 10/01/20 at 4:25 P.M. with Resident #32 revealed she was told the facility was closing, but was not given a written notice. She was told she was leaving 10/02/20, and her daughter was trying to find a place for her to live. Phone interview on 10/01/20 at 4:38 P.M. with Resident #5's guardian revealed Resident #5 was packing in preparation to move to a different facility, and he had not received written notice about the facility closing. Resident #5's guardian further stated SW/AD #87 called 09/30/20 and stated the facility was purchased, a lot of residents had already gone, and my aunt needed to be moved today or tomorrow. He was given a couple choices but told SW/AD #87 he did not want to make a decision on the spot, and was told to think about it and call back with decision. Interview on 10/01/20 at 4:47 P.M. with Resident #5 revealed she was not informed the facility was closing. Resident #5 further stated she noticed all the activity in the facility on 09/30/20 and asked what was going on. She was told the facility was closing and she was going to be moved. Resident #5 stated she felt torn about leaving the facility which was her home. Phone interview on 10/01/20 at 4:50 P.M. with Resident #17's guardian revealed he did not receive a letter stating the facility was closing. SW/AD #87 called him on 09/30/20 and he was told the residents were being moved either 10/01/20 or 10/02/20. SW/AD #87 gave him the name and address of the facility his aunt was being moved to. Resident #17's guardian further stated he was not given a list of facilities to choose from. Interview on 10/01/20 at 5:16 P.M. with the Administrator revealed by the end of the day there would be 13 residents in the facility. The Administrator stated Resident #40's family was very upset, and she had a meeting scheduled with them today. Phone interview on 10/01/20 at 5:35 P.M. with Resident #24's emergency contact person revealed she received a certified letter 10/01/20 stating the facility was closing. Resident #24 was moved on 09/30/20 to a different facility. Resident #24's contact person further stated she received a phone call on 09/30/20 from SW/AD #87 and was told Resident #24 would be moved between 09/30/20 and 10/05/20. Resident #24's contact person stated she was very upset the resident had been moved so quickly, and an informed decision had not been made. She stated the resident had lived in the facility [AGE] years and did not have a chance to say good by to her friends. Resident #24's contact person revealed the letter stated the resident would not be transferred before 12/29/20. SW/AD #87 told her the facility had been sold and the option was for Resident #24 to move to a different facility owned by the new corporation. Phone interview on 10/01/20 at 8:48 P.M. with Resident #40's daughter revealed she was very upset about the facility closing and the way it was handled. SW/AD #87 left a message on her sister's phone stating the facility was closing, and the residents would be moved by Friday 10/02/20. There was no mention that the resident had 90 days before transfer. Resident #40's daughter also stated she was very stressed out about this, family was made to feel like this had to happen immediately, and it took time to make such an important decision. Resident #40's daughter further stated the family and the resident had a relationship with other residents and the facility staff and it was not right to speed this process along. When she spoke to the new owner's consultants she was under the impression all the residents were moving to one of their facilities. Interview on 10/02/20 at 9:39 A.M. with Regional Property Manager #104 revealed he had been in the facility since 09/30/20 assisting residents to pack and get their belongings situated for their new home. Interview on 10/02/20 at 10:15 A.M. with SW/AD #87 revealed the consultant company told her which residents were leaving each day because they knew how many beds were available in their facilities. If a resident was not being discharged to a facility owned by the new corporation SW/AD #87 would call the facility to arrange the discharge. SW/AD #87 told RDO #102 Resident #1 could not be rushed out of the facility and would have to wait until Monday to move. SW/AD #87 further stated she had not seen the letter sent regarding the facility closure until 10/01/20 and thought the staff would have been notified of the closure before 09/30/20. Interview on 10/02/20 at 10:30 A.M. with Employees #105 and #106 stated everything happened so fast due to pressure from the new ownership. Interview on 10/02/20 at 11:00 A.M. with Resident #1 stated she was supposed to be transferred today, but now thinks the move won't be until Monday 10/05/20. Resident #1 further stated she was in shock, did not think it was legal to make the resident's move so quickly, and how can it be done safely. Resident #1 stated she needed a private room and was unable to move to a facility in the area because they did not have private beds available now. Resident #1 stated if she had been given notice the facility was closing she could have been on a waiting list. Resident #1 stated she had her belongings packed up and given to her family because she would not need them any longer. She was planning to die at the new facility because it is so far away her family, and friends will be unable to visit. There was no reason for her to live any longer. Interview on 10/05/20 at 10:44 A.M. with the Administrator stated she was not aware if Medical Director #107 or any of the resident's primary care physicians were notified in writing of the facility closure. The Administrator stated RDO #102 said she would notify the physicians. Interview on 10/05/20 at 10:59 A.M. with RDO #102 revealed Medical Director #107 was notified the facility was closing by phone on 09/30/20. Neither letters nor emails were sent to Medical Director #107 or any other physicians with residents in the facility to inform them the facility was closing. Interview on 10/05/20 at 11:20 A.M. with the DON revealed she notified the resident's primary care physicians the facility was closing. The physicians were not aware the facility was closing and asked what was going on. None of the physicians came to the facility, no support or counseling was provided to the residents. The DON further stated she expected the residents would all be moved out of the facility by 10/09/20.
F 0846 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Have policies and procedures ensuring the administrator's responsibilities for facility closure are completed successfully.**

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F 0846 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Based on record review and interviews, the facility failed to have written policies regarding facility closure and appropriate notifications. This had the potential to affect all 40 residents residing in the facility. Findings include: An interview on 10/02/20 with the Administrator at 10:45 A.M. revealed and verified they did not have a policy on facility closure notifications. Review of the discharge policy, revised 12/2016, revealed there was nothing regarding the closure of a facility or notifications in this policy.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, review of the facility's Coronavirus (COVID-19) policy, review of the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-14-NH (revised 3/13/20), review of the World Health Organization (WHO) hand hygiene brochure, and review of the Centers for Disease Control and Prevention (CDC) guidelines, observations, interviews, and record review the facility failed to implement appropriate infection control practices related to visitor screening, appropriate use of PPE for residents on COVID-19 quarantine precautions, use of recommended face coverings and proper hand hygiene. This resulted in Immediate Jeopardy on 09/21/20 when the facility COVID-19 screening policy was not followed, and the facility used vented N95 respirators in quarantined residents' rooms who were on droplet precautions. In addition, the facility failed to ensure staff members donned appropriate PPE when entering quarantined residents' rooms on droplet precautions and failed to ensure surgical masks and hand hygiene was consistently implemented to prevent the spread of Covid-19 infections. The lack of effective infection control practices placed all residents at the facility at risk for serious life-threatening harm, complications and/or death related to the facility's failed practice of infection control. The facility census was 40. The administrator was notified on 09/23/20 at 5:07 P.M. that Immediate Jeopardy began on 09/21/20 when the facility failed to implement appropriate and recommended infection control practices for a visitor entering the facility by not following the facility policy to use hand sanitizer, document temperature, and complete the questionnaire for Covid-19 symptoms. In addition, observations on 09/21/20 and 09/23/20 revealed LPN #80 and #85, RN #96, and STNA's #81, #84, #92 and #93 did not don N95 respirators, goggles/face shields, isolation gowns, and gloves when entering quarantined Residents #2, #3, #9, #16 and #33 rooms who were on droplet precautions. Observations were made of staff utilizing vented N95 respirators that are not recommended by the Centers for Disease Control (CDC). The facility also failed to ensure surgical masks and hand hygiene was consistently implemented to potentially prevent the spread of Covid-19 infections. The Immediate Jeopardy was removed on 09/30/20 when the facility implemented the following correction actions: On 09/23/20 at 4:00 P.M., the Director of Nursing (DON) and Assistant Director of Nursing (ADON) #94 checked all resident rooms on isolation precautions to ensure they all contained signs and equipment for PPE use. On 09/23/20 at 5:00 P.M., the DON and ADON #94 began educating all staff on the facility's policy for screening procedures. As of 09/30/20 at 4:00 P.M., all 42 staff members (all departments) had been educated. On 09/23/20 at 5:00 P.M., the DON and ADON #94 began educating all staff on the proper use of personal protective equipment (PPE) when entering a resident room that is on isolation precautions. As of 09/30/20 at 4:00 P.M., all 42 staff members had been educated. On 09/23/20 at 5:00 P.M., the DON and ADON #94 began educating all staff on hand hygiene. As of 09/24/20 at 4:00 P.M., all 42 staff members had been educated. On 09/23/20 at 5:00 P.M., the DON and ADON #94 began educating all staff on the proper use of face masks while in the facility. As of 09/30/20 at 4:00 P.M., all 42 staff members had been educated. On 09/24/20 at 9:00 A.M., the DON and ADON #94 conducted staff competencies to ensure all staff know the proper use of PPE when entering a resident's room that is on droplet precautions for 20 staff members, 17 more staff members will display competency on 09/25/20 by 4:00 P.M. The remaining five staff members were completed by 09/30/20 at 4:00 P.M. On 09/24/20 at 9:00 A.M., the DON and ADON #94 conducted staff competencies to ensure that all staff are competent on hand hygiene for 37 staff members. The remaining five staff members were completed on 09/30/20 at 4:00 P.M. On 09/24/20 at 9:00 A.M., the DON and ADON #94 conducted staff competencies to ensure all staff know the proper use of face masks while in the facility for 37 staff members. The remaining five staff members were completed on 09/30/20 at 4:00 P.M. On 09/28/20 at 5:00 P.M., the facility stopped using vented N95 masks. On 09/29/20 at 9:00 A.M., the DON and ADON #94 began re-educating all staff on the proper use of PPE when entering a resident's room that is on isolation precautions. As of 09/30/20 at 4:00 P.M., all 42 staff members will be educated. As of 9/24/20, when there is no receptionist at the front door there will be an assigned staff member to monitor front door to ensure everyone entering the building is screened. As of 9/30/20, all outside agency staff will be oriented on proper PPE usage, handwashing, and staff surveillance prior to the start of their shift, by reading the binders by the nurse's station and signing off on acknowledgment. Weekly for four weeks starting on 09/29/20, the Licensed Nursing Home Administrator (LNHA) or designee will conduct random audits to ensure facility screening procedures are being followed. Weekly for four weeks starting on 09/29/20, the DON or designee with conduct an audit by observing two staff members a week entering resident rooms on droplet precautions to ensure that all proper PPE is used while in the room. Weekly for four weeks starting on 09/29/20, the DON or designee will conduct an audit by observing two staff members [MEDICATION NAME] proper hand hygiene. Weekly for four weeks starting on 09/29/20, the LNHA will conduct random audits to ensure all staff are wearing masks while in the facility. Weekly for 4 weeks starting on 09/29/20, the LNHA will conduct random audits to ensure that all binders with education for agency staff are signed off on prior to the start of their shift. Negative findings, if any, will be addressed immediately by the Administrator and reported to the Quality Assurance (QA) committee, which includes the medical director and all department heads. Although the Immediate Jeopardy was removed on 09/30/20, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS) Memo QSO 20-20-ALL dated 03/03/20 revealed CMS is committed to taking critical steps to ensure America's healthcare facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (Covid-19). As part of CMS guidance, the Focused Infection Control Survey was made available to every provider in the country to make them aware of infection control priorities during this time of crisis, and providers may perform a voluntary self-assessment of their ability to meet these priorities. The Quality, Safety and Oversite Group (QSO) Memo included additional instructions to nursing homes. We are disseminating the Infection Control survey developed by CMS and Centers for Disease Control (CDC) so facilities can educate themselves on the latest practices and expectations. We expect facilities to use this new process, in conjunction with the latest guidance from CDC, to perform a voluntary self-assessment of their ability to prevent the transmission of Covid-19. We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program. Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and whom possible incidents of communicable diseases or infections should be reported (42 CFR 483.80 (a) (2) (i) and (ii). Observation on arrival to the facility on [DATE] at 6:20 A.M. revealed the main entrance was locked, and the door buzzer was used to gain entrance. Licensed Practical Nurse (LPN) #80 answered the buzzer and opened the door wearing a blue surgical mask. Observation revealed a receptionist desk in the lobby with a white electronic check-in station for Covid-19 screening, and a wall mounted hand sanitizer dispenser. LPN #80 did not ask Covid-19 screening questions, did not give direction to use the white check-in station or use hand sanitizer and did not use a thermometer to take temperature. LPN #80 confirmed Covid-19 screening was not done. Observation on 09/21/20 at 6:35 A.M. revealed State tested Nursing Assistant (STNA) #81 standing outside Resident #16's room with a blue surgical mask covering her nose and mouth. A droplet precaution sign was on the resident's door and a plastic cart with isolation gowns, vented N95 masks, and gloves was just to the left of the doorway. STNA #81 asked LPN #80 to help with care for the resident. Both entered the room without using hand sanitizer or washing their hands or donning an isolation gown or goggles/face shield. Neither LPN #80 nor STNA #81 changed their surgical mask to an N95 mask. Interview on 09/21/20 at 6:40 A.M. with LPN #80 as he exited Resident #16's room confirmed the resident was on droplet precautions, and he did not change his surgical mask to an N95 mask, don an isolation gown, face shield/goggles, use hand sanitizer or wash his hands before assisting with care for the resident. LPN #80 confirmed the N95 masks had vents and stated all the N95 masks in the facility had vents in them. Interview on 09/21/20 at 6:43 A.M. with STNA #81, after she left Resident #16's room, confirmed the resident was on droplet precautions, and she did not change her surgical mask to an N95 mask, don an isolation gown,

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) goggles/face shield, use hand sanitizer or wash her hands before giving care to the resident. Observation on 09/21/20 at 6:55 A.M. revealed STNA #82 standing in the 200-hallway without a mask on. STNA #83 was sitting in a chair at the nurse's station with a blue surgical mask below her nose and across her mouth. Resident #23 was sitting in a wheelchair in the hallway approximately four feet from STNA #82. STNA #82 confirmed she did not have a mask on. STNA #83 confirmed her mask was not covering her nose and stated she was hot and pulled her mask off her nose. Observation on 09/21/20 at 7:00 A.M. revealed STNA #84 was wearing a light-colored cloth mask. The mask was not covering her nose and was across her mouth. STNA #84 confirmed the mask was not across her nose and stated she brought a cloth mask from home to wear while she worked. Observation was made on 09/21/20 at 9:03 A.M. of LPN #85 as she walked to the medication cart and placed seven medications in a small plastic cup to be administered to Resident #32. LPN #85 walked into Resident #32's room, administered the medications, walked back to the medication cart, picked up a small plastic cup, put two medications for Resident #17 in it, picked the cup up and walked into Resident #17's room and administered the medications. LPN #85 left Resident #17's room, walked back to the medication cart and placed nine medications for Resident #2 in a small plastic cup, walked into the resident room and administered the medications. LPN #85 did not use hand sanitizer or wash her hands during the observation. LPN #85 confirmed she did not use hand sanitizer or wash her hands between giving medications to each resident. LPN #85 stated her hand sanitizer had been taken off the medication cart and she did not know where it was. Observation on 09/21/20 at 9:03 A.M. revealed Resident #2 had a droplet precaution sign on the door to his room and a PPE cart outside the doorway. LPN #85 did not don an N95 mask, isolation gown, gloves or goggles/face shield before entering Resident #2's room to administer medications. LPN #85 confirmed she did not don PPE prior to entering the room. Observation on 09/21/20 from 6:21 A.M. through 10:40 A.M. of resident care areas did not reveal any staff member wearing goggles or a face shield. Interview on 09/21/20 at 10:40 A.M. with the Administrator confirmed all N95 masks in the facility were vented. The Administrator also confirmed staff were not wearing goggles or face shields. Observation on arrival to the facility on [DATE] at 6:11 A.M. revealed LPN #86 answered the door buzzer wearing a blue surgical mask and screening was completed including electronic Covid-19 questionnaire and documentation of temperature, there was no instruction to use hand sanitizer. LPN #86 confirmed she did not request hand sanitizer be used. Observation on 09/23/20 at 7:00 A.M. revealed Social Worker/Activity Director (SW/AD) #87 entered the main entrance to the facility, proceeded to the electronic check-in station, answered the questions, and took her temperature. SW/AD #87 did not use hand sanitizer or sanitize the check-in station after use. Observation was made on 09/23/20 at 7:02 A.M. of STNA #88, Scheduler #89, Agency Housekeeper #90 and Housekeeper #91 as they entered the facility. SW/AD #87 called employees over to the electronic check-in station and Covid-19 screening questions were answered. SW/AD #87 took staff temperatures but did not have staff perform hand hygiene or sanitize the cleaning station between uses. SW/AD #87 confirmed that she did not have staff members use hand sanitizer and did not sanitize the check-in station between each staff member. SW/AD #87 also confirmed that she did not sanitize the check-in station after she answered the Covid-19 screening questions or use hand sanitizer. Observation on 09/23/20 at 7:30 A.M. revealed a three shelved metal cart in the 500-hall with three meal trays on it. STNA #84, wearing a blue surgical mask walked to the cart picked up a tray and entered Resident #33's room. Resident #33's door had a droplet precaution sign on it, and there was a plastic cart sitting to the left of the doorway with isolation gowns, N95 mask, and gloves inside the three drawers. STNA #84 did not don an N95 mask, isolation gown, goggles/face shield or gloves before entering the resident room. STNA #84 assisted the resident with meal preparation then exited room, did not use hand sanitizer or wash her hands, walked to the meal cart, picked up another tray and took it to Resident #8's room, assisted Resident #8 with tray set up, then walked out of the room to the cart for the next meal tray without using hand sanitizer or washing her hands. Interview on 09/23/20 at 7:35 A.M. with STNA #84 confirmed Resident #33 was on droplet precautions and she did not don goggles/face shield, N95 respirator, isolation gown, gloves or perform hand hygiene before entering Resident #33's room. Observation on 09/23/20 at 7:54 A.M. revealed STNA #93 wearing a blue surgical mask in the 200-hallway of the facility passing meal trays located in a metal dietary cart. STNA #93 picked up a meal tray from the metal cart and walked in Resident #3's room and assisted the resident with tray set-up, then walked out of room without washing hands or using hand sanitizer. Resident #3 had a droplet precaution sign on the door, and a PPE cart next to the doorway. STNA #93 did not put on an N95 mask, goggles/face shield, isolation gown or gloves before entering the room. STNA #93 confirmed she did not put PPE on prior to entering Resident #3's room. Observation on 09/23/20 at 7:58 A.M. revealed the call light above the door of Resident #3 was turned on. STNA #92 entered Resident #3's room, who was on droplet precautions, without using hand sanitizer, washing her hands, changing surgical mask to an N95 mask, donning an isolation gown, goggles/face shield and gloves. STNA #92 assisted the resident with care and left the room without using hand sanitizer or washing her hands. Interview on 09/23/20 at 8:01 A.M. with STNA #92 confirmed Resident #3 was on droplet precautions, and she did not don an N95 mask, isolation gown, goggles/face shield, gloves and she did not perform hand hygiene before or after entering resident room. Interview on 09/23/20 at 8:13 A.M. with the DON revealed if a resident was on droplet precautions staff should wash hands or use hand sanitizer, don an N95 mask, isolation gown and gloves before entering the resident room. PPE should be removed before leaving the room and hand hygiene performed. Observation on 09/23/20 at 10:24 A.M. of LPN #95 revealed a thermometer in her hand as she walked from the medication cart to the common area next to the nurses' station. As she walked, she reassuringly squeezed a resident sitting in a wheelchair on the shoulder, then went to a resident seated at a table and took their temperature, patted the resident on the arm, and walked back to the medication cart. LPN #95 did not disinfect the thermometer, use hand sanitizer or wash her hands before or after the observation. Interview on 09/23/20 at 10:27 A.M. with LPN #95 confirmed she did not disinfect the thermometer or use hand hygiene before or after taking the resident's temperature and touching the residents. Observation and interview on 09/28/20 at 2:43 P.M. with STNA #84 wearing a blue surgical mask verified vented N95 masks in PPE carts in the hallway outside Resident #33 and #13's rooms. STNA #84 stated when she entered a resident room on droplet precautions, she would wear an isolation gown, shoe covers, but would not need to put a different mask on because she was already wearing a mask. Observation on 09/28/20 at 2:52 P.M. with the DON confirmed vented N95 respirators were in the PPE cart outside Resident #13 and #33's room. The DON removed the vented N95 mask from the PPE carts. Observation on 09/28/20 at 3:35 P.M. of Registered Nurse (RN) #96 revealed she was standing in the 100-hall wearing an N95 mask covered by a blue surgical mask. RN #96 walked into Resident #9's room without performing hand hygiene, donning an isolation gown, goggles/face shield or gloves. Resident #9's room had a droplet precaution sign on the door and a PPE cart outside the doorway with isolation gowns, gloves and N95 mask in the drawers. RN #96 talked to the resident sitting in a chair then walked out of the room. Interview on 09/28/20 at 3:40 P.M. with RN #96 confirmed she did not don an isolation gown, goggles/face shield, perform hand hygiene, don gloves, or change her N95 mask before entering Resident #9's room. She stated she did not notice the droplet precaution sign on the door or the PPE cart outside the doorway. Interview on 09/29/20 at 1:05 P.M. with LPN #97 revealed she was employed by a staffing agency, and today was her first day in the facility. LPN #97 stated she did not receive any education or training when she arrived to the facility or during her shift at any time. Review of education and competency records on 09/29/20 at 1:47 P.M. revealed on 09/23/20, 15 staff members attended a hand washing in-service. Hand washing and staff surveillance competencies were completed on 09/24/20 for 31 staff members. On 09/24/20 a PPE competency in-service log was signed by 11 staff members. Further review revealed between 09/25/20 and 09/28/20, 13 PPE staff competencies were completed. Interview on 09/29/20 at 2:03 P.M. with the Administrator revealed some staff were educated by telephone on proper hand washing, staff surveillance and PPE. Review of the facility policy titled Coronavirus Disease (Covid-19) Prevention and Control, dated March 2020, stated the response to the current outbreak of Coronavirus disease is based on the most current recommendations from health policy officials, state agencies, and the federal government. Review of the Center for Disease Control and Prevention (CDC), Coronavirus Disease 2019 (Covid-19), Considerations for Wearing Masks, updated August 7, 2020 stated the purpose of masks is to keep respiratory droplets from reaching others to aid with source control. However, masks with one-way valves or vents allow air to be exhaled through a hole in the material, which can result in expelled respiratory droplets that can reach others. This type of mask does not prevent the person wearing the mask from transmitting COVID-19 to others. Therefore, CDC does not recommend using masks for source control if they have an exhalation valve or vent. Review of the CDC, Coronavirus Disease 2019 (Covid-19), Interim Infection Prevention and Control recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic Infection Control Guidance, updated July 15, 2020 stated Healthcare Personnel (HCP) should wear a face mask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. Further review stated HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or face mask if respirator not available), and gown, gloves and eye protection. HCP working in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365729	A. BUILDING _____ B. WING _____	10/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRAEVIEW MANOR	20611 EUCLID AVE EUCLID, OH 44117

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 -** Many	(continued... from page 4) facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with [DIAGNOSES REDACTED]-CoV-2 infection. If [DIAGNOSES REDACTED]-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They should also: Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters. Review of CMS policy memo QSO-20-14-NH revised 3/13/20 titled, Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, revealed facilities were to Increase the availability and accessibility of alcohol-based hand rubs, and to reinforce strong hand-hygiene practices. Review of the Centers for Disease Control and Prevention (CDC) training titled, Hand Hygiene in Nursing Homes, dated 02/25/19 revealed hand hygiene was an element of standard precautions. It was an important Infection Prevention Control (IPC) practice for breaking the chain of infection. Hand hygiene protects both residents and staff. Hand hygiene was a simple and effective method for preventing the spread of pathogens by direct and indirect contact. The hands of staff members may become transiently contaminated with pathogens after touching a resident or surfaces in their environment. Staff members can transfer those pathogens to themselves and they can also transfer those pathogens to other residents or surfaces. Performing hand hygiene removes pathogens and protects both staff and residents. Since staff cannot tell whether their hands have been contaminated with a pathogen, hand hygiene should be consistently performed. Review of the World Health Organization (WHO) Hand Hygiene brochure titled Hand Hygiene: Why, How, and When?, revised August 2009, revealed hands are the main pathways of germ transmission during health care and hand hygiene is therefore the most important measure to avoid the transmission of harmful germs and prevent health care-associated infections. The brochure further revealed hand hygiene is indicated after touching any object or furniture when leaving the patient surroundings to protect the health-care environment against germ spread.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable environment for the residents. This had the potential to affect all 40 residents residing in the facility. Findings include: Observation on 09/21/20 at 6:45 A.M. of the A Nursing Unit revealed large brownish black areas on the red/light brown carpet with flower and leaf patterns. There were bits of paper, plastic wrappers, dust clumps, and circular white ties used to secure towels strewn over the entire carpet. Further observation of the resident rooms in the 100 hallway revealed paper, towels, plastic wrappers and dust clumps all over the floors. Hand rails had many dents with paint missing. Observation on 09/21/20 at 6:50 A.M. of the B Nursing unit revealed red/light brown carpet with flower and leaf patterns had large brown/black areas covering 80 percent of the surface. Black taped areas were noted on the carpet throughout the unit. Shredded carpet noted around metal plates on the floor. Metal plates were approximately one quarter to one half inch below the level of the floor. The carpet was bunched up in areas and not lying flat on the floor. Hand rails had many unpainted areas with nicks. Observation on 09/21/20 at 7:00 A.M. of the 500 hallway (secured unit) revealed walls with large black scuff marks, walls with dents and paint missing, a heating unit in the common area next to the nurses station with large dents and large dark marks. The uncarpeted floors had scuff marks, areas of light brown gritty material, pieces of food, dust clumps and small pieces of paper and plastic all over them. Hand rails along the hallway had many nicks and unpainted areas. The common area at the end of the hallway had two large areas with a different color paint on one wall, and the walls were scuffed, and many unpatched areas without paint noted. Observation and interview on 09/23/20 at 6:30 A.M. with State tested Nurse Aide (STNA) #98 revealed Unit A and B's clean utility room had a blanket bunched up on the floor, unfolded towels laying on the floor and a sheet falling out of a clean linen cart dragging on the floor. There were six clean incontinent briefs laying on the floor, many wire hangars were lying on the floor and about 20 circular white ties used to secure wash cloths and towels were lying on the floor. The floor had dust clumps, small pieces of gray and white material on it. STNA #98 picked the towels, blanket and sheet off the floor and put them back on the clean linen cart. STNA #98 also picked the incontinent briefs off the floor and put them with the clean incontinent briefs located on a cart in the room. Observation on 09/23/20 at 6:50 A.M. of dirty utility room on the B Nursing Unit revealed a large gray trash can with a red biohazard bag inside it. A large red trash can was next to the gray trash can. STNA #98 confirmed the presence of the red biohazard bag in the gray trash can, and also confirmed the red trash can was empty. Observation on 09/23/20 at 7:10 A.M. with STNA #84 revealed the clean utility room in the 500 hallway had two resident gowns, washcloths and a sheet lying on the floor. A cardboard box with empty wrappers, cups with dried brown material, small pieces of white material, and ties used to secure towels and washcloths noted on the floor. The light did not work when the switch was turned on. A flashlight was used to visualize the interior of utility room. Observation on 09/23/20 at 7:15 A.M. with STNA #84 revealed the door to a small room adjacent to the common area at the end of the 500 hallway pushed open to reveal entire room to view. Observation of a large rectangular metal structure with many areas of gritty brown material on it. Leaning next to the metal structure was a large rectangular one half inch thick metal piece with sharp edges. The floor was covered in a reddish/orange dried material with a large coiled up garden hose on it. Next to the garden hose were several pipes approximately twelve to eighteen inches long. There was an open toilet bowl in the room covered in brown and orange/brown material both inside the bowl and on the outside. A resident sitting in a wheelchair was in the common area. STNA #84 closed the door but was unable to lock it. Observation and interview on 09/23/20 at 8:55 A.M. with the Administrator, Director of Nursing (DON), and Regional Nurse #100 of carpet, hand rails, walls in Nursing Units A and B. The previous findings were confirmed. Further observations and interviews confirmed the unlocked door adjacent to the common area in the 500 hallway with the metal objects, pipes, garden hose, and overall condition of the room. Also confirmed the light in the clean utility room did not work when the switch was turned on. Observation and interview on 09/23/20 at 9:00 A.M. with the Administrator of bath/shower area for 500 hallway residents revealed a white square rack hanging by one screw at an angle above the sink, and the toilet had a light layer of brownish clear material covering the surface. The small tiles on the floor were loose in some areas with tiles and grout pieces sitting next to area that did not have any tiles. The floor also had dust clumps, an orange [MEDICATION NAME] in the shower, and gritty areas of light gray material. The shower wall had a reddish brown area approximately four feet by two feet below two water handles and a hose attached to the faucet with a shower attachment on the end. The water faucets were continually dripping down the wall to the floor. The shower hose with the attachment was approximately two feet long and was almost 100 percent covered in reddish brown/black material. The Administrator stated the bathroom needed a little work. Interview on 09/23/20 at 9:24 A.M. with Resident #32 stated she was unhappy living in the facility because it was so dirty. The bathroom she shared with a resident in an adjacent room was often not cleaned and now had bowel movement areas on the toilet and on the floor. Observation of the shared bathroom revealed several dime to quarter size spots of dried brown material on the toilet seat and dried brown clumped up material on the floor. Interview on 09/23/20 at 9:36 A.M. with STNA #99 confirmed the shared bathroom for Resident #32 had brown areas on the toilet seat and on the floor. STNA #99 stated she would make sure it was cleaned. Interview on 09/29/20 at 1:31 P.M. with LPN #101 revealed the facility has two housekeeping staff members, but only one does the cleaning. The other staff member is usually doing maintenance work. LPN #101 stated the facility is dirty, especially the resident bathrooms.