STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06A172	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK FOREST CARE CENTER, INC.	**7045 STUART ST WESTMINSTER, CO 80030**

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure one of two residents (Resident #1) reviewed for abuse out of 15 sample residents remained free from abuse by staff. On 7/28/2020, social worker (SW#2) stopped Resident #1 in the south unit hallway as the resident attempted to return to her room from the outdoor smoking area. When the resident became upset, a male licensed practical nurse (LPN #1) put his arms up wide, stepping toward the resident and barricading the hallway. Resident #1, care planned to become overwhelmed easily and known to have behavioral issues related to difficulty following directions, pushed her walker away and leaned against the wall, frightened and crying until another staff arrived and walked with the resident, away from hallway. Resident #1, interviewed an hour later, was tearful and shaking as she described the incident with LPN #1. She stated she felt threatened and the LPN frightened her. After notice of Resident #1's fear, the facility failed to take steps to ensure Resident #1 remained free from abuse. The facility failed immediately to suspend LPN #1, contrary to facility policy. The facility failed to conduct a thorough investigation (Cross-reference F610) and therefore, failed to recognize, reinforce and ensure staff followed the resident's care planned interventions designed to de-escalate her behaviors. Further, the facility failed to train LPN #1 to ensure he knew how to react and respond to Resident #1's behaviors (Cross-reference F741). The facility's failures created a situation of serious adverse outcome - resident fear - that required immediate action to prevent reoccurrence. Findings include: I. Immediate Jeopardy A. Findings of immediate jeopardy On 7/28/2020, social worker (SW#2) stopped Resident #1 in the south unit hallway as the resident attempted to return to her room from the outdoor smoking area. When the resident became upset, a male licensed practical nurse (LPN #1) put his arms up wide, stepping toward the resident and barricading the hallway. Resident #1, care planned to become overwhelmed easily and known to have behavioral issues related to difficulty following directions, pushed her walker away and leaned against the wall, frightened and crying until another staff arrived and walked with the resident, away from hallway. Resident #1, interviewed an hour later, was tearful and shaking as she described the incident with LPN #1. She stated she felt threatened and the LPN frightened her. After notice of Resident #1's fear, the facility failed to take steps to ensure Resident #1 remained free from abuse. The facility failed immediately to suspend LPN #1, contrary to facility policy. The facility failed to conduct a thorough investigation (cross-reference F610) and therefore, failed to recognize, reinforce and ensure staff followed the resident's care planned interventions designed to de-escalate her behaviors. Further, the facility failed to train LPN #1 to ensure he knew how to react and respond to Resident #1's behaviors (cross-reference F741). The facility's failures created a situation of serious adverse outcome - resident fear - that required immediate action to prevent reoccurrence. The administrator was notified of the immediate jeopardy situation on 7/29/2020 at 11:29 a.m. B. Plan to abate immediate jeopardy On 7/29/2020 at 4:33 p.m., the director of nursing (DON) submitted a plan to abate the immediate jeopardy. It read: Surveyors with Colorado Health Facilities and Emergency Medical Services Division emailed IJ for F-600, 609, 610, 741. Investigation for abuse was re-opened by Behavioral Case Manager and will be completed by Behavioral Case Manager and then reviewed by Inter Disciplinary Team to ensure compliance. Staff development coordinator went to alleged abuser identified as LPN went and received report for cart from LPN was working and counted narcotics. LPN was suspended pending investigation for psychosocial abuse and was out of the facility premises by 1145. SDC watched LPN leave the building. (Local) Police department was contacted and awaiting call back. (Local) Police department contacted facility and officer (name) stated that due to resident not being physically harmed they would not be coming into the building and have provided a computer aided dispatch (CAD) number. Adult Protective Services and Ombudsman were contacted and occurrence report was filed. Resident was provided mental health services with psychologist via tele-medicine for psychosocial harm. Surveyors were provided with Non-violent crisis intervention foundation course participant workbook that LPN was certified of which provides education on how to de-escalate situations. LPN identified will be in serviced one on one and provided written material on different mental health disorders such as [MEDICAL CONDITIONS], depression, anxiety, and behavioral disturbances upon returning to work. Every resident has the potential for abuse. Staff will begin getting in serviced on July 29, 2020 on abuse and neglect. Educated on reporting abuse. Each staff will be in serviced before their shift. Quarterly abuse and neglect training will be performed All residents who are Alert and Oriented x4 will be interviewed by Behavioral Case Manager to determine if they have experienced any psychosocial abuse. If any issues arise a full investigation will be completed. Interviews will be completed by August 7, 2020. Any reports of abuse will be reviewed each morning Monday - Friday by Inter Disciplinary Team to ensure resident safety and that investigation was thorough and will be reviewed in QAPI monthly. Systemic change includes sending any staff member that has been reported by a resident of any type of abuse including psychosocial will be suspended pending investigation. C. Removal of the immediate jeopardy On 7/29/2020 at 4:42 p.m. the NHA was notified the facility's plan to remove the immediate jeopardy had been accepted based on systemic changes, including to suspend any staff member under investigation for abuse and education for abuse, neglect. However, deficient practice remained at a G level, actual harm. II. Incident 7/28/2020 A. Staff interviews Interviews with LPN #1 on 7/9/2020 at 9:18 a.m. and SW #2 on 8/3/2020 at 9:30 a.m. revealed on 7/28/2020 at approximately 11:30 a.m., SW #2 stopped Resident #1 in the south unit hallway as the resident attempted to return to her room. Staff said Resident #1 did not understand why the SW told her not to walk through the south unit hallway and became upset. LPN #1 then said Resident #1 could walk through the hallway but SW #2 disagreed. Thereafter, LPN #1 put his arms up wide and barricaded the hallway to prevent the resident from walking down the hall. This made Resident #1 more upset, and she pushed her walker away and leaned against the wall, crying. The maintenance director (MTD) responded to staff's call for support and walked with the Resident #1 away from the situation. Interview with the MTD on 7/29/2020 at 8:55 a.m. revealed he was the last one to arrive at the incident on 7/28/2020. He said when he arrived, Resident #1 was leaning against the wall, crying and frightened. He said there were multiple staff members surrounding her and forming a barricade to prevent her from walking through the hallway. He said when he asked staff which way the resident was supposed to go, staff members in the area pointed different directions down the hall. He said noticing how upset Resident #1 was, he walked with her one on one away from the situation to allow her to calm down. B. Resident interview Resident #1, age above 50, admitted to the facility on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/17/2020 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment. Active [DIAGNOSES REDACTED]. She received antidepressant and hypnotic medications for seven days prior to the assessment. She used a walker for mobility. Resident #1 was interviewed on 7/28/2020 at 12:37 p.m., approximately an hour after the incident in the south unit hallway. Resident #1 was crying and shaking as she approached the surveyor. She said she feared a male nurse (LPN #1) who had barricaded her as she tried to walk down the south unit hall. She said she regularly walks down this hallway after smoking. She said multiple

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 0600 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 1) staff members pointed different directions for her to walk and she became overwhelmed and confused, stating she always walked in that unit so she did not understand why it was not okay to enter the south unit hall. She said she continued to try to walk towards her room when LPN #1 put his arms up wide, stepped towards her, barricaded the hallway and refused to allow her to walk through. She said when the LPN put his arms up to barricade the hallway and stepped towards her, she felt threatened and fearful because of her history of abuse. She further said she felt she was singled out. C. Observations and other resident interview Resident #4, a cognitively intact resident, interviewed on 7/30/2020 at 2:34 p.m., said he had never felt threatened by LPN #1 but said Resident #1 was very shaken and scared after the incident on 7/28/2020 occurred. He said he talked to her outside after the incident and she cried while telling him what happened. He said he frequently saw residents walking on a unit they did not reside on, and he, too, said Resident #1 was singled out for something that many residents do. Observations on 7/28, 7/29 and 7/30/2020 confirmed many residents walked off the unit they resided on and onto another unit. III. Facility failures A. Failure to implement facility abuse policies and procedures 1. Facility abuse policies and procedures The Abuse Investigation and Reporting policy, revised March 2019, was provided by the director of nursing (DON) on 7/30/2020 at 10:52 a.m. It read, in pertinent part, Role of the administrator and/or director of nursing: If an incident or suspected incident of resident abuse, mistreatment, or neglect is reported . suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Protection of Residents During Abuse Investigations policy, revised March 2019, was provided by the DON on 7/30/2020 at 10:52 a.m. It read, in pertinent part, Employees accused of participating in the alleged abuse will be immediately suspended until the findings of the investigation have been reviewed by the administrator. The Abuse Prevention Program policy, revised March 2019, was provided by the DON on 7/30/2020 at 10:52 a.m. It read, in pertinent part, As part of the resident abuse preventions, the administration will: Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbal or physically aggressive resident behavior; identify and assess all possible incidents of abuse; and protect residents during abuse investigations. 2. Failure to implement the above policy and procedures. The surveyor notified the NHA on 7/28/2020 at approximately 1:00 p.m. that Resident #1 was fearful of LPN #1. On 7/29/2020 at 8:15 a.m., the NHA provided an investigation of the 7/28/2020 incident. Review of the investigation summary revealed it included no steps to ensure Resident #1 remained free from abuse by LPN #1; specifically, contrary to facility policy and procedures, LPN #1 was not immediately suspended; he finished his shift on 7/28/2020 and was observed working the floor with residents on 7/29/2020 at 11:14 a.m. 3. The NHA and DON were interviewed on 7/29/2020 at approximately 3:50 p.m. They said LPN #1 was not working with Resident #1 so they did not know he needed to be removed from providing resident care. B. Failure to conduct a thorough investigation (cross-reference F610) and therefore, failure to recognize, reinforce and ensure staff followed the resident's care planned interventions designed to de-escalate her behaviors. 1. Review of Resident #1's record revealed she was care planned for argumentative behaviors, issues related to difficulty following redirection, and impaired cognitive function/impaired thought processes due to dementia related to her diagnoses. -Regarding her argumentative behaviors, interventions included to advise the resident to calm down and to walk away. -Regarding her difficulty following redirection, the care plan read the resident decided when she was feeling overwhelmed, she would like staff to advise and allow her to take a time out. All staff were to redirect the resident to the social worker (SW #1) to address her concerns. -Regarding her impaired cognitive function/impaired thought processes which led to moments of confusion, impulsivity, and failure to listen fully to what was being said to her, staff were to keep the resident's routine consistent and present just one thought, idea, question, or command at a time. 2. Review of investigation provided by the NHA on 7/29/2020 at 8:15 a.m. revealed the investigation identified the resident's pertinent [DIAGNOSES REDACTED]. The investigation consisted of statements from Resident #1, LPN #1, the MTD, and DON. It also included other resident interviews, a behavior progress note by SW #2, past behavior notes, smoking policies, and Resident #1's care plan. However, the investigation and summary revealed it failed to recognize, reinforce and ensure staff followed the resident's care planned interventions designed to de-escalate her behaviors to prevent another incident, such as that on 7/28/2020 when the resident was surrounded by multiple staff, given confusing directions, and was barred from progressing down the hallway by LPN #1's barricade. These circumstances left the resident feeling overwhelmed, confused and frightened. Instead, the report summary written by the behavioral care manager (BCM) read the facility identified Resident #1's behavior as attention seeking and equated the incident with past behavior tendencies. It identified the resident had some moderate cognitive impairments, but knew she was not supposed to use the south unit entrance (which the resident denied). The summary further read in part, This incident fits the pattern of behavior displayed since her admission to the facility. Further review of the investigation report revealed the report failed to identify all of the staff in the area where the incident occurred. Therefore, these staff failed to receive education on Resident #1's care plan and how to respond to Resident #1 when she was confused and/or overwhelmed. C. Failure to train LPN #1 to ensure he knew how to react and respond to Resident #1's behaviors. 1. Facility characteristics and services The facility assessment, provided by the NHA on 7/29/2020 at 9:30 a.m., revealed the facility served residents with the following list of psychiatric/mood disorders [DIAGNOSES REDACTED]. The assessment revealed an average of 64 residents had behavioral health needs in the facility. The assessment further revealed the facility offered mental health and behavior services based on resident needs. The assessment read, this included managing medical conditions and medication related issues causing psychiatric symptoms and behavior, identifying and implementing interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, traumas/[MEDICAL CONDITION] (post-traumatic stress disorder), other psychiatric diagnoses, intellectual or developmental disabilities. The assessment revealed the following person centered/direct care for psycho/social/spiritual support: Build a relationship with the resident/get to know him/her; engage the resident in conversation. Find out what the resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for the resident have this information. Record and discuss treatment and care preferences. Prevent abuse and neglect. Identify hazards and risks for residents. 2. LPN #1 1. Review of in service training records and LPN #1's file revealed LPN #1 had a history of [REDACTED]. In service training records revealed LPN #1's most recent abuse training, related to abuse policies and procedures, was 12/18/2019. However, review of LPN #1's performance review dated 4/17/2020 revealed a performance improvement plan, designed by the DON and assistant director of nursing (ADON). The evaluation revealed the LPN failed to follow abuse policies and procedures and needed to improve on knowledge of abuse policies and procedures or seek unknown information. It further revealed he missed mandatory meetings and in-service training. The performance improvement plan was in effect for three months and signed by LPN #1 on 4/27/2020. LPN #1's file also revealed LPN #1 received a write up on 5/13/2020 for failing to complete required online training on time. Review of LPN #1's training log revealed he had not received training on major mental illness and behavioral health since his hire as an LPN in November 2019. 2. Staff interviews confirmed the deficiencies found in LPN #1's file In an interview on 7/29/2020 at 10:05 a.m., the DON confirmed LPN #1 had been written up for not following the abuse policy and procedures related to completing an incident report on a previous incident in the facility. In an interview on 7/29/2020 at 10:30 a.m. the assistant director of nursing (ADON) said LPN #1 was hired in November 2019. She confirmed that since his hire, LPN #1 had not received any training on major mental illnesses and behavioral health. There had been one mental health training since his hire, but he did not attend. She said LPN #1 completed training for dealing with combative persons; however, this training did not cover care and working with individuals with behavioral needs.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report an alleged violation of abuse to the administrator and the State survey and certification agency in accordance with State law affecting one (#14) of two residents reviewed for abuse out of 15 sample residents. Findings include: I. Facility policy and procedure The Reporting Suspected Cases of Abuse policy, revised March 2019, was provided by the nursing home administrator (NHA) on 7/30/2020 at 10:52 a.m. It read, in pertinent part, All suspected cases or incidents of abuse must be reported immediately to the administrator, director of nursing services, behavior management director, and/or charge nurse. The Abuse Investigation and Reporting policy, revised March 2019, was provided by the NHA on 7/30/2020 at 10:52 a.m. It read, in pertinent part, All alleged violations involving abuse, neglect, exploitation, or mistreatment will be reported by the facility administrator or her designee, to the

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) following persons or agencies: the State licensing/certification agency responsible for surveying/licensing the facility; the local/State ombudsman; the resident's representative of record; adult protective services; law enforcement officials; the resident ' s attending physician; and the medical director. The alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than: two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or 24 hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury. II. Resident #14 A. Resident status Resident #14, age below 30, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 5/27/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 14 out of 15. He was totally dependent and two-person assistance for activities of daily living (ADLs). He used a wheelchair for mobility. B. Record review The comprehensive care plan, revised 7/15/2020, revealed the resident had a history of [REDACTED]. C. Interview Resident #14 was interviewed on 7/30/2020 at 10:33 a.m. He was very upset and angry while he explained how certified nurse aide (CNA) #12 mocked him for being disabled. He said she held her arms up and imitated his arm contractures. He said he felt helpless because he wasn't able to defend himself due to his disability and he felt like he was retaliated against because of his anger towards staff. He said he reported it to a staff member, but then nobody ever talked to him about it. He said he was already depressed about being disabled and this made him feel more embarrassed and depressed about his inability to care for himself. IV. Staff interviews The behavioral care manager (BCM) was interviewed on 8/3/2020 at 9:42 a.m. She said the investigation into Resident #14's allegation revealed the resident reported to licensed practical nurse (LPN) #1 that he wanted to talk to someone because CNA #12 was rude to him. LPN #1 reported the allegation to social worker (SW) #1, asking her to talk to the resident. She said after SW #1 talked to the resident about his concerns with CNA #12, the allegation was not reported to administration and, therefore, an abuse investigation was not completed or the allegation reported to the State. The BCM said any allegation of abuse should be reported to her to initiate an investigation and report the allegation to the State survey and certification agency. SW #1 was interviewed on 8/3/2020 at 10:28 a.m. She said on 7/24/2020, Resident #14 reported to her that CNA #12 was rude to him. She said he did not explain in further detail and she did not conduct an investigation to identify what happened. Rather, she said she told the staff development coordinator (SDC) that CNA #12 should be removed from providing care to Resident #14. She said she had not received any training on the facility procedures for reporting and investigating abuse allegations. She said the only training she completed for abuse was an online training, which was not specific to facility reporting procedure. The NHA was interviewed on 8/3/2020 at 11:30 a.m. She said she would expect SW #1 to report the allegation to her immediately in order for her to initiate an investigation and report it to the State survey and certification agency.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility failed to timely and thoroughly investigate allegations of abuse involving two (#1 and #14) of two residents reviewed out of 15 sample residents. (Cross-reference F600 and F609) Findings include: I. Facility policy and procedure The Abuse Investigation and Reporting policy, revised March 2019, was provided by the director of nursing (DON) on 7/30/2020 at 10:52 a.m. It read, in pertinent part, All reports of resident abuse, neglect, exploitation, and mistreatment shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. The Protection of Residents During Abuse Investigations policy, revised March 2019, was provided by the DON on 7/30/2020 at 10:52 a.m. It read, in pertinent part, Within five working days of the alleged incident, the facility will give the resident, the resident ' s representative, the ombudsman, accused individuals, etc., a written report of the findings of the investigation and a summary of corrective action taken to prevent such incident from recurring. II. Resident #14 A. Resident status Resident #14, age below 30, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 5/27/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) of 14 out of 15. He was totally dependent and two-person assistance for activities of daily living (ADLs). He used a wheelchair for mobility. B. Record review The comprehensive care plan, revised 7/15/2020, revealed the resident had a history of [REDACTED]. C. Resident interview Resident #14 was interviewed on 7/30/2020 at 10:33 a.m. He said approximately a week ago certified nurse aide (CNA) #12 mocked him. He was very upset and angry while he explained how CNA #12 mocked him for being disabled. He said she held her arms up and imitated his arm contractures He said he felt helpless because he wasn ' t able to defend himself due to his disability and he felt like he was retaliated against because of his anger towards staff. He said he reported it to a staff member, but then nobody ever talked to him about it. He said he was already depressed about being disabled and this made him feel more embarrassed and depressed about his inability to care for himself. D. Staff interviews The behavioral care manager (BCM) was interviewed on 8/3/2020 at 9:42 a.m. She said Resident #14 reported to licensed practical nurse (LPN) #1 that he wanted to talk to someone because CNA #12 was rude to him. She said LPN #1 reported the resident's allegation to social worker (SW) #1, asking her to talk to the resident. She said SW #1 talked to the resident about his concerns with CNA #12 but that was it. She said no investigation of the allegation was conducted as the allegation was not reported to her or to administration. The BCM said any allegation of abuse should be reported to her to initiate an investigation. SW #1 was interviewed on 8/3/2020 at 10:28 a.m. She said on 7/24/2020, Resident #14 reported to her that CNA #12 was rude to him. She said he did not explain in further detail and she did not conduct an investigation to find out the details of what had happened. She said she just told the staffing development coordinator (SDC) that CNA #12 should be removed from providing care to Resident #14. She said she had not received any training on the facility procedures for reporting and investigating abuse allegations. She said the only training she completed for abuse was an online training, which was not specific to facility reporting procedure. The nursing home administrator (NHA) was interviewed on 8/3/2020 at 11:30 a.m. She said she would expect SW #1 to report the allegation to her in order for her to initiate an investigation and report the allegation to the State survey and certification agency. III. Resident #1 A. Resident status Resident #1, age above 50, was admitted on [DATE]. According to the August 2020 CPO, her [DIAGNOSES REDACTED]. The 7/17/2020 MDS assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. Active [DIAGNOSES REDACTED]. She used a walker for mobility. Review of Resident #1 ' s record revealed she was care planned for argumentative behaviors, issues related to difficulty following redirection, and impaired cognitive function/impaired thought processes due to dementia related to her diagnoses. -Regarding her argumentative behaviors, interventions included to advise the resident to calm down and to walk away. -Regarding her difficulty following redirection, the care plan read the resident decided when she was feeling overwhelmed, she would like staff to advise and allow her to take a time out. All staff were to redirect the resident to the social worker (SW #1) to address her concerns. -Regarding her impaired cognitive function/impaired thought processes which led to moments of confusion, impulsivity, and failure to listen fully to what was being said to her, staff were to keep the resident ' s routine consistent and present just one thought, idea, question, or command at a time. C. Resident and staff interview Resident #1 was interviewed on 7/28/2020 at 12:37 p.m. Resident #1 was crying and shaking as she approached the surveyor. She said she feared a male nurse (LPN #1) who had barricaded her as she tried to walk down the south unit hall. She said she regularly walks down this hallway after smoking. She said multiple staff members pointed different directions for her to walk and she became overwhelmed and confused, stating she always walked in that unit so she did not understand why it was not okay to enter the south unit hall. Interview with the maintenance director on 7/29/2020 at 8:55 a.m. revealed he arrived at the 7/28/2020 incident and found Resident #1 was leaning against the wall, crying and frightened. He said there were multiple staff members surrounding her and forming a barricade to prevent her from walking through the hallway. He confirmed when he asked staff which way the resident was supposed to go, staff members in the area pointed different directions down the hall. C. Review of facility investigation The investigation of the 7/28/2020 incident was provided by the NHA on 7/29/2020 at 8:15 a.m. It revealed the investigation identified the resident ' s pertinent [DIAGNOSES REDACTED]. The investigation consisted of statements from Resident #1, LPN #1, the maintenance director (MTD), and DON. It also included other resident interviews, a behavior progress note by SW #2, past behavior notes, smoking policies, and Resident #1 ' s care plan. However, the investigation report provided by the NHA failed to include consideration of the resident ' s care planned interventions (see above), designed to de-escalate her behaviors to prevent another incident, such as that on 7/28/2020, when the resident was surrounded by multiple staff, given confusing directions, and was barred from progressing down the hallway by LPN #1; circumstances that left the resident feeling overwhelmed, confused and frightened. Instead, the report summary written by the behavioral care manager (BCM) read the facility identified Resident #1 ' s behavior as attention seeking and equated the incident with past behavior tendencies. It identified the resident had some moderate cognitive impairments, but knew she was not supposed to use the

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) south unit entrance (which the resident denied). The summary further read in part, This incident fits the pattern of behavior displayed since her admission to the facility. Further review of the investigation report revealed the report also failed to identify all of the staff in the area where the incident occurred. Therefore, these staff members failed to receive education on Resident #1 ' s care plan and how to respond to Resident #1 when she was confused and/or overwhelmed. D. Staff interviews The BCM was interviewed on 8/3/2020 at 9:42 a.m She said she was responsible for completing abuse investigations. She said abuse investigations should identify and include interviews from staff and residents who witnessed or were informed of the alleged violation, as well as interventions to protect the resident during the facility's investigation.
F 0741 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure staff received the appropriate competency and skills training to ensure residents with mental and psychosocial disorders maintained the highest practicable physical, mental, and psychosocial well-being, affecting one resident (#1) reviewed for mental and psychosocial disorders. Specifically, the facility failed to ensure licensed practical nurse (LPN) #1 received training on the mental and psychosocial disorders and care needs of residents admitted to the facility and identified in the facility assessment, prior to providing direct resident care. LPN #1's lack of behavioral health training was displayed in an inappropriate response to Resident #1's behaviors which contributed to Resident #1, crying and shaking, and feeling threatened and fearful of LPN #1. (Cross-reference F600) Findings include: I. Facility characteristics and services The facility assessment, provided by the nursing home administrator (NHA) on 7/29/2020 at 9:30 a.m., revealed the facility served residents with the following list of psychiatric/mood disorder [DIAGNOSES REDACTED]. The assessment revealed an average of 64 residents had behavioral health needs in the facility. The assessment further read the facility offered mental health and behavior services based on resident needs. It read this included managing medical conditions and medication related issues causing psychiatric symptoms and behavior, identifying and implementing interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, traumas/[MEDICAL CONDITION], other psychiatric diagnoses, intellectual or developmental disabilities. The assessment revealed the following person-centered/direct care for psycho/social/spiritual support: Build a relationship with the resident/get to know him/her; engage the resident in conversation. Find out what the resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for the resident have this information. Record and discuss treatment and care preferences. Prevent abuse and neglect. Identify hazards and risks for residents. Centers of Medicare and Medicaid Services (CMS) form number CMS-672 Census and Condition form which categorizes the care that residents require while in the facility was provided by the NHA on 7/28/2020 at 11:00 a.m. The form documented there were 41 residents with behavioral healthcare needs, 44 residents with documented signs and symptoms of depression, 41 with a documented psychiatric diagnosis (excluded dementias and depression), and 31 receiving health rehabilitative services for mental illness and or intellectual disability. II. Resident #1 A. Resident status Resident #1, age above 50, admitted to the facility on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/17/2020 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment. Active [DIAGNOSES REDACTED]. She received antidepressant and hypnotic medications for seven days prior to the assessment. She used a walker for mobility. B. Resident #1's care and service needs Resident #1's person-centered care plan, revised 7/28/2020, revealed the resident had argumentative behaviors and can be verbally aggressive towards staff and other residents. The care planned interventions read: -If resident becomes aggressive, advise resident when she calms down, you will assist her; -If resident continues to be aggressive, walk away and advise resident's nurse and case manager; -Allow resident time to express her feelings, thoughts, or concerns; and -Speak slowly to the resident. Additionally, the care plan read the resident had behavioral issues related to difficulty following redirection at times. It revealed she had been working with her therapist on this topic and she decided when she was feeling overwhelmed, she would like staff to advise and allow her to take a time out. The term time out was identified by Resident #1 to help her when she was overwhelmed. Interventions included: -Assist the resident to develop more appropriate methods of coping and interacting. Talk with the resident about her concern and options that might help solve the situation. Encourage the resident to express feelings appropriately; -Be specific with expectations, set boundaries, and it's ok to walk away when the resident creates a scene; and -Have one person designated as the go-to person, which it will be her social worker. All staff will redirect this resident to the social worker to address the resident's concerns. Further, the care plan revealed the resident had impaired cognitive function or impaired thought processes due to Wernicke's Korsakof's dementia. The resident had moments of confusion, she was impulsive, and did not listen fully to what was being said to her. She had repetitive anxious concerns. Interventions included: -Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion; and -Present just one thought, idea, question, or command at a time. III. Incident 7/28/2020 (Cross-reference F600) Review of an incident on 7/28/2020 revealed staff, including LPN #1, failed to respond to Resident #1's behaviors in an appropriate manner and as set forth in her person-centered care plan. A. Staff interviews Interviews with LPN #1 on 7/9/2020 at 9:18 a.m. and social worker (SW) #2 on 8/3/2020 at 9:30 a.m. revealed on 7/28/2020 at approximately 11:30 a.m., SW #2 stopped Resident #1 in the south unit hallway as the resident attempted to return to her room. Staff said Resident #1 did not understand why the SW told her not to walk through the south unit hallway and became upset. LPN #1 then said Resident #1 could walk through the hallway but SW #2 disagreed. Thereafter, LPN #1 put his arms up wide and barricaded the hallway to prevent the resident from walking down the hall. This made Resident #1 more upset, and she pushed her walker away and leaned against the wall, crying. The maintenance director (MTD) responded to staff's call for support and walked with the Resident #1 away from the situation. Interview with the MTD on 7/29/2020 at 8:55 a.m. revealed he was the last one to arrive at the incident on 7/28/2020. He said when he arrived, Resident #1 was leaning against the wall, crying and frightened. He said there were multiple staff members surrounding her and forming a barricade to prevent her from walking through the hallway. He said when he asked staff which way the resident was supposed to go, staff members in the area pointed different directions down the hall. He said noticing how upset Resident #1 was, he walked with her one on one away from the situation to allow her to calm down. B. Resident interview Resident #1 was interviewed on 7/28/2020 at 12:37 p.m., approximately an hour after the incident in the south unit hallway. Resident #1 was crying and shaking as she approached the surveyor. She said she feared a male nurse (LPN #1) who had barricaded her as she tried to walk down the south unit hall. She said she regularly walks down this hallway after smoking. She said multiple staff members pointed different directions for her to walk and she became overwhelmed and confused, stating she always walked in that unit so she did not understand why it was not okay to enter the south unit hall. She said she continued to try to walk towards her room when LPN #1 put his arms up wide, stepped towards her, barricaded the hallway and refused to allow her to walk through. She said when the LPN put his arms up to barricade the hallway and stepped towards her, she felt threatened and fearful because of her history of abuse. IV. Failure to train LPN #1 to ensure he knew how to react and respond to Resident #1's behaviors. Review of LPN #1's training log revealed he had not received training on major mental illness and behavioral health since his hire as a LPN in November 2019. It further revealed he missed mandatory meetings and in-service training. A performance improvement plan was in effect for three months and signed by LPN #1 on 4/27/2020. LPN #1's file also revealed LPN #1 received a write up on 5/13/2020 for failing to complete required online training on time. In an interview on 7/29/2020 at 10:30 a.m. the assistant director of nursing (ADON) said LPN #1 was hired in November 2019. She confirmed that since his hire, LPN #1 had not received any training on major mental illnesses and behavioral health. There had been one mental health training since his hire, but he did not attend. She said LPN #1 completed training for dealing with combative persons; however, this training did not cover care and working with individuals with behavioral needs. She said the facility did not require behavioral health training for nursing staff prior to their working with residents.
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 observations, record review and interviews, the facility failed to establish and maintain an effective infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 4) development and transmission of communicable diseases and infections, including COVID-19, in four of four resident neighborhoods. The failure affected all residents present in the facility, which placed the facility in an immediate jeopardy situation. Observations, interviews and record review 7/28, 7/29 and 7/30/2020, revealed systemic failures in the facility's infection control program, specifically, multiple failures in infection source control, including personal protective equipment (PPE) use, staff and resident mask use, hand washing, social distancing and staff screening. The facility's failures, coupled with the staff's lack of knowledge and training in infection control, created the likelihood for serious harm due to potential transmission of the highly infectious COVID-19 virus to all facility residents. Findings include: I. Facility status The facility COVID-19 line listing documented three positive staff members for July 2020. The last positive staff person was identified 7/24/2020. In addition, the facility line listing documented two positive residents in July 2020. The last COVID-19 positive results for a resident was on 7/29/2020. The line listing identified two more residents with signs and symptoms of COVID-19 for July 2020. Previous month's results were not documented on the line listing. Observations revealed 11 residents were on isolation for possible symptoms or exposure to COVID-19. One resident was in isolation for positive COVID-19 test results. II. Immediate Jeopardy A. Findings of Immediate Jeopardy Multiple observations on 7/28 and 7/29/2020 revealed direct care staff failed to don personal protective equipment (PPE), gowns, mask, gloves, and eye protection when providing care for residents in isolation for confirmed and suspected COVID-19. Staff reported they were educated to wear less than full PPE when entering COVID-19 positive resident rooms. Moreover, they reported the facility did not have all the PPE required per CDC guidance when caring for residents on isolation. Further observations of direct care staff on 7/29 and 7/30/2020 revealed one staff entered the facility without a facemask and proceeded down a hallway, still without a facemask despite stopping at the screening desk. Another staff wore her facemask below her chin. A number of observations on 7/28, 7/29 and 7/30/2020 revealed residents outside their rooms without facemasks and interacting with staff who failed to encourage them to wear a face covering or to social distance. Additional observations 7/28 and 7/29/2020 revealed staff failed to encourage residents on isolation to stay in their rooms and wear face coverings when out of their rooms, failed to isolate newly admitted and/or readmitted residents with unknown COVID-19 status in different rooms, and failed to offer residents hand hygiene before meals. Finally, record review and interview revealed the facility failed to ensure staff on the isolation unit were actively screened prior to starting their shifts, and failed to ensure staff received adequate education and training in infection control. These failures created the likelihood for serious harm to all facility residents due to potential transmission of the highly infectious COVID-19 virus. B. Facility notice of immediate jeopardy On 7/30/2020 at 5:04 p.m., the NHA was notified the failure to develop and implement an effective infection control program created the likelihood of serious harm to facility residents from COVID-19. C. Facility plan to remove immediate jeopardy On 7/30/2020 at 7:47 p.m., the NHA provided a plan to remove the immediate jeopardy. The plan read: Staff will be educated using CDC guideline materials by DON (director of nursing), ADON (assistant director of nursing), Nurse Managers and/or designee at the beginning of each shift starting on July 30, 2020 about wearing full PPE including eye protection anytime staff enters an isolation room, training will be completed by August 3, 2020. Staff will be re-educated using CDC guideline materials by DON, ADON, Nurse Managers and/or designee at the beginning of each shift starting on July 30, 2020 about encouraging residents on isolation room to use a facemask to cover their mouth and nose before staff enters their room, training will be completed by August 3, 2020. Staff working COVID unit will be educated using CDC guideline materials by DON, ADON, Nurse Managers and/or designee that the outgoing nurse/CNA will screen incoming Nursing/CNA members at the entrance of COVID unit and document it on screening form starting July 30, 2020. DON or designee will monitor screening forms every morning. If the Nurse or CNA does not pass screening then the on call nurse manager will be called and the nurse and/or CNA will be sent home. Staff will be re-educated using CDC guideline materials by DON, ADON, Nurse Managers and/or designee at the beginning of each shift starting on July 30, 2020 about encouraging residents to wear masks when out of their room. Training will be completed by August 3,2020. Nurse's carts will have disposable face masks available for residents daily and as needed for soiled masks. Staff will be re-educated using CDC guideline materials by DON, ADON, Nurse Managers and/or designee at the beginning of each shift starting on July 30, 2020 about wearing surgical masks or higher grade masks upon entering the building, while in the building, and while providing resident care. Training will be completed by August 3, 2020. Staff will be re-educated using CDC guideline materials by DON, ADON, Nurse Managers and/or designee at the beginning of each shift starting on July 30, 2020 about encouraging residents to perform hand hygiene when leaving their rooms, before meals, and at other times. Training will be completed by August 3,2020. Residents will be offered hand hygiene before meals and when leaving the room. Staff will be re-educated using CDC guideline materials by DON, ADON, Nurse Managers and/or designee at the beginning of their shift starting on July 30, 2020 about encouraging residents to social distance while in common areas. Training will be completed by August 3,2020. Common areas will have floor markings that are six feet apart. The DON and all designees, will audit 50% of staff weekly to ensure compliance. A quiz will be administered by DON and designee at the end of training of topics to ensure understanding and proper knowledge of training. D. Removal of Immediate Jeopardy On 7/30/2020 at 7:53 p.m., the NHA was notified the immediate jeopardy was removed, based on the facility's education plans and audits to ensure the plans were implemented. However, deficient practice remained at F level, potential for more than minimal harm that is widespread. III. Systemic failure to establish and maintain an effective infection prevention and control program. A. Failure to ensure staff donned personal protective equipment (PPE) - gowns, mask, gloves, and eye protection - when providing care for residents in isolation for confirmed and suspected COVID-19. 1. Professional reference and facility policy and procedure According to the Centers for Disease Control and Prevention (CDC), Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, updated 6/25/2020, retrieved 8/3/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. According to the CDC guidance Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs), last updated 6/25/2020, retrieved 8/3/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. The facility's COVID-19 Prevention policy, revised 6/26/2020, was received from the DON, who also identified herself as the infection preventionist, (DON/IP) on 7/30/2020 at 11:05 a.m. The policy documented in pertinent part, COVID-19 is thought to spread mainly from person to person between people who are in close contact with another (within six feet) through respiratory droplets produced when an infected person coughs or sneezes. Staff will wear appropriate PPE as per facility guidance and follow appropriate precautions. Droplet precautions will be implemented for residents with suspected or confirmed COVID-19 for 14 days after the illness onset. 2. Observations of and interviews with direct care staff providing care and services to residents on isolation for confirmed and suspected COVID-19. On 7/28/2020 at 11:43 a.m., registered nurse (RN) #3 entered room [ROOM NUMBER], a COVID-19 isolation room. She did not wear eye protection and her gown was not wrapped completely around her. She had a short sleeve gown on with long sleeve scrubs exposed. She put her gloves on first, then the gown. Certified nurse aide (CNA) #14 also went into the isolation room without eye protection and did not wear a N95 or higher respirator/mask. -RN #3 and CNA #14, interviewed following the above observation, said they did not have eye protection or long sleeve gowns available for use. CNA #14 said she dropped her N95 mask and needed a new one. She said she was called to assist with this resident and did not have time to get a new N95 mask. On 7/28/2020 at 11:52 a.m., CNA #9 was observed delivering lunch trays to residents' rooms. She delivered room trays to room [ROOM NUMBER], a COVID-19 isolation room. She wore only a mask when she entered the room; she did not put on eye protection, a gown, or gloves. CNA #9 said the DON trained her to wear PPE only if she provided direct care to residents in isolation rooms. On 7/29/2020 at 8:18 a.m., observations revealed housekeeper (HK) #1 cleaning room [ROOM NUMBER], a COVID-19 isolation room. She was not wearing eye protection. As she cleaned the isolation room, her gown broke and hung halfway off her body. She wore a short sleeve gown and a long sleeve blouse which was exposed while cleaning the room. When she finished cleaning the room, she took off her PPE then moved to clean another room. She did not perform hand hygiene after she removed her gloves. -HK #1, interviewed following the above observation, said eye protection was not available for her to use. However, the room [ROOM NUMBER] isolation cart was observed at 8:20 a.m. There were four pairs of eye protection glasses on the cart. On 7/30/2020 at 10:08 a.m., RN #6 was observed on the unit with confirmed COVID-19 positive residents. She said she wore a gown, mask and gloves to care for the residents. She said she did not wear any eye protection and had not been educated by the facility to wear goggles or a face shield when caring for residents who were

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) positive for COVID-19. On 7/30/2020 at 9:31 a.m., CNA #2 was interviewed. He said the DON had educated him to wear a mask in isolation rooms unless he was going to come in contact with body fluids and provide direct care. He said he did not know if the facility had any eye protection such as goggles or face shields. He confirmed he had not been told to wear eye protection and he had not been wearing eye protection in isolation rooms. Later, at 11:54 a.m., CNA #2 was observed delivering lunch trays to room [ROOM NUMBER] wearing only a mask, no gown, no eye protection, and no gloves. On 7/30/2020 at 12:59 p.m., CNA #12 was interviewed. She said the DON had trained her on PPE about two weeks ago. She said she was not educated to wear eye protection in COVID-19 isolation rooms; rather, the DON educated her to wear a mask in the isolation rooms and had said she only needed to wear a gown and gloves if she was going to come in contact with body fluids 3. DON/IP and NHA interviews On 7/30/2020 at 12:38 p.m., the DON/IP was interviewed regarding the facility's supply of PPE. She said she was in contingency mode and her current supply would last three weeks. She said she had 16,000 large gloves, 13,000 medium gloves, 3000 small gloves, 13,200 surgical masks, 900 face shields, 120 sets of goggles, 2000 KN95 masks, 900 long sleeve gowns, 200 long sleeve overalls. She did not know how many cloth face coverings or tissues she had for residents. She said she had short sleeve gowns on the floor currently, but did not know how many she had. She said she has been educating the staff to conserve their supplies and only wear a gown if they were going to come in contact with body fluids. On 7/30/2020 at 2:55 p.m., the DON/IP and NHA were interviewed. The DON/IP said the staff were educated on PPE. She said they only needed to wear a mask in isolation rooms unless they were going to provide direct care, like changing a resident, and might come in contact with body fluid. She said if they were going to come in contact with body fluid, they needed to wear a gown and gloves. The DON/IP said staff did not need goggles or face protection. She did not respond when asked what would happen if a resident in isolation coughed or sneezed on a staff person who was in the room without full PPE. B. Failure to ensure staff wore face coverings while in the facility, and wore the face coverings appropriately while providing care. 1. Professional reference and facility policy and procedure According to the CDC guidance, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 3/20/2020, retrieved 8/3/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf: -PPE must be donned correctly before entering the patient area. - PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted. - Face masks should be extended under the chin. - Both your mouth and nose should be protected . The facility's COVID-19 Prevention policy, revised 6/26/2020, was received from the DON/IP on 7/30/2020 at 11:05 a.m. The policy read in pertinent part, Staff will don a facemask throughout their shift. In addition, the Personal Protective Equipment policy, dated 9/2010, was received from the DON/IP on 7/30/2020 at 11:05 a.m. This policy read in pertinent part, Be sure the mask covers the nose and mouth. 2. Observations of and interviews with direct care staff providing care and services to residents. On 7/29/2020 at 12:26 p.m., CNA #2 was observed assisting a female resident to the bathroom in the Shawnee River neighborhood. The female resident did not have a mask on. CNA #2 had a mask positioned below his chin, not covering his mouth or nose. On 7/29/2020 at 2:04 p.m., CNA #9 entered the facility through the front door without wearing a mask. She continued around the corner to the front desk to be screened by the person at the reception desk. The person at the desk screened CNA #9, but did not advise her to don a mask. At the time, an ambulatory female resident stood at the reception area, also without a mask on. The CNA continued down the hall toward the dining room, past a male resident in a wheelchair. She stated to another staff member, I need to find my mask. When interviewed, she said, I am looking for my mask and walked away, proceeding further down the hall into an office area and shutting the door. On 7/29/2020 at 2:10 p.m., the staff person at the reception desk completing screenings, CNA #4, was interviewed. She said CNA #9 should have had a mask on before coming in the facility, but my job is just to screen them. On 7/30/2020 at 9:02 a.m., licensed practical nurse (LPN) #2 was observed speaking to two staff members on the south hallway. The staff members were standing two feet apart. LPN #2 had a facemask on, but positioned below her chin and not covering her mouth or nose. CNA #2 was interviewed on 7/30/2020 at 9:31 a.m. He said a facemask should be worn over the nose and under the chin. He said the staff were supposed to have their mask on before they entered the facility. 3. DON/IP and NHA interviews On 7/30/2020 at 2:55 p.m., the DON/IP and NHA were interviewed. The DON/IP said the staff should have a facemask on before entering the facility. She said staff needed to wear the mask above their nose and below their chin at all times. C. Failure to ensure staff encouraged residents to have facemasks/face coverings while outside of their rooms, and failure to assist and encourage social distancing 1. Professional reference and facility policy and procedure The Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last updated 6/25/2020, retrieved 8/3/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html included the guidance that long term care facilities ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. According to the CDC guidance Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs), last updated 6/25/2020, retrieved 8/3/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html Enforce social distancing among residents. Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. The facility's COVID-19 Prevention policy, revised 6/26/2020, was received from the DON/IP on 7/30/2020 at 11:05 a.m. Contrary to the CDC guidance above that all residents wear a cloth face covering whenever they leave their room or are around others, the facility policy read the resident was to wear a mask if under droplet precautions and required movement or transport outside of the room, and encouraged residents with signs and symptoms of respiratory illness to wear a mask. The policy further read, COVID-19 is thought to spread mainly from person to person between people who are in close contact with one another (within six feet). 2. Observations and resident interview On 7/28/2020 at 10:53 a.m., Resident #9, who was cognitively intact, was observed with a surgical mask on that appeared brown and dirty. The mask was dated 7/8/2020. He said he had asked for a new mask but was told masks cost money and he could not have a new mask. On 7/28/2020 at 10:55 a.m., three residents sat in a common area in the Wheatfield neighborhood. Two of the residents were seated in wheelchairs with their arms almost touching. The third resident was approximately two feet from the other residents. None of the residents had a mask on. A CNA walked by the area; the CNA neither offered masks to the residents nor asked or assisted the residents to sit further apart. Additionally, there was a resident in the hallway without a mask, and another male resident being assisted to his room by a staff member. The resident was not wearing a mask. On 7/28/2020 at 10:57 a.m., a female resident in a wheelchair propelled herself down the Wheatfield hallway past the nurse at the medication cart. She did not have a mask on and the nurse did not offer her a mask. At the same time, another female resident in a black dress ambulated the opposite direction down the Wheatfield hall, past the nurse. She, too, was not wearing a mask. The nurse did not offer or assist her with a mask. On 7/28/2020 at 11:02 a.m., a resident came out of room [ROOM NUMBER] on the north side of the facility. The resident did not have a mask on. CNA #9 spoke to the resident about lunch but did not offer or assist the resident with a mask. On 7/28/2020 at 11:15 a.m., a male resident in a red shirt propelled himself down the hallway in the North Forty neighborhood, past RN #3. He did not have a mask on. The RN did not encourage or assist him with a mask. Two other residents sat in a common area in this neighborhood. The residents did not have masks on. On 7/28/2020 at 11:32 a.m., a female resident propelled herself in a wheelchair down the hallway in the Bobcat neighborhood. She did not have a mask on. She urinated through her clothing and wheelchair onto the floor. LPN #1 came and wheeled her back to her room. He did not clean up the urine, or place a wet floor sign. A female and a male resident walked through the urine and kept walking toward the north side of the facility. On 7/28/2020 at 11:40 a.m., a male resident was wheeled into the main dining room by a staff person. He was not wearing a mask. Multiple staff were assisting residents to the dining room but none offered or assisted the resident with a mask. On 7/28/2020 at 11:46 a.m., a male resident in a wheelchair propelled himself down the hallway in the Bobcat neighborhood, past the front door. He was not wearing a mask. A CNA greeted him, but did not encourage or assist him with a mask. On 7/28/2020 at 12:47 p.m., a male resident was observed leaving the main dining room without a mask. He was not encouraged by the staff to put on a mask. On 7/28/2020 at 12:57 p.m., two residents, a male and a female, sat close together in wheelchairs in the hall in the North Forty neighborhood. They did not have masks on. Staff members walked by the residents, but did not encourage them to put masks on. On 7/29/2020 at 8:04 a.m., a male resident came out of room [ROOM NUMBER] while the housekeeper was at the room door. The resident left the room without wearing a mask. The housekeeper did not encourage the resident to put on a mask. On 7/29/2020 at 8:10 a.m., a male resident sat in the common area on the south side of the facility. LPN #1 stood at the medication cart within sight of the common area. The resident was not encouraged to wear a mask. On 7/29/2020 at 8:13 a.m., five residents were observed in the north unit common area. The residents neither wore masks nor distanced at least six feet apart. On 7/29/2020 at 8:14 a.m., a male

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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 6) resident ambulated down the Bobcat neighborhood, not wearing a mask. CNA #12 passed the resident in the hallway. She did not encourage the resident to wear a mask. On 7/29/2020 at 8:15 a.m., a resident in a gray sweat suit stood at the front desk without a mask. The staff person at the desk did not encourage the resident to put on a mask. On 7/29/2020 at 8:17 a.m., CNA #11 escorted three residents into the common area from the smoking area on the north side of the facility. The residents did not have masks on and were not encouraged to put masks on. On 7/29/2020 at 8:24 a.m., a male resident in a tan shirt went into an activity area on the south side of the facility. He was not wearing a mask. CNA #12 walked by the resident. She did not encourage the resident to put on a mask. On 7/29/2020 at 8:25 a.m., three male residents sat in the common area on the south side of the facility. The three men were approximately four feet from one another. Two residents were in wheelchairs and one in a regular chair. The three residents did not have masks on. On 7/29/2020 at 8:26 a.m., a male resident in a blue shirt sat in a wheelchair at the nurses' medication cart in the Wheatfield neighborhood. The man spoke to the nurse who was preparing medications. He was not wearing a mask. The nurse did not encourage or offer the resident a mask. On 7/30/2020 at 9:00 a.m., a male resident ambulated down the Shawnee River neighborhood. He did not have a mask on. The NHA walked by the resident. Another male resident in a yellow shirt ambulated the opposite direction without a mask. The NHA did not encourage either resident to wear a mask. 3. Staff interviews On 7/30/2020 at 12:11 p.m., CNA #2 was interviewed. He said the residents all have their own masks. CNA #2 said they do not like to wear them because the ties do not stay tied or the earpieces are too tight. However, he said staff should have encouraged the residents to wear the masks since the facility had a resident test positive for COVID-19 yesterday; he did not know who the resident was or what unit the resident resided was on. The DON/IP and NHA were interviewed on 7/30/2020 at 2:55 p.m. The DON/IP said staff should encourage the residents to wear masks at all times. She said the only residents who should not have a mask on were those residents that could not remove the masks themselves. She further said the staff should have encouraged social distancing of the residents. D. Failure to ensure staff encouraged residents on isolation to stay in their rooms and wear face coverings when out of their rooms. 1. Professional reference and facility policy and procedure According to the CDC, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (7/15/2020) retrieved 8/3/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures over 99.0 degrees Fahrenheit might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19. HCP (health care providers) who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. The facility policy for COVID-19 Prevention policy, revised 6/26/2020, was received from the DON/IP on 7/30/2020 at 11:05 a.m. Contrary to CDC guidance, the policy documented in pertinent part, droplet precautions will be implemented for residents with suspected or confirmed COVID-19 for 14 days after the illness onset. Residents with onset of signs and symptoms of a respiratory infection such as fever, cough or sore throat will be encouraged to self-isolate. 2. Observations On 7/28/2020 at 12:02 p.m., Residents #2 and #15, who were both on isolation due to sharing a bathroom with another resident with COVID-19 symptoms, were observed as they ambulated through the halls without a mask on. They were not encouraged to stay in their room or wear a mask. On 7/29/2020 at 8:13 a.m. Resident #2, who was on isolation for possible exposure to COVID-19, was observed smoking in the courtyard with nine other residents in close proximity to one another. 3. Interview The DON/IP and NHA were interviewed on 7/30/2020 at 2:55 p.m. The NHA said, We cannot force them to stay in their room or wear a mask. However, during the observations above, there were no attempts by staff to redirect residents on isolation to their rooms or to encourage use of a facemask. E. Failure to ensure staff assisted residents with hand hygiene prior to meals 1. Professional reference and facility policy and procedure The CDC Interim Infection Prevention and Control (3/13/2020) Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes, retrieved 8/3/2020 from: https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf, reads in pertinent part, Remind residents to practice social distancing and perform frequent hand hygiene. The facility policy on Handwashing Hand Hygiene, revised 8/2019, was received from the DON/IP on 7/30/2020 at 11:05 a.m. The policy read in pertinent part, residents will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets and other written material provided at admission and posted throughout the facility. 2. Observations On 7/28/2020 at 11:37 a.m., five residents were observed in the main dining room and four residents in the Quiet dining room for lunch. The residents were not offered hand hygiene prior to their lunch being served. One male resident was observed eating a slice of bread with his hands. On 7/28/2020 at 11:40 a.m., a male resident was wheeled by staff into the dining room without a mask. He began adjusting his table. No hand hygiene was offered prior to his plate of food being served. On 7/28/2020 at 11:55 a.m., CNA # 11 was pushing a metal cart in the hallway. He took a plate of food into room [ROOM NUMBER]. The resident was not offered or encouraged to wash his or her hands before lunch. On 7/28/2020 at 12:06 p.m., CNA #11 and CNA #1 were observed delivering plates of food from a metal cart to room [ROOM NUMBER]. The CNAs placed the plates in front of the two residents. No hand hygiene was offered or encouraged. On 7/29/2020 at 8:17 a.m., CNA #11 escorted three residents back into the facility from the smoking area. The residents were not encouraged to wear masks or perform hand hygiene. On 7/29/2020 at 12:09 p.m., CNA #12 took two plates into a room and set them down before the residents. Hand hygiene was not offered or encouraged. 3. Resident Interviews On 7/28/2020 at 12:10 p.m., Resident #1, #2 and #4, all alert and oriented, were interviewed. The three residents said the staff never offered or encouraged residents to perform hand hygiene. 4. Staff interviews On 7/30/2020 at 9:31 a.m., CNA #2 was interviewed. He said residents should be offered hand hygiene before meals and after using the bathroom. He said he did not know if hand hygiene was to be offered when the meal was delivered to the resident or prior to the food arriving. The DON/IP and NHA were interviewed on 7/30/2020 at 2:55 p.m. The DON/IP said hand hygiene was always encouraged for the residents. She said the residents participate in a coupon program and get a coupon when they perform hand hygiene. However, no resident hand hygiene was observed to be encouraged or offered to residents on 7/28 and 7/29/2020 (see above). Moreover, no coupons were observed being distributed. The DON/IP said she could not explain why hand hygiene was not being offered before meals and after smoking. She said she was unsure if the staff go around and offer hand hygiene to everyone before the meal or if they offer it immediately before the meal arrives. F. Failure to ensure the facility actively screened staff prior to the start of their shift for signs and symptoms of COVID-19 on the COVID-19 isolation unit. 1. Professional reference and facility policy and procedure The CDC Coronavirus 2019 COVID-19,(6/25/2020) Preparing for COVID-19 in Nursing Homes retrieved 8/3/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, read, in pertinent part, Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. The facility's COVID-19 Prevention policy, revised 6/26/2020, was received from the DON/IP on 7/30/2020 at 11:05 a.m. The policy documented in pertinent part, Staff will be monitored for any onset of respiratory illness such as fever of 100 or higher, dry cough, sneezing, nausea, vomiting, body aches, shortness of breath, loss of taste or smell, nasal congestion and sore throat. If any of the following are present, staff will be sent home until further notice. 2. Interviews and record review RN #6 was interviewed on 7/30/2020 at 10:08 a.m. on the COVID-19 isolation unit. She said she takes her own temperature when she gets onto the unit each shift. She said she does not document her temperature or any type of COVID-19 screening. The employee COVID-19 screenings for staff working the COVID-19 isolation unit in the previous two weeks were requested from the ADON on 7/30/2020 at 11:15 a.m. Review revealed there was no documentation of COVID-19 health screenings for the following employees who worked on the COVID-19 isolation unit in the previous two weeks: -RN #4,