STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365705	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WALTON MANOR HEALTH CARE CENTER	19859 ALEXANDER RD WALTON HILLS, OH 44146

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide needed staff assistance for completion of routine personal care and bathing for Resident's #200, #203, and #224 and failed to administer medications and treatments as ordered for 23 resident (Resident's #200, #203, #204, #209, #210, #211, 216, #217, #223, #225, #226, #227, #230, #232, #236, #238, #243, #244, #248, #249, #253, #258, #259). This affected three of three residents reviewed for personal care and bathing and 23 of 23 residents reviewed for missed medications and treatments. The facility census was 57. Findings include: 1. Review of Resident #200's medical record revealed an admission date of [DATE] and medical [DIAGNOSES REDACTED]. Review of the MDS 3.0 Assessment revealed resident had severe cognitive impairment with total dependence for personal care/bathing. Review of 100 West Shower Schedule, updated 10/01/19, revealed Resident #200 was scheduled for showers Mondays and Thursdays. The shower schedule further stated if any resident refused; tell the nurse immediately, do not wait until the end of the shift. Review of the electronic record bathing tab under tasks for Resident #200 revealed shower/bathing was not marked off as completed for 08/10/20, 08/13/20 and 08/17/20. Review of Resident #200's electronic progress notes did not reveal documentation resident had refused bathing/shower. 2. Review of the Resident #203's medical record revealed an admission date of [DATE] and medical [DIAGNOSES REDACTED]. Review of the MDS 3.0 Assessment revealed resident had moderate cognitive impairment and required extensive assistance with personal hygiene and was one-person physical assist for bathing. Review of the 100 West Shower Schedule, updated 10/01/19 revealed Resident #203 was scheduled for showers Tuesday's and Friday's. The shower schedule further stated if any resident refused tell the nurse immediately, do not wait until the end of the shift. Review of the electronic bathing tab under tasks for Resident #203 revealed shower/bathing not marked off completed 08/11/20, 08/18/20, and 08/21/20. Review of Resident #203's progress notes did not reveal documentation resident refused bath/shower. 3. Review of Resident #224's medical record revealed and admission date of [DATE] and medical [DIAGNOSES REDACTED]. Review of the MDS 3.0 Assessment revealed resident was cognitively intact and needed limited assistance and one- person physical assistance using the toilet room. Review of the 100 West Shower Schedule, updated 10/01/19 revealed Resident #224 was scheduled for showers Tuesday's and Friday's. The shower schedule further stated if any resident refused; tell the nurse immediately, do not wait until the end of the shift. Review of the electronic bathing tab under tasks for Resident #224 indicated showers/bath not completed 08/11/20, 08/18/20 and 08/21/20. Review of Resident #224's electronic progress notes did not reveal documentation resident had refused bath/shower. Observation and interview on 08/18/20 at 9:20 A.M. of Resident #204 revealed he had resided in the facility a short time, the laundry lost his clothes and as a result he washed his clothes in the sink in his bathroom. The facility was not making appointments for him, ignored him when he needed assistance, and he did not receive his medications at times. Observation from the doorway of his room revealed a bag of clothing sitting on the floor in a corner of the room. Resident #204 confirmed it was a bag of his soiled clothing that needed washed. Interview on 08/18/20 at 9:51 A.M. with Laundry Aide #75 confirmed Resident #204's clothing was lost, and other clothing needed washed. Laundry Aide #75 stated the Administrator will make sure he is reimbursed. Interview on 08/20/20 at 2:34 P.M. with Licensed Practical Nurse (LPN) #55 revealed she sometimes worked on the 300-West unit and the Covid-19 unit. One state tested nurse aide (STNA) was assigned per unit and did not cross to other units. LPN #55 stated some days she worked very fast to get her medications passed on time. Usually she would assist the STNA's with the resident's care, but on those busy days she was not able to help, and the STNA's would have to do things like Hoyer lifts by themselves. Interview on 08/21/20 at 3:11 P.M. with LPN #74 revealed the facility was short staffed sometimes, and stated we were very short staffed when the managers were out with Covid-19. LPN #74 stated she prioritized her medication pass to give residents critical medications before less critical medications in case she was too busy to get all of them passed on time. Examples of critical medications were insulin and blood pressure medications. Interview on 08/21/20 at 4:51 P.M. with Resident #204 revealed when certain nurses worked, he received all his medications on time. Other days, he did not get all his medications and frequently the medications were not given on time. Resident #204 further stated he did not leave the facility 08/04/20. Review of missed medications/treatments revealed the following: Review of #204's medical record revealed an admission date of [DATE] and included medical [DIAGNOSES REDACTED]. Review of the Minimum Data Set 3.0 Assessment (MDS) revealed Brief Interview for Mental Status (BIMS) indicated resident was cognitively intact. Review of Resident #204's medication administration record (MAR) revealed on 08/04/20 medications due at 12:00 P.M. included [MEDICATION NAME] (blood pressure), [MEDICATION NAME] (ulcer), [MEDICATION NAME] (vitamin supplement), and Tylenol (pain) were not signed off as administered. Medications due at 2:00 P.M. included [MEDICATION NAME] (blood pressure), [MEDICATION NAME] (decrease ammonia levels), and mupirocin ointment (antibacterial ointment) were not signed off as administered. Medication due at 3:00 P.M. included [MEDICATION NAME] (pain) was not signed off as administered. Review of Resident #244's medical record revealed an admission date of [DATE] and included [DIAGNOSES REDACTED]. Review of the MDS 3.0 Assessment revealed BIMS indicated resident had severe cognitive impairment. Review on 08/26/20 at 12:20 P.M. of Resident #244's MAR revealed on 08/25/20 medications due at 6:00 A.M. included [MEDICATION NAME] (hormone for [MEDICAL CONDITION]) 75 milligrams (mg) one tablet and [MEDICATION NAME] (pain) 325 mg two tablets, and neither medication was signed off as administered. Further review revealed on 08/26/20 medications due at 9:00 A.M. included [MEDICATION NAME] (anti-diabetic) 500 mg one tablet, [MEDICATION NAME] extended release (blood pressure) 25 mg one tablet, [MEDICATION NAME] (cognition enhancer) 10 mg one tablet, sodium chloride (salt supplement) 1 gram one tablet, HHL might shake (nutritional supplement), and Resource 2.0 (nutritional supplement) 90 milliliters (ml) were not signed off as administered. Resident #216: 08/18/20 at 7:00 A.M. left knee, cleanse with soap and water, pad dry, cover with four by four gauze and abdominal (ABD), secure with tape daily and as needed (PRN); ice machine to left leg were not signed off as completed as ordered by the physician. Resident #226: 08/20/20 at 10:30 P.M. [MEDICATION NAME] ([MEDICAL CONDITION]) 1 mg was not signed off as administered as ordered by the physician. Resident #203: 08/18/20 at 7:00 A.M. and 7:00 P.M., 08/19/20 at 7:00 A.M., and 08/20/20 at 6:00 A.M. Droplet Precautions / Isolation for Covid-19 was not signed off as completed as ordered by the physician. Resident #238: 08/17/20 at 7:00 A.M. Obtain stool for Gualac (test for blood in stool) for abnormal hemoglobin and hematocrit was not signed off as completed as ordered by the physician. Resident #243: 08/16/20 at 7:00 A.M. Sodium Chloride Solution 0.9% 75 milliliter (ml)/hour (hr) intravenously (IV) every shift for febrile (fever) times one liter was not signed off as administered as ordered by the physician. Resident #244: 08/16/20 at 12:00 P.M. HHL Mighty Shake (nutritional supplement); 08/16/20 at 2:00 P.M. Tylenol (pain reliever/fever reducer) 325 mg two tablets; 08/16/20 at 6:00 A.M. [MEDICATION NAME] Sodium (hormone for [MEDICAL CONDITION]) 75 micrograms (mcg); 08/16/20 at 6:00 A.M. Tylenol 325 mg two tablets; 08/16/20 at 9:00 P.M. [MEDICATION NAME] HCL (anti-diabetic) 500 mg; 08/16/20 at 9:00 P.M. Donepezil HCL (cognition enhancer) 10 mg; 08/16/20 at 9:00 P.M. [MEDICATION NAME] (cognition enhancer) 10 mg; 08/16/20

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

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) at 9:00 P.M. Sodium Chloride (salt supplement) one gram (GM); 08/16/20 at 9:00 P.M. HHL Mighty Shake; 08/16/20 at 10:00 P.M. Tylenol 325 mg two tablets; 08/17/20 at 6:00 A.M. Tylenol 325 mg two tablets; 08/17/20 at 6:00 A.M. Accucheck (finger stick blood sugar), notify physician if below 60 or above 400; 08/17/20 at 6:00 A.M. [MEDICATION NAME] Sodium 75 mcg; 08/19/20 at 6:00 A.M. [MEDICATION NAME] 75 mcg; 08/19/20 at 6:00 A.M. Accucheck notify physician if below 60 or above 400; 08/19/20 at 6:00 A.M. Tylenol 325 mg two tablets were not signed off as completed/administered as ordered by the physician. Resident #200: 08/16/20 at 7:00 A.M. and 7:00 P.M., 08/17/20 at 7:00 A.M. and 7:00 P.M., 08/18/20 at 7:00 A.M. and 7:00 P.M. Droplet Precautions / Isolation Precautions for Positive Covid-19 was not signed off as completed as ordered by the physician. Interview on 08/24/20 at 11:15 A.M. with the Administrator revealed she was not permitted to give surveyor the missed medications, missed treatments and late medications/treatments report related to missed medications from 08/16/20 to 08/20/20 above from the electronic record because it was part of the facility Quality Assurance information. Interview on 08/24/20 at 4:40 P.M. with the Administrator and Regional Nurse #58 revealed an investigation was started into concerns regarding resident missed medications. An agency nurse worked the night shift of 08/19/20 and through review of resident MAR and progress notes it was indicated that medications were not given to 18 residents (Residents' #203, #204, #209, #210, #211, 216, #217, #223, #225, #227, #230, #232, #236, #248, #249, #253, #258 and #259) . The agency was contacted about the missed medications, and attempts were made to contact the involved nurse. Interview on 08/25/20 at 12:16 P.M. with Regional Nurse #58 revealed there had been several unsuccessful attempts to contact the agency nurse by phone. Regional Nurse #58 further stated all 18 residents were impacted by the medication pass with the agency nurse but did not experience harm or negative effects. Interview on 08/25/20 at 12:46 P.M. with Regional Nurse #58, the Director of Nursing (DON), and the Administrator revealed two facility nurses worked night shift 08/19/20, the agency nurse was given an assignment and informed the medications still needed to be given to the residents. The resident's physicians were not notified the medications were not given. The situation was not managed appropriately by the agency nurse. All 18 Residents' (#203, #204, #209, #210, #211, 216, #217, #223, #225, #227, #230, #232, #236, #248, #249, #253, #258, #259) were interviewed and it was confirmed they did not receive their medications. There were no negative resident outcomes. The facility notified the physicians and responsible parties for all 18 residents. Completion of the Minimum Direct Care Daily Average of 2.50 Survey Tool, revised 05/2012 revealed on 08/12/20 the daily direct care requirement was 2.43, which is below the required 2.50 minimum staffing requirement. This deficiency substantiates Complaint Number OH 003.
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, based on observation, interview and record review the facility failed to provide needed staff assistance for completion of routine personal care and bathing for Resident's #200, #203, and #224 and failed to administer medications and treatments as ordered for 23 resident (Resident's #200, #203, #204, #209, #210, #211, 216, #217, #223, #225, #226, #227, #230, #232, #236, #238, #243, #244, #248, #249, #253, #258, #259). This affected three of three residents reviewed for personal care and bathing and 23 of 23 residents reviewed for missed medications and treatments. This had the potential to affect all 57 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, Nursing Home Guidance from the Centers for Disease Control (CDC), review of the facility's policy and procedure, review of the facility's Coronavirus (Covid-19) timeline, review of daily resident census reports, observations, record review, and staff interview, the facility failed to perform adequate staff screening to properly identify, quarantine, and appropriately test residents with exposure to staff members who had tested positive for Covid-19. The facility failed to implement appropriate quarantine procedures and ensure staff used appropriate personal protective equipment (PPE) to prevent the spread of Covid-19 within the facility. This resulted in Immediate Jeopardy on 07/25/20 when the facility failed to identify a staff member with Covid-19 symptoms of loss of taste and smell indicated on the facility screening tool and permitted her to work with direct patient care until 08/02/20. Her Covid-19 test was positive on 07/31/20. The facility failed to ensure staff members discarded N95 and KN95 respirators after caring for Covid-19 positive residents, before leaving the Covid-19 unit, and donning a new N95 or KN95 respirator to care for non Covid-19 positive residents. 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 facilities failure to control the spread of Covid-19. Cross reference F880. 2. 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. 3. Based on observation, interview and record review the facility failed to provide needed staff assistance for completion of routine personal care and bathing for Resident's #200, #203, and #224 and failed to administer medications and treatments as ordered for 23 resident (Resident's #200, #203, #204, #209, #210, #211, 216, #217, #223, #225, #226, #227, #230, #232, #236, #238, #243, #244, #248, #249, #253, #258, #259). This affected three of three residents reviewed for personal care and bathing and 23 of 23 residents reviewed for missed medications and treatments. Cross reference F684.
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 57 residents residing in the facility. Findings include: The following concern of Immediate Jeopardy was identified at the time of the Complaint and 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, Nursing Home Guidance from the Centers for Disease Control (CDC), review of the facility's policy and procedure, review of the facility's Coronavirus (Covid-19) timeline, review of daily resident census reports, observations, record review, and staff interview, the facility failed to perform adequate staff screening to properly identify, quarantine, and appropriately test residents with exposure to staff members who had tested positive for Covid-19. The facility failed to implement appropriate quarantine procedures and ensure staff used appropriate personal protective equipment (PPE) to prevent the spread of Covid-19 within the facility. This resulted in Immediate Jeopardy on 07/25/20 when the facility failed to identify a staff member with Covid-19 symptoms of loss of taste and smell indicated on the facility screening tool and permitted her to work with direct patient care until 08/02/20. Her Covid-19 test was positive on 07/31/20. The facility failed to ensure staff members discarded N95 and KN95 respirators after caring for Covid-19 positive residents, before leaving the Covid-19 unit, and donning a new N95 or KN95 respirator to care for non Covid-19 positive residents. 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 facilities failure to control the spread of Covid-19. Cross Reference F880.
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 [DATE], Nursing Home Guidance from the Centers for Disease Control (CDC), review of the facility's policy and

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) procedure, review of the facility's Coronavirus (Covid-19) timeline, review of daily resident census reports, observations, record review, and staff interview, the facility failed to perform adequate staff screening to properly identify, quarantine, and appropriately test residents with exposure to staff members who had tested positive for Covid-19. The facility failed to implement appropriate quarantine procedures and ensure staff used appropriate personal protective equipment (PPE) to prevent the spread of Covid-19 within the facility. This resulted in Immediate Jeopardy on [DATE] when the facility failed to identify a staff member with Covid-19 symptoms of loss of taste and smell indicated on the facility screening tool and permitted her to work with direct patient care until [DATE]. Her Covid-19 test was positive on [DATE]. The facility failed to ensure staff members discarded N95 and KN95 respirators after caring for Covid-19 positive residents, before leaving the Covid-19 unit, and donning a new N95 or KN95 respirator to care for non Covid-19 positive residents. 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 facilities failure to control the spread of Covid-19. The facility census was 57. The administrator was notified on [DATE] at 1:10 P.M. that an Immediate Jeopardy began on [DATE] when a staff member (Activity Director(AD) #63) notified the facility she was experiencing loss of taste and smell and was permitted to continue to work with direct resident contact until [DATE]. In addition, observations on [DATE] revealed staff members were not changing all personal protective equipment (PPE), particularly N95 and KN95 respirators when exiting resident rooms that had tested COVID-19 positive. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following correction actions: All residents residing in the facility are impacted and currently are at their baseline and are without symptoms. Residents likely to be impacted: all residents. Regional Director of Clinical Services, Registered Nurse (RN) #58, reviewed all resident records for current symptom screening, completed [DATE]. There were no negative findings. On [DATE] at 4:30 PM: Staff and visitor screening tools from [DATE] to present were audited by the Director of Nursing (DON), Infection Preventionist (RN #57) and the Licensed Nursing Home Administrator (LNHA) to identify any positive screens not previously identified, completed on [DATE]. No other concerns were identified. On [DATE] at 5:00 PM: a 30-day supply of PPE on hand, verified by Infection Preventionist, RN #57. The DON and Infection Preventionist (RN #57) educated nursing staff regarding indicators for Covid-19 testing as well as practice of requesting from the physician Covid-19 testing with identification of symptoms, completed on [DATE]. The DON and Infection Preventionist (RN #57) educated all staff regarding indications for PPE, isolation measures and donning/doffing of PPE. The education started on [DATE] and was completed on [DATE]. The DON and Infection Preventionist (RN #57) educated all staff regarding performance of and indications for hand hygiene. The education started on [DATE] and was completed on [DATE]. The DON and Infection Preventionist (RN #57) educated all staff regarding identification of Covid-19 symptoms. All staff were educated regarding restrictions to facility access related to Covid-19 symptoms. All staff were educated regarding Covid-19 symptom reporting requirements, completed on [DATE]. All staff designated to perform staff and essential visitor screens were educated on performance, denial of access to facility with positive screen and competency performed. The education and competency were completed by Regional Director of Clinical Services (RN #58), the DON and Infection Preventionist (RN #57); started on [DATE] and completed on [DATE]. Director of Policy Management (RN #73) updated staff on [DATE] on the Essential Visitor Screening Tool updated [DATE]. The DON and Infection Preventionist (RN #57) initiated all staff competencies for donning/doffing PPE and Hand Hygiene which were completed [DATE]. To monitor and maintain ongoing compliance the DON or Infection Preventionist (RN #57) will complete observations of five staff weekly times four weeks, then monthly times two months for donning/doffing PPE and hand hygiene to ensure staff have implemented effective and recommended infection control practices to decrease the spread of Covid-19 within the facility. The DON or Infection Preventionist (RN #57) will review respiratory screeners (documentation of resident symptom screening) during clinical morning meeting five days a week times four weeks, then monthly times two months to ensure staff effectively respond to a resident with potential signs and symptoms of Covid-19. The Licensed Nursing Home Administrator will compare the staff/essential visitor screening tool against the schedule five days a week times four weeks, then monthly times two months to verify that staff members or essential visitors expressing symptoms of Covid-19 are not permitted to work with direct resident care or gain access to the facility. An as needed Quality Assurance and Performance Improvement (QAPI) meeting was completed on [DATE] with the Interdisciplinary Team (IDT), the Medical Director and the Regional Director of Clinical Services #58. The results of the audits will be forwarded to the facility QAPI for further review and recommendations. Although the Immediate Jeopardy was removed on [DATE], 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 ,[DATE]-ALL dated [DATE] 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 and interview on [DATE] at 6:15 A.M. with State tested Nursing Assistant (STNA) #51 revealed she wore a white mask (KN95) and full PPE when she cared for residents with Covid-19. STNA #51 stated the white masks were good for a couple days and at the end of her shift she sprayed the mask with 91 percent (%) alcohol she kept with her and put the mask in a paper bag and left it in her car until she worked again. Observation on [DATE] at 6:55 A.M. revealed STNA #53 walking in the 100-West hallway (the Covid-19 unit) with a blue surgical mask on her face. Interview on [DATE] at 6:55 A.M. with STNA #53 revealed the blue surgical mask was worn while she was in the hallway of the Covid-19 unit, and the white KN95 was kept in her pocket until she entered resident rooms to give care. She stated she put the white mask on, took care of the resident then she would go to the bathroom, remove her PPE, take the white mask off and put it in her pocket until she needed to help another resident. Interview on [DATE] at 7:15 A.M. with RN #54 revealed she tested positive for Covid-19 on [DATE] and was off work until [DATE]. RN #54 stated she usually worked on the 100-West (the Covid-19 unit) and 300-West units and wore one KN95 mask every day when she came to work. She indicated she did not change it during her shift and discarded it when she left. Interview on [DATE] at 7:50 A.M. with Social Worker (SW) #57 revealed she was also an RN and the facility Infection Preventionist. SW #57 stated her office was in the 100-West hallway which was also the facility Covid-19 unit. SW #57 stated the National Guard tested facility staff on [DATE], and eight staff members tested positive for Covid-19. All staff denied symptoms on [DATE]. SW #57 further stated she tested positive for Covid-19 and was off work until [DATE]. Staff members were permitted a new KN95 or N95 mask every day. SW #57 further stated Health Department Official (HDO) #59 did not give the facility guidance on the use of PPE. Observation on [DATE] at 8:51 A.M. revealed STNA #72 wearing a KN95 mask entering resident room [ROOM NUMBER] on the Covid-19 unit. The STNA donned appropriate PPE and doffed it prior to leaving resident room. There was no observation of the STNA changing the KN95 mask after leaving the Covid-19 unit. Interview on [DATE] at 9:00 A.M. with STNA #72 revealed she wore one KN95 mask per day and did not change it until she left the facility when her shift was over. Observation and interview on [DATE] at 9:10 A.M. with STNA #60 revealed the facility stockroom was full of boxes of hand sanitizer, isolation gowns, N95 masks and KN95 masks, surgical masks and gloves. STNA #60 stated we do not have a shortage of PPE. Observation on [DATE] at 9:51 A.M. revealed LPN #56 entering resident room [ROOM NUMBER] on the Covid-19 unit wearing a KN95 mask and proper PPE. There was no observation the KN95 mask was removed prior to leaving the Covid-19 unit. Interview on [DATE] at 9:55 A.M. with LPN #56 revealed the KN95 mask was not removed after she left the Covid-19 unit. LPN #56 stated it was only changed if it became wet or dirty. Interview on [DATE] at 4:55 P.M. with LPN #56 revealed when she arrived for work each day she would fill out a screening tool and collect a surgical mask and a KN95 mask from the desk and proceed to her assigned area which was usually 100-West (the Covid-19 unit) and 300-West. She stated she passed medications and gave care to the residents in the 300-West unit first then proceeded to 100-West (COVID) unit. LPN #56 stated she donned gown, gloves, face shield, and had

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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 3) her KN95 mask and surgical mask on. LPN #56 stated when she finished giving care to the residents in the Covid-19 unit she doffed the gown and gloves and placed them in the red biohazard bin in the resident room, and wiped the face shield off with disinfecting wipes between residents. LPN #56 stated she changed her mask during the day if it was wet or dirty, otherwise she wears the same mask all day and discards it in the biohazard bin when she leaves for the day. Phone interview on [DATE] at 8:38 A.M. with Admissions Representative (AR) #64 revealed she worked about a week with symptoms including runny nose and sneezing. before the National Guard tested the facility staff on [DATE]. AR #64 did not notify administration because she did not think she had Covid-19 and did not mark any symptoms on the screening tool when she arrived for work each day. AR #64 received positive Covid-19 results on [DATE] and was off work from [DATE] until [DATE] when she was cleared to return by Regional Nurse #58. Phone interview on [DATE] at 8:47 A.M. and 4:52 P.M. with AD #63 revealed she lost her sense of taste and smell on [DATE] and continued to work until she received her positive Covid-19 test results from the facility on [DATE]. AD #63 further stated she did a lot of one on one activities with the residents. She indicated she would go in the resident rooms in the morning to pass out activities and give the residents a little one on one attention. Regional Nurse #58 cleared her to return to work on [DATE]. Review of the facility Employee/Medical Provider/Visitor/Surveyor Screening Tool on [DATE] revealed AD #63 marked new loss of taste and smell as symptoms of Covid-19 on [DATE], [DATE] and [DATE]. AD #63 tested positive for COVID-19 on [DATE]. Review of AD #63's Timecard Report revealed she worked [DATE] from 9:31 A.M. until 5:39 P.M. and returned to work [DATE] and worked from 9:34 A.M. until 5:16 P.M. Phone interview on [DATE] at 9:01 A.M. with LPN #65 revealed on Friday [DATE] she worked on 100-West (the Covid-19 unit) and 300-West and during her night shift she developed chills but did not notify anyone because she thought she was just cold. She did not work the weekend, but her symptoms got progressively worse, and she was tested for Covid-19 on [DATE]. LPN #65 received positive Covid-19 results on [DATE], her symptoms worsened, and she went to the emergency room and was admitted to the hospital on [DATE]. Interview on [DATE] at 9:53 A.M. with the Administrator revealed she developed a fever on [DATE] and went to the emergency room where she tested positive for Covid-19. The administrator said she returned to work [DATE]. Interview on [DATE] at 11:17 A.M. with the DON revealed Resident #201 expired on [DATE] positive for Covid-19; Resident#202 tested positive for Covid-19 on [DATE] and expired on [DATE]; Resident #200 and #203 tested positive on [DATE]. Review of electronic physician orders for Resident #200 and #203 revealed no orders for droplet precautions. Interview on [DATE] at 8:17 A.M. with Medical Doctor (MD) #66 revealed she was unaware of Covid-19 in the facility. MD #66 indicated she was told everything was fine and there was no Covid-19. The MD indicated the facility had one resident that had Covid-19 and was cured. MD #66 stated she would always ask if there was Covid-19 so she would be prepared with PPE. Interview on [DATE] at 2:34 P.M. with LPN #55 revealed she floated between the East and West wings in the facility. When she worked in the West wing, she started with the 300-unit which was non-Covid-19 and worked her way to the Covid-19 unit. At noon she again passed medications on the 300-unit and worked her way to the Covid-19 unit. LPN #55 stated she wore one KN95 each day she worked and did not change it. Interview on [DATE] at 2:50 P.M. with STNA #67 revealed she wore a new KN95 mask every day, and she did not change it while she worked. She indicated she discards the mask in the biohazard bin at the end of her shift. STNA #67 stated she sometimes worked on the Covid-19 unit. Interview on [DATE] at 3:26 P.M. with HDO #59 revealed she did not give guidance on the use of PPE or the Covid-19 screening tool that was used for the facility. HDO #59 further stated the line list received from the facility had a total of seven positive cases, four residents and three staff. She received a phone call from SW/Infection Preventionist/RN #57 on [DATE] stating the facility had more positive cases, but they were not on the line list as of [DATE]. Review of facility timeline for Covid-19 revealed 12 staff members tested positive for Covid-19, LPN #55 received positive test results on [DATE], the Administrator tested positive on [DATE], the DON, Dietary Aide (DA) #68, AR #64, AD #63, RN #54 and Maintenance Director #69 all received positive results on [DATE]. LPN #65 received positive Covid-19 test results on [DATE], STNA #70 received positive results on [DATE], and LPN #71 received positive results on [DATE]. Review of the facility policy titled, Transmission-Based Precaution Policy, revised, [DATE], revealed facility staff providing care for the resident will be notified by the facilities infection control coordinator and/or charge nurse regarding needed precautions based on infectious agent or condition. Review of the facility competency for Personal Protective Equipment (PPE) Donning and Doffing for Standard Precautions and Transmission Based Precautions under doffing revealed remove mask/respirator (respirator removed after exit room/closed door), grasp bottom, then top ties or elastics and remove, discard in waste container. Review of guidance from the CDC indicated, Perform expanded [MEDICAL CONDITION] testing of all residents in the nursing home if there is an outbreak in the facility (i.e., a new [DIAGNOSES REDACTED]-CoV-2 infection in any HCP or any nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident). A single new case of [DIAGNOSES REDACTED]-CoV-2 infection in any HCP or a nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with [DIAGNOSES REDACTED]-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing [MEDICAL CONDITION] testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent [DIAGNOSES REDACTED]-CoV-2 transmission. Review of CDC Guidance titled Preparing for Covid-19 in Nursing Homes, updated [DATE] revealed if HCP develop fever (Temperature above 100.0 degrees Fahrenheit) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace. Have a plan for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers). Review of National Institute for Occupational Safety and Health (NIOSH) Pandemic Planning, titled Recommended Guidance for Extended Use and Limited Re-Use of N95 Filtering Facepiece Respirators in Healthcare Settings, revealed discard N95 respirators following close contact with, or exit from, the care area of any patient co-infected with an infectious disease requiring contact precautions. This deficiency substantiates Complaint Number OH 003.