STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075327	A. BUILDING _____ B. WING _____	10/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB MYSTIC	28 BROADWAY MYSTIC, CT 06355

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 0678 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documents, Emergency Medical Services (EMS) records, hospital medical records,and interviews for the one sampled resident (Resident #1) who experienced a medical emergency, the facility failed to provide immediate emergency basic life support when the resident was unresponsive and in respiratory distress to ensure adequate airway clearance to sustain effective breathing and maintain oxygen needs to meet body requirements. The findings include: Review of the clinical record on [DATE] identified that Resident 1was admitted on [DATE] with [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. An admission Resident Care Plan defined a full code status as an advanced directive to begin cardiopulmonary resuscitation (CPR) in the event of cardiac or respiratory arrest. An admission Minimum Data Set assessment dated [DATE] identified that the resident had moderate cognitive impairment, a height of sixty-one (61) inches, weight of two hundred sixty (260) pounds, was without a swallowing disorder, had the ability to feed self once set up, required extensive assistance of two staff for all other activities of daily living (ADL) and was totally dependent on staff for transfers with lower extremity limitation. Review of the twenty-four hour shift to shift report dated [DATE] (time unknown) identified Resident #1 had experienced an acute change in condition. The report identified that the resident had a temperature of 97.4 degrees Fahrenheit, pulse 106 beats per minute, respirations 20 breaths per minute, blood pressure ,[DATE], and an oxygen saturation level of 84%. The documentation further identified Resident #1 was slow to respond, with signs of cough, congestion and excessive oral secretions present with emergent transfer to an acute care hospital for evaluation. Further review of the clinical record identified Resident #1 had reentered the facility on [DATE] following a hospital admission on [DATE]. Review of the hospital discharge summary dated [DATE] identified primary [DIAGNOSES REDACTED]. The clinical record identified Resident #1 experienced and second emergent discharge on [DATE] at 12:10 PM with hospital admission and subsequent re-admission to the facility on [DATE]. Review of the hospital discharge summary dated [DATE] identified primary [DIAGNOSES REDACTED].#1 was found in acute respiratory distress on [DATE] at about 5:40 AM by Nurse Aide #1. The note identified Registered Nurse (RN) #1 assessed Resident #1 and identified a greyish blue skin color and irregular respirations with periods of apnea, The nursing note also indicated that when the nurse attempted to obtain the resident's oxygen saturation level, Resident #1 vomited with frothy white liquid that flowed out of the nose and mouth. Further review of the note identified that when EMS responders arrived, they used the facility's suction machine to attempt clearance of the vomit from the resident's mouth. Review of the EMS run report identified the 911 call was received on [DATE] at 5:48 AM with EMS personnel dispatched at 5:51AM. The report identified EMS personnel arrived at the scene at 5:59 AM and reached the patient at 6:00AM (twenty minutes into the assessed medical emergency with acute respiratory distress). The EMS report identified Resident #1 was unconscious/unresponsive with cyanotic, mottled skin, lying on his/her back (supine) in bed with vomitus in and outside the mouth. The report further identified that fire department first responders were actively suctioning the patient to clear the mouth and reported vital signs of a rapid heart rate ([MEDICAL CONDITION] and an oxygen saturation of fifty percent (50%). The report identified according to a facility nurse, Resident #1 was last seen conscious, alert and oriented at 2:30 AM. Further review of the report identified the resident was placed on high flow oxygen at 15 liters per minute with a non-rebreather mask and was transferred onto a stretcher, placed in an upright seated position and into an ambulance before Resident #1 stopped breathing and became pulseless. The report identified CPR was immediately started, suctioning of the airway was provide twice prior to transport, provision of advanced life support and continuous CPR was administered during the Resident #1's transport to an acute care hospital. Review of Resident #1's hospital medical record for the period from arrival at the Emergency Department (ED) on [DATE] to hospital admission and discharge date d [DATE] through [DATE] medical records identified Resident #1 presented to the ED on [DATE] at 6:44 AM for evaluation of [MEDICAL CONDITION], required advanced life support with resolution of spontaneous circulation/blood pressure. Respiratory Therapy progress note dated [DATE] at 8:10 AM identified treatment continued for respiratory arrest that presented after a [MEDICAL CONDITION], with unknown down time, and evidence of significant neurologic changes that suggested an oxygen deficiency occurred ([MEDICAL CONDITION]). Physician note dated [DATE] at 11:29 AM identified Resident #1 had a clear-cut aspiration event during the episode. Review of physician consultation note dated [DATE] at 2:15 PM identified Resident #1 was provided ventilatory support and diagnostic imagery testing identified devastating changes on head computerized topography (CT) consistent with severe hypoxic [MEDICAL CONDITION] with poor prognosis for the future. On [DATE] at 6:43 AM, Resident #1's advanced directives were changed to Do Not Resuscitate (DNR) with no CPR. The record further identified Resident #1 was extubated from life sustaining ventilatory support with family at the bedside, and expired on [DATE] at 4:13 PM. Interview and review of the clinical record with NA #1 on [DATE] at 6:25 AM identified s/he worked the night shift (11:00 PM to 7:00 AM) on the night of [DATE] to [DATE]. NA #1 identified the facility staffing on the night shift typically included (1) RN and (2) NAs and on [DATE] three staff were working. S/he stated that Resident #1 was provided hands on care during rounds that were completed for all the facility residents sometime between 2:00 and 4:00 AM. She indicated she completed rounds with NA #2 and that during the 4:00 AM rounds she looked in on Resident #1 from the door, noted the resident looked comfortable, noted the Resident was in a back lying position with feet elevated on a pillow, and without signs of restlessness. She further identified neither NA #1 or she had entered Resident #1's room, provided care, or offered the Resident repositioning during the 4:00 AM rounds. NA #1 further identified rounds started at 5:00 AM on the upper hallway and moved on to the rehab wing around 5:30 AM on [DATE]. She indicated at about 5:40 AM upon entering Resident #1's room with NA #2 the resident looked awful, was sweaty, and didn't respond to his/her name being called or when tapped on the arm. She indicated fluids were coming out of Resident #1's mouth and nose and she instructed NA #2 to stay with the Resident while she ran to get RN #1. Interview and clinical record review with RN #1 on [DATE] at 7:05 AM identified on [DATE] around midnight while obtaining Resident #1's vital signs the Resident was alert, joking around, and denied distress or discomfort. Review of the Medication Administration Record [REDACTED]. She identified the last time she had checked on Resident #1 was a little after two. To recall this time, RN #1 identified she had provided medication administration for another resident who resided down the hall from Resident #1's room. She recalled looking in on the Resident from the doorway after the 2:00 AM medication administration. She noted Resident #1 was in a back lying position with signs of rhythmic breathing that were observed from her position at the doorway. She identified at 5:00 AM she began the med pass on the team two hallway that was located near the facility's kitchen in an opposite hallway away from where the NAs began the 5:00 AM rounds. She identified when NA #1 alerted her of Resident #1's change in condition she attempted to obtain vital signs with the medical equipment located just outside the Resident's room. She indicated the pulse ox was applied to several fingers and the Resident's toe without obtaining a reading. She identified when she left to call [DATE] NA #1 and NA #2 remained with Resident #1. She indicated that on her return to the Resident's room she

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 0678 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) collected her vital signs kit that contained a digital blood pressure cuff. She articulated the digital device registered vital sign numbers that were all over the place with a very rapid pulse. She identified she left the Resident's room with the NAs in attendance a second time to obtain the facility crash cart and had just hooked up the suction machine when the first EMS responders arrived and took over suctioning of the Resident's mouth. Interview with EMS personnel on [DATE] at 12:48 PM identified R#1 was found in a back lying (supine) position on [DATE] at 6:00 AM without the benefit of effective airway management. She identified due to the dependent supine position Resident #1 was maintained in the vomit pooled in the back of the mouth and nose obstructing the airway. She identified that as additional EMS personnel arrived and prepared for transport R #1 was further assessed as cyanotic that resulted in full [MEDICAL CONDITION] as Resident #1 was moved into the ambulance. EMS personnel initiated immediate Cardiopulmonary resuscitation (CPR) as transport began to an acute care hospital. Without implementation of immediate repositioning measures such as turning the unconscious/unresponsive Resident onto his/her side to clear the mouth of the expectorated body fluids and/or elevating the head of the bed after oral secretions were cleared, and/or providing rapid response with suctioning the facility failed to provide immediate emergency basic life support for a Resident in respiratory distress in regard to airway, breathing, and circulation (ABC) that resulted in irreversible hypoxic injury and subsequent death.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, observations and interviews for one of two nursing units reviewed for environmental safety, the facility failed to provide adequate supervision for six of six sampled residents (R #3, #4, #5, #6, #7, and #8) who required limited to total assistance for Activities of Daily Living (ADL) and for one sampled resident (R #2) reviewed the facility failed to ensure the environment remained free of accident hazards. The findings include: 1. Review of clinical records on 9/26/20 identified Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] identified moderate cognitive impairment and limited assistance with ADLs. The Resident Care Plan (RCP) dated 10/1/20 identified R#3 required assistance with ADLs and at was risk for contracting the Coronavirus Disease 2019 (COVID-19) due to a recent hospitalization . Interventions included transmission-based isolation precautions in accordance with state/federal guidelines and facility policy. 2. Resident #4 was admitted on [DATE] with medically complex [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] identified intact cognition and extensive assistance with ADLs. Review of the RCP dated 9/29/20 identified a risk for rehospitalization related to precarious medical condition secondary to abdominal surgery and risk of contracting COVID-19 due to recent hospitalization . Interventions included assistance with ADLs, monitor vital signs every shift, monitor for wound changes/abdominal pain, and transmission-based isolation precautions in accordance with state/federal guidelines and facility policy. 3. Resident #5 was admitted on [DATE] with [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] identified sever cognitive impairment and supervision with ADLs. The RCP dated 10/1/20 identified the Resident required a hip replacement due to a fall, risk of contracting COVID-19 due to recent hospitalization and required assistance to complete ADLs. The RCP identified a focused statement of risk with problematic behaviors related to wandering and restlessness secondary to cognitive impairment, and transmission-based isolation precautions in accordance with state/federal guidelines and facility policy. 4. Resident #6 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission MDS assessment dated [DATE] identified sever cognitive impairment, extensive assistance with ADLs, and total assist with transfers. Review of the RCP dated 10/5/20 identified recent admission to the facility following hospitalization for [MEDICAL CONDITION] with joint repair and risk of contracting COVID-19 due to recent hospitalization . Interventions identified assistance of two was required with ADLs, care givers were to utilize the WATCH CLOSE procedure to detect signs and symptoms of [MEDICAL CONDITION], and transmission-based isolation precautions in accordance with state/federal guidelines and facility policy. 5. Resident #7 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of physician orders [REDACTED]. Review of the RCP updated 9/23/20 identified problem statement for alteration in skin integrity related to admission with surgical wound, risk of contracting COVID-19 due to recent hospitalization and transmission-based isolation precautions in accordance with state/federal guidelines and facility policy. The significant change in condition MDS assessment dated [DATE] identified Resident #7 was medically complex and required extensive assistance with ADLs. 6. Resident #8 was admitted on [DATE] with [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] identified intact cognition and supervision with ADLs. The RCP dated 9/18/20 identified risk of contracting COVID-19 due to recent hospitalization . Interventions included set up assistance and supervision with ADLs, monitor vital signs every shift, and transmission-based isolation precautions in accordance with state/federal guidelines and facility policy. Review of the facility bed board dated 9/26/20 identified the capacity was a 60-bed residential skilled nursing facility with a resident census of forty-three (43). The resident population resided on two nursing units (short-term rehab and long-term care). Review of the facility floor plan and observations made during tour on 9/26/20 identified the short-term rehab unit was separated from the long-term care unit by closed fire doors. Interview with Registered Nurse Supervisor (RN #2) on 9/26/20 at 9:00 AM identified the short-term rehab unit was a cohort for residents with a negative COVID-19 status who were under a fourteen-day observation period with transmission-based droplet isolation precautions related to potential COVID exposure. Intermittent observations on 9/26/20 from 9:15 AM to 10:00 AM identified the six residents of the cohort on the short-term unit were without the benefit of staff presence on the unit. The observation further identified the lack of staff movement into the unit left the residents unattended for 45 minutes without the benefit of safety surveillance on a unit separated by closed fire doors. Interview, review of clinical records, and review of the Interim Infection Prevention and Control Recommendations for Patients with Suspected of Confirmed COVID-19 policy with the Director of Nursing (DON #1) on 9/26/20 at 1:18 PM identified the purpose of the fire door closure to the short-term rehab unit was for COVID-19 infection prevention and control measures. Review of the policy identified a strategic step to minimize potential infection spread was to coordinate care of residents through allocated staffing. Review of the staffing for 9/26/20 identified resident care for the COVID-19 precautions cohort was without the benefit of a dedicated staff member. The DON further identified current staffing failed to reflect adequate staffing numbers to support allocation of a dedicated staff to the residents of the cohort and the unit was frequently left unattended while the provision of care was conducted with the facility's COVID-19 negative residents that resided on the other side of the fire doors. 7. Further clinical record review on 9/26/20 identified Resident #12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The RCP dated 2/27/20 identified an alteration in cognitive function with interventions for redirection when inappropriate action/behaviors were exhibited. The quarterly MDS assessment dated [DATE] identified a severe cognitive deficit with symptoms of inattention, disorganized thinking, supervision with ADLs, and independent in mobility on and off the unit with use of a wheelchair. Observations made in the presence of RN #2 during tour of the long-term care unit on 9/26/20 at 10:15 AM identified hazardous products stored in an unsecure manner within the unit in areas that were easily accessible to Resident #12. The door to the facility's medical supply storage room was identified as open. Inside the room bottles of [MEDICATION NAME], rubbing alcohol, hydrogen peroxide, and topical creams/ointments were stored on shelves at wheelchair accessible height. Across the hallway from the medical supply storage another open door allowed access into the facility's shower room. Further inspection of the shower room identified additional potentially hazardous products stored in an unsecure manner. Cans of shave cream, tubes of barrier cream, bottles of shampoo and liquid soap were identified without the benefit of resident name labeling and stored on the wall mounted grab bars in the shower stalls, on low tables, and on the back of a toilet inside the room. A blow dryer was identified stored on a low table and remained plugged into the wall socket. Interview with RN #2 at the time of the observation identified the door to the medical supply room was her responsibility to ensure it was closed and locked after use. She further identified a supply of health and beauty products were stored in a wall mounted locked cabinet for use as needed and the blow dryer had a storage place within a pouch that was also located on the wall in the shower room. Interview with DON #1 on 9/27/20 at 2:00 PM identified the standard of practice was to store personal care products that were label for individual use in the resident's bed side cabinet. She further identified the products stored in the locked cabinet within the shower room were available as needed, should be labeled with the resident's name when taken for use, then stored properly with the resident's other personal care products in their rooms. The facility failed to provide adequate supervision for residents who resided on the COVID-19 cohort unit and failed to ensure the environment remained free of accident hazards.

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documents, and interviews for one sampled resident (Resident #1) reviewed for quality of care and treatment, the facility failed to ensure clinical record entries were complete and accurate. The findings include: Review of the clinical record on 10/15/20 identified Resident #1was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] identified moderate cognitive impairment, height 61 inches, weight 260 pounds, ability to self-feed once set up without swallowing disorder, extensive assist of two for ADLs and total dependence for transfers with lower extremity limitation. Review of a narrative structured progress note dated 8/25/20 at 3:00 AM documented by RN #1, identified a routine shift note was assessed with [REDACTED]. Further review of the record failed to reflect Resident #1 experienced a change of condition with subsequent admission note dated 9/1/20 at 1:44 PM. The note identified Resident #1 reentered the facility following a hospital admission on 8/25/20. Interview, review of the clinical record, review of the Change in Resident Condition/family/MD notification policy, and review of the 24-hour shift to shift report with DON #1 by telephone conferencing on 10/15/20 at 11:46 AM identified the 24-hour report was a tool for nursing to quickly identify resident concerns for the facility's two of two nursing team and was not considered part of a resident's clinical record. She identified Resident #1 experienced an emergent transfer to an acute care hospital for a change in condition on 8/25/20 sometime around the 7:00 AM shift change. She further identified the change in condition occurred during the care entrusted to RN #1 during the night shift (11:00PM to 7:00 AM) and RN #1 was the individual responsible for documenting the event that resulted in the transfer of Resident #1 on 8/25/20 in accordance with facility policy. Review of the 24 hour report dated 8/25/20 (time unknown) identified Resident #1 experienced an acute change in condition. The vital signs documented on the 24-hour report included a temperature 97.4 degrees Fahrenheit, pulse 106 beats per minute, respirations 20 breaths per minute, blood pressure 138/84, and an oxygen saturation of 84%. The documentation further identified Resident #1 was slow to respond, with signs of cough, congestion and excessive oral secretions coming from the Resident's mouth, a call was placed to an on call physician, and the Resident was sent to the hospital for evaluation. Review of the hospital discharge summary dated 9/1/20 identified primary [DIAGNOSES REDACTED]. Interview and clinical record review with RN #1 on 10/16/20 at 7:05 AM identified she completed her charting between 3:00 and 4:00 AM and the medication pass began around 5:00 AM. She identified there were many tasks that the night shift nurse was responsible for and sometimes staffing constraints impacted what tasks cannot be completed. She identified one task that often is left undone included the 24 hour chart audits. She identified the facility corporate compliance regulations allowed the nurse up to 30 minutes after the completion of a shift for overtime as needed and even that 30 minutes was often questioned by administration that required a written report of why the overtime occurred. She indicated staffing on the night shift was one RN and two NAs to for all the residents in the facility. She identified staffing was based on census. She further identified if the facility census reached forty-five (45) or more residents a medication nurse from the day shift (7:00AM-3:00PM) would come in early around 5:00 AM to help with the medication pass. Review of the facility staffing dated 8/25/20 identified the facility census was forty (40) and the night shift was covered by RN #1, NA #1, and NA #2. RN #1 identified Resident #1's emergent transfer on 8/25/20 occurred around 5:30-6:00 AM. She identified NA #1 came to her and requested a check on Resident #1 due to the Resident's slow response when care was provided. She identified vital signs were checked and included a blood sugar value of 224. She indicated she prepared the transfer paper work, filled out the corporate required hospitalization form, documented the transfer on the 24 hour report and must have forgotten to go back to the clinical record to report the transfer event. Further review of the facility documents and the clinical record failed to reflect the records were completed accurately and failed to reflect Resident #1's responsible party (family) were notified of the transfer on 8/25/20 in accordance with facility policy.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documents, observations, and interviews for two of five sampled residents (Residents #10 and #11) reviewed for infection prevention and control, the facility failed to clean/disinfect medical equipment per device and manufacturer's instruction for use, and for one sampled residents (Resident #12) the facility failed to ensure movement of the resident was for a medically necessary reason and that the movement was completed in accordance with Coronavirus Disease 2019 (COVID-19) facility policy, and for one of three sampled residents (Resident #13) reviewed for oxygen equipment the facility failed to change oxygen tubing timely in accordance with physician orders, and the facility failed to ensure Personal Protective Equipment (PPE) was cleaned, decontaminated, maintained, and stored for reuse in accordance with national/local guidelines and/or facility policy. The findings include: 1. Review of clinical records on 10/16/20 identified Resident #10 reentered the facility on 8/18/20 with [DIAGNOSES REDACTED]. Physician order [REDACTED]. Review of the Medication Administration Record [REDACTED]. 2. Review of Resident #11's record identified a re-entry date of 2/21/18 with [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified severe cognitive impairment, extensive to total assist with ADLs, and zero insulin injections during the seven-day assessment period. Review of the MAR indicated [REDACTED]. Observation during tour of the facility on 10/16/20 at 5:45 AM identified RN #1 had returned to the medication cart with a medical devise (glucometer) used for monitoring blood glucose levels. She identified three of the five residents who required early morning blood glucose monitoring had received a fingerstick and the glucometer she held in her hand was used to obtain the glucose readings. She was observed documenting on the 24-hour shift report the levels obtained for the three readings collected, she obtained additional supplies from the medication cart, picked up the glucometer without benefit of observed disinfection of the device, and left the cart to proceed onto the next resident who required a fingerstick for blood glucose monitoring. Subsequent to Surveyor inquiry RN #1 articulated knowledge of how a glucometer was to be cleaned between use and identified the disinfectant/germicidal wipes she needed to clean the glucometer where not available for use. She identified the last wipe in the specified canister was used at the beginning of the shift to clean the glucometer prior to checking the device high/low values per the daily protocol. She further identified she used alcohol prep wipes to clean the glucometer prior to use on Resident #10 and #11. RN #1 further identified she was unaware of how to obtain the required disinfectant/germicidal wipe from the facility's supply storage. She proceeded to unlock another medication cart and discovered that cart contained the required wipes, the glucometer was cleaned, allowed to dry in accordance with manufacturer's instructions and she proceeded to complete the other two glucometer readings with proper infection prevention and control practice. Interview and review of the Blood Glucose Monitoring via Glucometer/Accu-check policy with the Director of Nursing (DON #2) and the glucometer manufacturer's instructions on 10/16/20 at 12:30 PM identified all components that come into contact with blood samples should be considered a biohazard capable of transmitting diseases between patients and health care professionals (HCP). The policy further identified the meter should be cleaned and disinfected after each use with a specified Environmental Protection Agency (EPA) approved disinfectant. Inspection of the facility's supply storage and subsequent interview with DON #2 identified the facility had an ample supply of the EPA approved disinfectant wipes and RN #1 would be provided education on how to access supplies when neede. 3. Review of Resident #12's clinical record identified an admission date of [DATE] with [DIAGNOSES REDACTED]. The admission Resident Care Plan (RCP) dated 10/8/20 identified a coronavirus focused problem statement related to recent hospitalization with interventions to maintain transmission-based isolation precautions per facility policy and the Resident would be provided and encouraged a mask to be worn when leaving his/her room. The Admission MDS assessment identified severe cognitive impairment and extensive to total assistance with ADLs. Review of nursing note dated 10/12/20 at 9:15 PM identified Resident #12 demonstrated poor safety awareness and had transfer self to the recliner chair in his/her room. Nursing notes dated 10/14/20 at 0:10 AM and at 11:55 PM identified Resident #12 experienced two unwitnessed falls without injury. Review of the facility bed board dated 10/16/20 identified the capacity was a 60-bed residential skilled nursing facility with a resident census of forty (40). The resident population resided on two nursing units (short-term rehab and long-term care). Further review of the bed board and observations made during tour on 10/16/20 at 5:20 AM identified the short-term rehab unit was a cohort for residents with a negative COVID-19 status who were under a fourteen-day observation period with transmission-based droplet isolation precautions related to potential COVID exposure. Review of the facility floor plan identified the COVID-19 under observation cohort was separated from the rest of the facility by fire doors. The fire doors from the COVID-19 under observation cohort to the hallway closet to the

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) nurse's station were open. Further review of the floor plan identified a lounge (the serenity room) was centrally located near the nurse's station. The serenity room was in the facility's COVID-negative cohort and separated residential rooms on a short hallway and the team two long term care rooms. Furnishings in the serenity room included a small dining table and a recliner chair. A resident was observed sleeping in the recliner without the benefit of mask wearing. Interview with NA #1 on 10/16/20 at 6:25 AM identified the sleeping resident in the serenity room recliner was Resident #12. She identified the night shift (11:00 PM to 7:00 PM) rounds started with Resident #12 due to her restlessness. She indicated the resident was out of bed at 11:00 PM and had completely disrobed, at 11:30 PM h/she was out of bed looking for something on the floor and it was necessary to assist the Resident back to bed several times. She identified around midnight-1:00 AM Resident #12 was moved from the private room on the COVID-19 under observation cohort into the recliner located in the serenity room where the resident could be checked on more frequently. Furthermore, she identified the fire doors to the COVID-19 under observation cohort unit were closed during the day and evening shifts. She indicated the unit was staffed with a dedicated NA during those shifts but on the night shift facility staffing included one registered nurse (RN) and one or two nurse aids. She identified the fire doors to the COVID-19 under observation cohort were opened during the night shift to ensure staff surveillance of the residents on that unit was conducted regularly. Interview, review of clinical records, and review of the Interim Infection Prevention and Control Recommendations for Patients with Suspected of Confirmed COVID-19 policy with the Director of Nursing (DON #2) on 10/16/20 at 12:30 PM identified the purpose of the fire door closure to the short-term rehab unit was for COVID-19 infection prevention and control measures. Review of the policy identified a resident under observation for COVID-19 was provided a private room and movement of a resident outside of their room should be limited to medically necessary purposes. The policy further directed that when movement was necessary, ensure that infected or colonized areas of the resident's body were covered (i.e. ensure the resident's mouth and nose were covered with a face mask). The facility failed to ensure movement of the resident was for a medically necessary reason and failed to maintain infection prevention and control strategies in accordance with the facility's COVID-19 policy. 4. Review of Resident #13's clinical record identified an admission date of [DATE] with [DIAGNOSES REDACTED]. Physician order [REDACTED]. The quarterly MDS assessment dated [DATE] identified moderate cognitive impairment, extensive assistance with ADLs, and shortness of breath with exertion. Review of the MAR indicated [REDACTED]. During tour of the facility with the DON #2 on 10/16/20 at 8:30 AM identified Resident #13's oxygen tubing was labeled as changed on 9/27/20 (3 weeks prior). The facility failed to ensure infection prevention and control strategies were completed in accordance with physician orders. 5. During tour of the facility's cohort unit for residents with a negative COVID-19 status who were under observation with transmission-based droplet isolation precautions related to potential COVID exposure on 10/16/20 at 5:30 AM identified Personal Protective Equipment (PPE) supplies were stored in a wall mounted storage bin outside ten of ten rooms on the cohort unit. The bins included surgical type face masks, single use disposable isolation gowns and gloves. The bins also contained medical equipment such as a stethoscope and manual blood pressure cuff. Hanging on a hook outside of each door was a single disposable type face shield. Further inspection of the ten face shields failed to reflect they were labeled with a staff name. Two of the three wall mounted alcohol-based liquid hand rub dispensers were identified as empty. Observation on 10/16/20 at 6:10 AM identified NA #1 taking off (doffing) PPE prior to exiting room [ROOM NUMBER]. She doffed all PPE while in the Resident's room an placed the face shield on the door hook without the benefit of sanitation with an EPA approved disinfectant. Interview with NA #1 as she exited into the hallway identified the disinfectant wipes required for cleaning the face shield was not available for use and she cleaned the face shield with soap and water. She identified the face shields on the doors were used for care in that specific room and reused by any staff that entered that specific room. Interview and review of the Interim Infection Prevention and Control Recommendations for Patients with Suspected of Confirmed COVID-19 policy with the Director of Nursing (DON #2) on 10/16/20 at 12:30 PM identified eye protection should be removed and reprocessed (disinfected) when visibly solid or removed (i,e., when leaving the isolation area). The policy directed if a disposable face shield was reprocessed, it should be dedicated to one Health Care Professional (HCP). The facility failed to ensure Personal Protective Equipment (PPE) was cleaned, disinfected, maintained, and stored for reuse in accordance with national/local guidelines and/or facility policy.