STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395241	A. BUILDING _____ B. WING _____	06/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLVIEW HEALTHCARE AND REHABILITATION CENTER	700 S. CAYUGA AVENUE ALTOONA, PA 16602

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and residents' clinical records, as well as staff interviews, it was determined that the facility failed to monitor the resident's fluid intake as ordered by the physician for two of four residents reviewed (Residents 3, 4). Findings include: The facility's policy regarding encouraging and restricting fluids, dated December 20, 2019, indicated that staff were to document the resident's fluid intakes in milliliters (ml) when measuring was clinically indicated, and the specific instructions for fluid intake or restriction were to be followed. A [DIAGNOSES REDACTED]. physician's orders [REDACTED]. A [DIAGNOSES REDACTED]. physician's orders [REDACTED]. There was no documented evidence that Resident 4's actual fluid intake was monitored daily to determine if he was maintaining the fluid restrictions as ordered by the physician. Interview with the Nursing Home Administrator on May 22, 2020, at 11:21 a.m. confirmed that there was no documented evidence to show that Resident 3's and 4's actual daily fluid intakes were monitored to determine if the residents were following the fluid restrictions as ordered by the physicians. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure communication between a [MEDICAL TREATMENT] provider and the facility's nursing staff for one of 13 residents reviewed (Resident 9). Findings include: The facility's policy regarding [MEDICAL TREATMENT] (mechanical cleansing of the blood to remove waste products when the kidneys are not functioning properly), dated December 20, 2019, indicated that agreements between the facility and the contracted [MEDICAL TREATMENT] provider included all aspects of how the resident's care would be managed, including how information was to be exchanged between the facilities. The facility's policy regarding charting and documentation, dated December 20, 2019, indicated that documentation of procedures and treatments was to include care-specific details, including notification of a resident's family, physician, or other staff if indicated. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated May 3, 2020, revealed that the resident was understood and could understand, and had [DIAGNOSES REDACTED]. The resident's care plan, dated October 2, 2019, revealed that the resident received [MEDICAL TREATMENT], and staff were to coordinate [MEDICAL TREATMENT] care with the [MEDICAL TREATMENT] treatment facility. A nursing note for Resident 9, dated April 8, 2020, at 9:19 a.m. revealed that after review of the resident's symptoms, a new order was received for contact and droplet precautions (special steps and procedures used to prevent germs from spreading), the resident was to be moved to the A Wing, and a new order was received for the resident to have COVID-19 testing completed upon return from [MEDICAL TREATMENT]. There was no documented evidence that Resident 9's [MEDICAL TREATMENT] provider was notified regarding the resident's symptoms, the resident being placed into contact and droplet precautions, or that the resident was being tested for COVID-19. Interview with the Licensed Practical Nurse 3/Infection Preventionist on June 11, 2020, at 5:20 p.m. confirmed that there was no documented evidence that Resident 9's [MEDICAL TREATMENT] provider was notified regarding the resident's symptoms, the resident being placed into contact and droplet precautions, or that the resident was being tested for COVID-19. 28 Pa. Code 211.12(d)(3) Nursing services.
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 policies and documents, and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Disease Control (CDC), the Center for Medicare/Medicaid Services (CMS), and the Pennsylvania Department of Health (PA DOH) to reduce the spread of infections and prevent cross-contamination during the COVID-19 pandemic. Findings include: The CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, updated May 16, 2020, revealed that points of entry to the facility were to be limited and monitored, and upon arrival, visitors were to be advised to put on a cloth face covering or facemask and await screening for fever and other symptoms of COVID-19, regardless of symptoms. The facility was to take steps to ensure everyone adhered to respiratory hygiene and cough etiquette, hand hygiene, and all patients were to follow triage procedures throughout the duration of the visit. The facility was to post visual alerts (e.g. signs, posters) at the entrance and in strategic places (e.g. waiting areas, elevators, cafeterias) to provide instructions (in appropriate languages) about hand hygiene, respiratory hygiene and cough etiquette, and instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene. At facility entrances and in waiting rooms, the facility was to provide supplies for respiratory hygiene and cough etiquette, including alcohol-based hand rub (ABHR) with 60-95 percent alcohol, tissues, and no-touch receptacles for disposal. Physical barriers (e.g. glass or plastic windows) were to be installed at reception areas, to limit close contact between triage personnel and potentially infectious patients, and triage personnel were to have a supply of facemasks or cloth face coverings that could be provided to all patients who were not wearing their own cloth face covering at check-in, assuming a sufficient supply existed. At the time of patient check-in, the facility was to ensure that all patients were asked about the presence of fever, symptoms of COVID-19, or contact with patients with possible COVID-19. The facility's instructions for its screening process, dated May 1, 2020, included that entrance and exit screening was essential. On entrance to the facility, an active review of respiratory symptoms was to be performed, the person's temperature was to be taken, and staff were to ensure that hand hygiene was performed. Staff were to be observed putting on their personal protective equipment (PPE). On exit, temperatures were to be taken and hand hygiene was to be performed. A designated staff member was to be assigned at high volume times (change of shift). During low volume times, the entrance was to remain locked, with a system in place to alert staff that someone was requesting entrance to the facility (e.g. doorbell). At no time was the screening area to be left unattended if the doors were not locked. A face mask that covered both the mouth and nose was to be worn immediately upon entrance, during screening, and at all other times. Observations of the facility's screening process on June 10, 2020, at 7:48 a.m. revealed that the Director of Maintenance was stationed behind a folding table in the hallway outside of the Nursing Home Administrator's office. The Director of Maintenance was not wearing a mask or gloves. Laying on the table were two pens, a digital thermometer, screening forms, a spray bottle of hand sanitizer, and a box containing surgical masks. The Director of Maintenance had both Department of Health surveyors standing beside each other (both were wearing surgical masks) and four staff members were waiting in line without masks on and they were not [MEDICATION NAME] social distancing. One at a time, the Director of Maintenance sprayed the surveyors' hands with the hand sanitizer, then began to ask 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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) screening questions and obtain their temperatures. The surveyors each signed their screening forms, and the Director of Maintenance sprayed their hands again with the hand sanitizer. The surveyors were then instructed to obtain surgical masks from the box that was on the screening table, and the pens were placed back on the table without being cleaned. Observations of the four staff in line revealed that the same process was followed for each of them. The staff did not have masks on, they did not practice social distancing, and the pens were not cleaned between uses. Observations of the facility's screening process on June 10, 2020, at 2:43 p.m. revealed that the Director of Social Services, who was wearing a mask, was stationed behind a folding table in the hallway outside of the Nursing Home Administrator's office. On the table were two pens lying on a disinfecting cloth with another disinfecting cloth lying on top of them, a digital thermometer, screening forms, a spray bottle of hand sanitizer, and a box containing surgical masks. There were two staff members standing beside each other without any facial covering on and they were not [MEDICATION NAME] social distancing. The Director of Social Services sprayed the staffs' hands with the hand sanitizer, began to ask the screening questions, and obtained their temperatures. The two staff each signed their screening forms, and the Director of Social Services sprayed their hands with hand sanitizer again. The staff then obtained surgical masks from the box that was on the screening table, and the pens were placed back on the disinfecting cloth without being cleaned. Observations of the facility's screening process on June 11, 2020, at 7:55 a.m. revealed that the Director of Maintenance, who was wearing a mask, was stationed behind a folding table in the hallway outside of the Nursing Home Administrator's office. On the table were two pens lying on a disinfecting cloth, a digital thermometer, screening forms, a spray bottle of hand sanitizer, and a box containing surgical masks. The Director of Maintenance had two facility staff standing beside each other at the table, and the two staff did not have masks on. The Director of Maintenance sprayed the staffs' hands with the hand sanitizer, began to ask them the screening questions, and obtained their temperatures. He sprayed their hands with the hand sanitizer and then the staff obtained surgical masks from the box that was on the screening table. At 8:06 a.m. two more facility staff entered the facility at the screening area without masks on. Both staff stood beside each other at the screening table while the Director of Maintenance sprayed their hands with the hand sanitizer, asked the screening questions, and obtained their temperatures. He sprayed their hands again, and then the staff obtained surgical masks from the box that was on the screening table. Interviews with the Nursing Home Administrator and the Director of Nursing on June 11, 2020, at 10:33 a.m. confirmed that the screeners should have been wearing masks, enforcing social distancing rules and/or should have been cleaning the pens properly, and staff members should had a mask on when entering the facility. The facility's Coronavirus Disease (COVID-19) policy, updated on May 7, 2020, revealed that the facility followed current guidelines and recommendations for managing COVID-19. The infection preventionist was to conduct active (daily) surveillance for new respiratory illness and report activity in the facility, and maintain communication and collaborate with local and state health authorities. The facility was to accept a new admission only if a private isolation room was available, place a mask on the resident upon entering the facility, and place the resident in a predetermined holding room (curtain pulled and door closed). Only identified staff were to enter the room, they were to utilize full PPE (gown, N-95 respirator, goggles/face shield, gloves, shoe covers), and a log of the staff who entered the isolation room was to be maintained. The resident was to be monitored for any changes in condition and be placed on every eight hour vital sign checks. If at any time the resident developed COVID-19 symptoms (cough, sore throat, lethargy, elevated temperature, etc.) the vital sign checks were to be increased from every shift to every four hours. After completing three days of isolation, the facility would obtain a COVID-19 swab on the new admission, and if the test was positive, move the resident to the COVID-19 positive unit and follow the checklist for a COVID positive patient. If the test was negative, it was to be repeated on Day 9. If the second test was negative, isolation could be discontinued and the resident could be transferred to a regular facility room on Day 14, with the general population. A nursing note for Resident 10, dated June 9, 2020, at 4:20 p.m. revealed that the resident was readmitted from the hospital with [DIAGNOSES REDACTED]. coli infection) and pneumonia (lung infection). The resident was placed on contact precautions (requires the use of a gown and gloves) and droplet precautions (requires the use of goggles or face shield, an N-95 mask, a gown, gloves and shoe covers) for 14 days for COVID-19 precautions. Observations of Resident 10's room on June 10, 2020, at 10:41 a.m. revealed that there were isolation signs posted on the door indicating that there were contact and droplet precautions in effect and eye protection, a gown, gloves, an N-95 respirator (mask) and boot covers were to be worn when entering the room. There was a cart in the hall next to Resident 10's door that contained the required PPE. At 10:43 a.m. a Certified Registered Nurse Practitioner (CRNP) came out of Resident 10's room, removed her gloves, and then her goggles. She proceeded to clean the goggles without gloves on, and then placed them in the isolation cart for re-use. Interview with the CRNP at that time confirmed that the goggles were cleaned and placed back in the cart for re-use and that the disinfectant wipes had a ten minute kill time (time required to kill organisms that may be on the surface). Observations on June 10, 2020, at 10:48 a.m. revealed that Housekeeping Aide 1 went into Resident 10's room with a gown, goggles, an N-95 respirator, gloves and shoe coverings in place. He took his broom and dust pan in. At 10:51 a.m. he opened the door, placed his broom in the cart, wet his mop in the bucket and went back into the room. At 10:55 a.m. he came out of the room without his gown, gloves and shoe coverings on, placed the mop in his cart and removed his goggles. Without gloves on, he then cleaned the goggles with a disinfectant wipe and placed them in the isolation cart without gloves. He cleansed his hands with hand sanitizer and pushed his cart into the housekeeping closet at the end of the hall. Interview with Housekeeping Aide 1 at that time confirmed that he did not have gloves on when cleaning the goggles and that he did not clean the handles of his broom or mop and he should have. 28 Pa. Code 211.12(d)(1) Nursing services.