STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395423	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORNER VIEW NURSING AND REHABILITATION CENTER	**6655 FRANKSTOWN AVENUE PITTSBURGH, PA 15206**

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 0574 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**The resident has the right to receive notices in a format and a language he or she understands.** Based on review of facility policy, observation, and staff interview it was determined that the facility failed to post the State complaint hotline contact information (name, address, e-mail, and phone number) for five out of five nursing units (2nd floor, 3rd floor, 4th floor, 5th floor, and 6th floor nursing units). Findings include: The facility Resident Rights-Required Postings policy, last reviewed April 15, 2020, indicated it is the policy of the facility to inform its residents in such a manner to acknowledge and respect resident rights. The facility must post a list of names, addresses, e-mail, and telephone numbers of all pertinent State agencies, the State survey agency, State licensure office, and the Office of the State Long-Term Care Ombudsman program. The facility must post a statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation. During an observation of the bulletin board located on the Fifth floor nursing unit on 8/24/20, at 11:30 a.m. the State complaint hotline number was not posted. During an interview on 8/24/20, at 11:35 a.m. Activity Employee E8 confirmed that the State complaint hotline number was not posted on the Fifth floor nursing unit bulletin board. During observations on 8/25/2020, with the Nursing Home Administrator (NHA), the sixth floor resident bulletin board was observed at 3:13 pm and did not include a phone number for the State complaint hotline. During observations on 8/25/2020, the fourth floor resident bulletin board was observed at 3:18 pm and did not include a phone number for the State complaint hotline. During observations on 8/25/2020, the third floor resident bulletin board was observed at 3:20 pm and did not include a phone number for the State complaint hotline. During an interview on 8/25/2020 at 3:20 pm, the NHA confirmed that the facility failed to post the State complaint hotline in a prominent location for the third, fourth, and sixth floors as required. 28 Pa Code: 201.18 (a)(b)(e)(1) Management. 28 Pa Code: 201.29 (a) Resident Rights.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a facility specific document and facility policies, observations and staff interviews, it was determined that the facility failed to make certain that the procedure for house-supplied medications was followed during medication administration for two of eight residents (Resident R77 and R108), and failed to store medications under proper temperature controls in one of five medication room refrigerators (2nd floor medication room), or separately by route of administration and dated in two of seven medication carts (2nd and 3rd floor carts) and treatments were kept separated in the wound care cart. Findings include: The facility was granted a permanent exception on March 13, 2017, as related to their house-supplied medications. The exception noted that the facility utilized a list that detailed the names of all residents who were prescribed house-supplied medications, the list was received weekly from the pharmacy and listed the resident names and specified the house-supplied medications they received and the nurse would review and update the list for accuracy daily during medication pass. The facility policy House-Supplied (Floor Stock) Medications dated 4/15/20, indicated that the floor stock medication list was posted in medication rooms and that the medications were kept in their original manufacturer's container. The facility policy Labeling of Medication Containers dated 4/15/20, indicated that labels for each floor stock medication included all necessary information such as: the name and strength of the drug, the lot and control numbers, the expiration date, appropriate accessory and cautionary statements and directions for use. Neither of the facility policies addressed the procedure for house-supplied medications as per the facility's permanent exception. The facility policy Storage of medications dated 4/15/20, indicated medications requiring refrigeration are kept in a refrigerator at temperatures between 36 Fahrenheit (F) and 46 F. Orally administered medications are kept separate from externally used medications and treatments such as suppositories. When the original seal of a manufacturers container is broken the container or vial will be dated. Each residents medication shall be assigned to an individual cubicle, drawer or other holding area. During an observation of a medication pass on 8/25/20, at 8:50 a.m. Licensed Practical Nurse (LPN) Employee E2 dispensed and administered the following house-supplied medications to Resident R108: -Iron (supplement) 325 milligram (mg) tablet -Fish oil 1,000 mg tablet -[MEDICATION NAME] (decreases stomach acid) 20 mg tablet During an observation of a medication pass on 8/25/20, at 9:08 a.m. LPN Employee E2 dispensed and administered the following house-supplied medication to Resident R77: -Senna (stool softener) 8.6 mg via gastrostomy tube. There were no resident names on the bottles of iron and fish oil supplements, the [MEDICATION NAME] and Senna and LPN Employee E2 did not reference a house-supplied medication list. During an interview on 8/25/20, at 9:30 a.m. LPN Employee E2 reported not knowing anything about a house-supplied medication list and when the front of the medication binder was checked a house-supplied medication list, dated 8/25/20, was found however it was inaccurate and did not include the names of Resident R77 and R108. During an interview on 8/25/20, at 9:35 a.m. Assistant Director of Nursing Employee E1 confirmed that the facility had an exception as related to the house-supplied medications and that the facility failed to make certain that the procedure for the house-supplied medications was followed by the nurses during medication administration. During an observation of the facilities wound treatment cart on 8/25/20, at 8:05 a.m. dermoplast (topical anesthetic), wound cleanser, hydrogen peroxide, and ammonium [MEDICATION NAME] (lotion for dry skin) were observed to be clustered together in a drawer. During an interview on 8/25/20, at 8:15 a.m. the facilities wound care Registered Nurse confirmed the above observation and confirmed that the facility clustered residents treatments in the same drawer, and failed to separate resident treatments. During an observation of the second floor medication room refrigerator on 8/25/20, at 10:56 a.m. with the Director of Nursing (DON) the medication refrigerator thermometer indicated the temperature was 48 F. Stored inside the refrigerator was three bottles of [MEDICATION NAME]. During an observation of the second floor medication cart on 8/25/20, at 11:00 a.m. with the DON three containers, one each of sodium [MEDICATION NAME] (administered by mouth), [MEDICATION NAME] (administered by mouth) and [MEDICATION NAME] (administered by mouth) were stored in the same compartment as opened in use [MEDICATION NAME] suppositories (administered externally). During an observation of the third floor medication cart on 8/25/20, at 11:15 a.m.with the DON the cart contained a container of [MEDICATION NAME] acid with manufacturers expiration date of March 3, 2022, the manufacturers seal was broken and the date the seal was broken was not written on the label. During a second observation of the second floor medication room refrigerator on 8/25/20, at 12:40 p.m. with LPN Employee E15 the thermometer was observed to be placed in the freezer section and not in the refrigerated section with 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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) [MEDICATION NAME]. During a third observation of the second floor medication room refrigerator on 8/25/20, at 1:00 p.m. with LPN Employee E15 the temperature was observed to be 48 F. During an interview on 8/27/20, at 11:00 a.m. the DON confirmed that the facility failed to store refrigerated medications at proper temperatures, separate by route, label with expiration date when opened, and separate treatments in the wound cart. 28 Pa. Code: 211.9(h)(k) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services. Previously cited 11/8/19 and 10/8/19.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on a review of facility policies, observations and staff interviews, it was determined that the facility failed to maintain proper sanitary conditions, air dry equipment and perform handwashing in the Main Kitchen (Main Kitchen). Findings include: A review of facility HACCP (Hazard Analysis Critical Control Point) and Food Safety policy dated 4/15/2020, indicated that facility is aware that sources for food - borne organisms are from contaminated equipment, improper sanitation and cross contamination. A review of facility Food Storage policy date 4/15/2020, indicated that scoops are provided for bulk food such as sugar and flour. Scoops are not to be stored in the food. A review of facility General Sanitation of Kitchen policy dated 4/15/2020, indicated that the staff shall maintain the sanitation of the kitchen by completing a cleaning schedule. A review of facility Dry Storage Areas dated 4/15/2020, revealed that ceilings must protect food from leaking pipes or contamination. A review of facility Employee Sanitary Practices policy dated 4/15/2020, indicated that guidelines for handling clean silverware include that staff is to pick up silverware by their handles. A review of facility Hand Washing policy dated 4/15/2020, indicated that hand washing is performed after handling soiled equipment or utensils and after engaging ina activities that contaminate the hands. During an observation of the Main Kitchen on 8/24/2020, at 8:45 am the following was revealed: - the top of the convection oven contained a build up of dust and debris. - a bulk container of sugar contained a scoop stored in the food product with the handle in direct contact of the food product. - in the dry storeroom a ceiling tile was missing from the ceiling. - in walk in refrigerator number two the shelving contained a build up a black substance. During an interview on 8/24/2020, at 9:00 am the Food Service Supervisor Employee E12 confirmed that the facility failed to maintain the Main Kitchen in proper sanitary condition which created the potential for cross contamination. During an observation on 8/25/2020, at 11:18 am Dietary Aide Employee E13 was observed with gloved hands used a terry cloth towel to dry meal service trays. He then placed the towel on the countertop, placed a napkin on the tray and then placed silverware on the napkin touching the eating portion of the utensil with the same gloved hands. He proceeded to pick up the towel from the countertop and repeat the procedure for the next tray. During an interview on 8/25/2020, at 11:40 am. Food Service Supervisor Employee E12 confirmed that Dietary Aide Employee E13 improperly wiped meal service trays with a terry cloth failing to allow the equipment to air dry and to properly handle silverware by the handle which created the potential for cross contamination. 28 Pa Code: 211.6 (c)(f) Dietary services Previously cited: 2/19/19, 5/16/18, and 3/30/18
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Dispose of garbage and refuse properly.** Based on a review of facility policies, observations and staff interviews it was determined that the facility failed to maintain the outdoor refuse area in a sanitary condition to prevent the potential for rodent and pest infestation. (Outdoor refuse area). Findings include: A review of facility Food Safety - Food Service manager's Responsibility dated 4/15/2020, indicated that the Food Service manager to to make certain that proper waste disposal methods are used. During an observation of the outdoor refuse area on 8/24/2020, at 9:05 am revealed the following: - the lids and one door were open on one dumpster that contained bags of garbage and broken medical equipment. - doors on both side were open on a second dumpster that contained bags of garbage. - there were spilled liquid and food debris on the asphalt located outside of both dumpster areas. - at a separate area along the entrance to the refuse area were stored a large uncovered garbage can that contained garbage bags and a covered dumpster that contained debris protruding out from under the lid so that the cover failed to seal and completely cover the dumpster. During an interview on 8/24/2020 at 9:15 am the Food Service Supervisor Employee E12 confirmed that the facility failed to maintain the outdoor refuse area in a sanitary condition which created the potential for rodent and pest infestation. 28 Pa Code: 207.2(a) Administrator's responsibility. Previously cited: 2/19/19, 11/1/18, 9/18/18, 5/16/18, 3/30/18 2/18/18 and 1/16/18.
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 review of facility signage and policy, observations and staff interviews, it was determined that the facility failed to make certain that procedures were properly completed and consistently followed related to the prevention and mitigation of the spread of [MEDICAL CONDITION] (Screening process of visitors and employees). Finding include: A sign posted on the front door of the facility informed all staff and visitors that their temperatures were taken upon entrance into and exit from the facility. The facility policy, COVID-19 dated 3/10/20, indicated that what was known about the COVID-19 virus was that it was spread by person-to-person mainly between people who are within six feet of one another through respiratory droplets and that interventions were taken within the facility to prevent the spread of respiratory germs which included monitoring residents, staff and visitors upon entry to and exit from the facility and heightened surveillance activities were implement such as not sharing objects between people. The policy also noted that two separate forms were utilized: one when signing into the facility and another when signing out. During an observation of the screening procedure upon entrance to the facility on [DATE], at 8:15 a.m. Activity Employee E8 took visitors' temperature and there was one pen being utilized by multiple persons to sign into the facility. During an interview on 8/24/20, at 8:20 a.m. the Nursing Home Administrator (NHA) and Director of Nursing (DON) reported that this is the procedure the facility had been using, acknowledged the potential for spreading disease by one pen being utilized by multiple persons and confirmed the failure to effectively implement a procedure for the prevention and mitigation of the spread of [MEDICAL CONDITION] during the screening process. 28 Pa. Code: 201.14(a) Responsibility of licensee. Previously cited 11/8/19. 28 Pa. Code: 201.18(b)(1) Management. Previously cited 11/8/19 28 Pa. Code: 211.10(d) Resident care policies. Previously cited 11/8/19. 28 Pa. Code: 211.12(d)(1)(3) Nursing services. Previously cited 11/8/19.