STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195344	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRING LAKE SKILLED NURSING AND REHABILITATION	**8622 LINE AVENUE SHREVEPORT, LA 71106**

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

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on records review and interview the facility failed to inform the resident's physician and/or nurse practitioner of a resident's change in condition for 1 (#4) out of a total of 5 (#1, #2, #3, #4, #5) sampled residents reviewed for notification of change. The facility failed to ensure the physician and/or nurse practitioner were notified of Resident #4's significant weight loss. Findings: Resident #4 was admitted to the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's weights revealed on 11/7/19 Resident #4 weighed 252.0 lbs (pounds) and on 5/21/2020 Resident #4 weighed 213.2 lbs, which resulted in a weight loss of 15.4% in six months. Review of Resident #4's Nurse Practitioner progress notes dated 5/21/2020, 5/26/2020 and 5/28/2020 failed to reveal significant weight loss was documented and addressed. Review of Resident #4's Registered Dietician progress note dated 5/22/2020 failed to reveal significant weight loss was documented and addressed. During an interview on 6/9/2020 at 3:45pm S9ADON (Assistant Director of Nursing) reported she monitors resident weights for the facility and if a weight loss was noted the resident would be re-weighed for verification, the physician or nurse practitioner would be notified and a registered dietician consult would be requested. After review of Resident #4's weights from November 2019 to May 2020, S9ADON acknowledged Resident #4 had a significant weight loss and neither the physician or the nurse practitioner were notified and should have been. S9ADON also acknowledged a registered dietician consult was not requested and should have been.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an assessment was accurate for 1 (#4) out of a total of 7 (#1, #2, #3, #4, #5, #6, #7) sampled residents reviewed for assessments. The facility failed to ensure significant weight loss was assessed for Resident #4. Findings: Resident #4 was admitted to the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's weights revealed on 11/7/19 Resident #4 weighed 252.0 lbs (pounds) and on 5/21/2020 Resident #4 weighed 213.2 lbs, which resulted in a weight loss of 15.4% in six months. Review of Resident #4's MDS (minimum data set) dated 5/27/2020 was coded 0 = No or unknown for weight loss of 10% or more in the last 6 months. During an interview on 6/10/2020 at 10:50am S10MDS reviewed Resident #4's MDS dated [DATE] and weights from November 2019 to May 2020 and acknowledged the MDS failed to show a weight loss of 10% or more in the last six months and should have been coded as yes.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure a comprehensive plan of care had been developed for 2 (#3, #4) of 8 (#1, #2, #3, #4, #5, #7, #8, and #10) residents reviewed for care plans. The facility failed to ensure comprehensive plan of care had been developed for the following: -Resident #3 - Refusing care; -Resident #4 - Weight loss. Findings: Resident #3: Review of Resident #3's medical record revealed Resident #3 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #3's March 2020 and April 2020 MAR (Medication Administration Record) revealed Resident # 3 refused the following: -Resource 8 ounces on 3/3/2020 at 8:00 am and 3/10/2020 at 8:00 pm; -Resource 8 ounces on 4/10/2020 at 8:00 am; -House supplement 2.0 on 4/30/2020 at 8:00 am and 4:00 pm; and -[MEDICATION NAME] Powder on 4/1/2020 at 8:00 am and 4/10/2020 at 8:00 am. Review of Resident #3's care plan failed to reveal Residents # 3 was care planned for refusing medications. During an interview on 6/8/2020 at 11:50 am S2DON (Director of Nursing) reviewed Resident #3's current care plan and indicated Resident #3 had been care planned for refusing meals but was not care planned for refusal of medications or supplements. During an interview on 6/10/2020 at 10:15 am S3MDS (Minimum Data Set) reviewed Resident #3's care plan and indicated Resident #3 was not care planned for refusal of medications or supplements and should have been. Resident #4: Resident #4 was admitted to the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's weights revealed on 11/7/19 Resident #4 weighed 252.0 lbs (pounds) and on 5/21/2020 Resident #4 weighed 213.2 lbs, which resulted in a weight loss of 15.4% in six months. Review of Resident #4's care plan failed to reveal Resident #4 was care planned for weight loss. During an interview on 6/10/2020 at 11:42 am S3MDS, after review of Resident #4's care plan, acknowledged that Resident #4 was not care planned for weight loss and should have been.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**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 record reviews, interviews and observations, facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for 1 (#1) of 8 (#1, #2, #3, #4, #5, #6, #7, #8) residents reviewed for quality of care out of 10 total sampled residents. The facility failed to ensure the resident's (#1) blood glucose was monitored while receiving insulin. An actual harm occurred for resident #1 on 03/29/2020 at 2:50 a.m. when the resident was found unresponsive to tactile and verbal stimuli with a blood glucose level of 36 mg/dl. The resident, who had a history of [REDACTED]. However, there was no evidence of routine monitoring of the resident's blood glucose levels on 03/26/2020 and 03/28/2020. After being found unresponsive on 03/29/2020 at 2:50 a.m., 911 was called and the resident was transferred to a local hospital where she received 250 milliliters of D10 ([MEDICATION NAME] 10%) and was diagnosed with [REDACTED]. Findings: A review of the facility's Nursing Care of the Resident with Diabetes Mellitus Policy revealed: Glucose Monitoring: (1.) The management of individuals with diabetes mellitus should follow relevant protocols and guidelines (3.) Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. Documentation: (14.) Blood sugar results and other pertinent laboratory studies A review of Resident #1's medical record revealed an admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's March physician's orders [REDACTED]. Review of Resident #1's Nurses Notes revealed the following entries: 03/29/2020 3:39am - 0250 writer called to resident room by aide. Aide stated that resident did not awake during pericare and that was unusual. Resident was observed lying supine with eyes closed. VS (vital signs) as follows 195/77, P82, R24, unable to obtain temp (temperature). One touch was 36. 911 contacted at 0307. One touch was 26 when checked by fire dept. (department). Resident departed from facility

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) via (by way of) 911 stretcher at 0325 and transported to hospital Review of Resident #1's hospital records dated 03/29/2020 revealed the following: Nurses Notes: - 3:56am - presenting complaint: EMS (emergency medical service) states: Patient was found by nursing home staff unresponsive, staff attempted sternal rub and patient remained unresponsive. EMS checked one touch was 26, gave 250ml (milliliter) of D10 ([MEDICATION NAME] 10%) - 8:03am - D10 at 60ml/hr (hour), OT (one touch) Q (every) 30 minutes . Physician ER Documentation: - 4:04am - The patient presents with decreased responsiveness. Found unresponsive at ECF (extended care facility)_blood sugar was 26 on arrival by EMS and they bolused D10 - Exam: Neuro - Orientation: Not oriented to person, place, time. - 4:48am - Daughter states that yesterday AM she checked in on her mother and she was out of it and not really responding. Discharge Summary - admitted 3.29.2020. discharged 4.1.2020. - Hospital Course: The patient is a [AGE] year old insulin dependent diabetes discharged to skilled nursing home with acute mental status change and severe [DIAGNOSES REDACTED] with glucose level at 26 .After admission, the patient required D10 drip until discharge the patient's mental status change mostly secondary to metabolic [MEDICAL CONDITION] secondary to low sugar and urinary tract infection . Review of the resident's MAR indicated [REDACTED]. Further record review revealed no evidence the resident's blood glucose levels were monitored on 03/26/2020 or 03/28/2020. However, the resident's blood glucose levels were obtained on 03/25/2020 at 2:25 p.m. with a result of 218 mg/dl and on 3/27/2020 at 6:00 a.m. (118 mg.dl) at 11:30 am (131 mg/dl) and at 2:00 p.m. (127 mg/dl). On 03/29/2020, the resident's blood glucose level was not checked until the resident was found unresponsive at 2:50 a.m. Review of the resident's Comprehensive Metabolic Panel (CMP) lab results done on 03/27/2020 at 4:39 a.m., revealed the resident's blood glucose level was 32 (normal range 74-109mg/ml (milligrams/milliliter). Review of Resident #1's Interdisciplinary Team Note revealed the following entry dated: 03/27/2020 Late entry reflecting 2:00pm - .received call from lab r/t (related to) the following critical lab results from lab drawn at 4:30am: Glucose=32 Writer rechecked residents FSBS (Finger stick blood sugar) and it was WNL (within normal limits) at 127 at 2:05pm .Will notify NP (Nurse Practitioner). Observation on 6/5/2020 at 9:50 a.m. revealed Resident #2 (diabetic) in his room sitting in his wheelchair, dressed with long pants on, sock and shoe on left foot, right BKA with leg immobilizer in place, clean in appearance, clean and short fingernails, baseball cap on, face mask in place, call light within reach. Further observation revealed Resident #2 holding a see through plastic bag with a sandwich, mayonnaise packet, sugar-free shortbread cookies, and apple juice. Resident #2 was oriented. During an interview on 06/08/2020 at 11:50 am, S16 NP verified there is no routine checking of blood glucose listed on physician standing orders. NP further reported that if the Resident #1 did not have orders to check blood sugar, the nurse should have questioned it and notified her to get orders. NP verified she was not notified of the glucose critical lab value of 32 on 03/27/2020. During a telephone interview on 06/08/2020 at 12:10 pm a contracted agency LPN confirmed she was taking care of Resident #1 on 03/28/2020; she worked 11p-7a. The LPN reported as she was coming in that evening she walked down the hallway and looked in Resident #1's room. The LPN stated Resident #1 looked like she was sleeping and could hear her snoring. She reported that during the shift the aide called her to Resident #1's room because she wasn't waking up during incontinence check. The LPN confirmed Resident #1 was not responding so she took vital signs and remembered Resident #1 was a diabetic so she checked her blood sugar and it was 36. The contracted agency LPN confirmed she called 911. During an interview on 06/09/2020 at 2:45 pm S18 LPN reported during her shift on 03/27/2020 the contracted agency LPN called her to Resident #1's room. LPN (which one) reported when she entered the room, Resident #1 looked like she was sleeping but would not respond to verbal/tactile stimuli. LPN indicated they checked her vital signs and checked her blood sugar which was 36; 911 was called. During an interview on 06/09/2020 at 3:15 pm S4 ADON verified there was no evidence the resident's blood glucose levels were monitored on 03/26/2020 or 03/28/2020, and that on 03/29/2020, the resident's blood glucose level was not checked until the resident was found unresponsive at 2:50 a.m. S4ADON further indicated if there were no orders for blood glucose checks, the nurse may not complete them. S4 ADON stated, If it was me I would do them. Observation on 6/10/2020 at 10:20 am revealed Resident #5 (diabetic) lying in bed on air loss mattress turned to right side. Resident with no odors noted, well-groomed and dressed. Feeding pump noted in room; resident receives continuous feeding in the evening and night. Resident is non-verbal/aphasic. During an interview on 06/10/2020 at 1:45 pm S5 ADON verified blood sugar checks were not done routinely on Resident #1 on 3/26 and 3/28 and should have been. S5 ADON reported that any resident who is receiving insulin should get routine blood sugar checks. S5 ADON reported if Resident #1 didn't have orders for blood sugar monitoring the NP or MD should have been contacted. Observation on 6/10/2020 at 3:40 pm revealed Resident #6 (diabetic) sitting in wheelchair in room, dressed, well-groomed, with clean trimmed nails and no odors. Resident #6 has a brace on right lower leg with feet elevated and protected. Resident #6 is oriented and pleasant. During an interview on 06/11/2020 at 11:24 am S4 ADON verified she received critical glucose lab value of 32 for Resident #1 on 03/27/2020 from the lab and charted she would notify NP. S4 ADON reported she normally would notify the NP but stated, I don't know what happened that day and it should have been reported. S4 ADON confirmed there is no further documentation to show where the NP was notified of blood glucose was 32.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to adequately monitor 1 (#3) of 1 (#3) resident reviewed for monitoring related to the use of a diuretic. The facility failed to adequately monitor Resident #3 for [MEDICAL CONDITION] related to the use of the diuretic [MEDICATION NAME]. Findings: Review of Resident #3's medical record revealed Resident #3 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. Review of Resident #3's April 2020 Physician order [REDACTED].#3's March and April 2020 MAR (Medication Administration Record) failed to reveal diuretic ([MEDICATION NAME]) monitoring for [MEDICAL CONDITION]. Review of Resident #3's Care Plan revealed Resident #3 had a potential for fluid volume overload related to heart failure: [MEDICAL CONDITION] with approaches that included, in part, administer meds as ordered, report to MD (Medical Doctor) s/s (signs/symptoms) increase in fluid load such as [MEDICAL CONDITION], serve therapeutic diet as ordered, weigh resident per protocol, encourage compliance with medical regime, lethargy, bounding pulses, crackles to lungs. During an interview on 6/8/2020 at 11:50am S2DON (Director of Nursing) reviewed Resident #3's April 2020 MAR and indicated she did not see where monitoring of [MEDICAL CONDITION] for the diuretic [MEDICATION NAME] was done and it should have been.
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to document a resident received treatment and care for 3 (#5, #6, #7) of 4 (#5, #6, #7, #8) residents reviewed for quality of care out of a total sample of 10 residents. The facility failed to document rechecked blood sugars for residents (#5, #6, and #7) with blood sugar values greater than 400 one hour after administration of insulin. Findings: Review of Facility's Policy for Nursing Care of the Resident with Diabetes revealed: Glucose Monitoring: (1) The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. (3) Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. Resident #5 Review of medical records revealed Resident #5 admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of Resident #5's June 2020 physician's orders [REDACTED].#5's April 2020 MAR (Medication Administration Record) revealed blood glucose levels > (greater than) 400 on 04/01/2020 at 11am (495) and 04/02/2020 (497) at 11am with no recheck values documented. Review of Resident #5's April 2020 Nurse's Notes failed to reveal documentation of blood glucose rechecks 1 hour after insulin was given for the following blood glucose checks on 04/01/2020 at 11am (495) and 04/02/2020 (497) at 11am. During an interview on 6/10/20 at 4:20 pm S4 ADON (Assistant Director of Nursing) reported blood glucose rechecks should be documented on the MAR or in the nurses notes and they were not. During an interview on 6/11/2020 at 9:37 am S2 DON (Director of Nursing) reported resident blood sugar rechecks should be completed in an hour when a resident's blood sugar was 401 or greater and documented in the resident's medical record. Resident #6 Review of medical records revealed Resident #6 admitted on [DATE] with a [DIAGNOSES REDACTED]. Review of Resident #6's June 2020 physician's orders [REDACTED].(milligram) tablet give one tablet twice a day with meals 5/15/2020: [MEDICATION NAME] R 100unit/ml vial give per sliding scale before meals and bedtime: 0-60=0 unit; recheck in 1 hour if still < 60 notify MD, 200-250=2 units, 251-300=4 units, 301-350=6 units, 351-400=9 units, [PHONE NUMBER]=12 units; recheck in 1 hour if still >400 notify MD. Review of Resident #6's May and June 2020 MAR's failed to reveal documentation of rechecked blood sugar values for blood glucose levels >400 on the following days: 5/15/2020 - 547 (6am), 572 (11am), 5/16/2020 - 530 (11am), 557 (4pm), 482 (8pm), 5/17/2020 - 450 (4pm), 5/18/2020 - 518 (6am), 404 (8pm), 5/19/2020 - 443 (6am), 550 (8pm), 5/20/2020 - 561 (11am), 427 (8pm), 5/21/2020 - 405 (11am), 490 (4pm), 5/22/2020 - 506 (11am), 566 (8pm), 5/23/2020 - 490 (11am),

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 5/24/2020 - 552 (11am), 5/25/2020 - 452 (4pm), 5/26/2020 - 433 (6am), 416 (11am), 441 (8pm), 5/28/2020 - 414 (11am), 5/29/2020 - 487 (11am), 5/30/2020 - 440 (11am), 6/02/2020 - 600 (4pm), 6/04/2020 - 405 (11am), 6/06/2020 - 527 (8pm), 6/07/2020 - 544 (4pm) and 6/08/2020 - 584 (4pm). Review of Resident #6's May and June 2020 Nurse's Notes failed to reveal documentation of blood glucose rechecks 1 hour after insulin was given for the following blood glucose checks: 5/15/2020 - 547 (6am), 572 (11am), 5/16/2020 - 530 (11am), 557 (4pm), 482 (8pm), 5/17/2020 - 450 (4pm), 5/18/2020 - 518 (6am), 404 (8pm), 5/19/2020 - 443 (6am), 550 (8pm), 5/20/2020 - 561 (11am), 427 (8pm), 5/21/2020 - 405 (11am), 490 (4pm), 5/22/2020 - 506 (11am), 566 (8pm), 5/23/2020 - 490 (11am), 5/24/2020 - 552 (11am), 5/25/2020 - 452 (4pm), 5/26/2020 - 433 (6am), 416 (11am), 441 (8pm), 5/28/2020 - 414 (11am), 5/29/2020 - 487 (11am), 5/30/2020 - 440 (11am), 6/02/2020 - 600 (4pm), 6/04/2020 - 405 (11am), 6/06/2020 - 527 (8pm), 6/07/2020 - 544 (4pm) and 6/08/2020 - 584 (4pm). During an interview on 6/10/2020 at 3:52pm S16 NP (Nurse Practitioner) reported she was not aware of documentation of blood sugar recheck levels in Resident #6's medical record for review by NP or MD. During an interview on 6/10/20 at 4:20 pm S4 ADON reported blood glucose rechecks should be documented on the MAR or in the nurses notes and they were not. During an interview on 6/11/2020 at 9:37 am S2 DON reported resident blood sugar rechecks should be completed in an hour when a resident's blood sugar was 401 or greater and documented in the resident's medical record and were not. Resident #7 Review of Resident #7's medical record revealed Resident # 7 was admitted to facility on 7/18/16 and had [DIAGNOSES REDACTED]. Review of Resident #7's April 2020 Physician order [REDACTED]. order sliding scale provided by S5 ADON revealed: <60 give OJ (orange juice), recheck in 1 hr. If still <60 give [MEDICATION NAME] 1mg IM (intramuscular). 200-250=2U (unit), 251-300=4U, 301-350=6U, 351-400=9U, >400=12U and recheck in 1 hour if still >400 notify MD Review of Resident #7's April 2020 MAR failed to reveal documentation of rechecked blood glucose values for blood glucose levels >400 on the following days: 4/1/2020 at 4:00pm (403), 4/2/2020 at 11:00am (410), and 4/7/2020 at 11:00am (438). Review of Resident #7's April 2020 Nurse Notes failed to reveal documentation of blood glucose rechecks 1 hour after insulin was given for the following blood glucose checks: 4/1/2020 at 4:00pm (403), 4/2/2020 at 11:00am (410), and 4/7/2020 at 11:00am (438). During an interview on 6/11/2020 at 9:35am S5 ADON indicated blood glucose rechecks should be documented in the nurse notes and were not. During an interview on 6/11/2020 at 9:37 am S2 DON reported resident blood sugar rechecks should be completed in an hour when a resident's blood sugar was 401 or greater and documented in the resident's medical record and were not.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations and interviews the facility failed to ensure staff practices were consistent with current infection control principles and practices by failing to ensure proper infection control techniques were practiced: - During perineal care with indwelling catheter for 1 (#9) of 1 residents observed for perineal care; - For Foley drainage bag care for 1 (#10) of 6 residents identified with indwelling catheters according to resident census and conditions of residents report; - During enhanced COVID-19 (Coronavirus disease 2019) precautions regarding entrance screening procedures for facility staff. Findings: Perineal care with indwelling catheter: Observation on 6/10/2020 at 9:22am revealed S13CNA (certified nursing assistant) completing perineal care for Resident #9 with an indwelling catheter. Observations revealed S13CNA wiped Resident #9's anal area after recent bowel movement with wet cloth and gloved hands; then placed clean incontinence pad on the resident's bed without taking off dirty gloves. S13CNA with same dirty gloves, rolled Resident #9 to the other side of her bed to pull the clean incontinence pad under Resident #9. S13CNA failed to change gloves between dirty and clean processes. With dirty gloves on S13CNA opened drawers in Resident #9's room in search of a new diaper and placed new clean diaper on Resident #9 without donning new clean gloves. Further, S13CNA did not clean Resident #9's indwelling catheter tubing. During an interview on 6/10/2020 at 9:42am S13CNA acknowledged that gloves should have been changed in between dirty and clean processes of perineal care and that the indwelling catheter tubing should have been cleaned. Foley drainage bag care: Observation on 6/10/2020 at 10:10 am revealed Resident #10's Foley drainage bag sitting on the trash can in his room. During an interview on 6/10/2020 at 10:15 am S11CNA stated I put it there when asked about Resident #10's Foley drainage bag on the trash can. S11CNA further reported she put it on the trash can because the clip to hang the bag on the side of the bed was broken. During an interview on 6/10/2020 at 10:15 am S12LPN (licensed practical nurse) confirmed that Resident #10's Foley drainage bag should not be placed on the trash can and S11CNA should have gotten a new bag. Enhanced COVID-19 precautions regarding entrance screening procedures for facility staff: Observation on 6/8/2020 at 8:22am, as surveyor was sitting in her car in the facility parking lot, revealed a facility therapy staff member enter the facility using a separate door from the parking lot directly into the facility therapy area. Signage posted on this door stated Please use front entrance. During an interview on 6/8/2020 at 8:35am S1Administrator reported every staff member should enter the facility using the front door entrance in order to participate in the COVID-19 screening process. During an interview on 6/8/2020 at 8:36am S14PTA (physical therapy assistant) reported she entered the facility through the door directly into the therapy area from the parking lot and did not enter the facility using the front entrance and had not participated in the COVID-19 screening process. S14PTA further reported she usually enters the facility through the door directly into the therapy area, gathers her stuff and then goes down the hallway to the front entrance area to participate in the COVID-19 screening process on her way to conduct resident therapy. When asked by the surveyor what stuff she gathers, S14PTA reported she gathers the resident gait belt, resident walker, gloves, and face mask. During an interview on 6/8/2020 at 8:38am S15ST (speech therapy) (acting supervisor for therapy area for the week) reported therapy staff have been instructed to enter the facility using the front door and participate in the COVID-19 screening process prior to reporting to the therapy area and conducting therapy with residents. During an interview on 6/8/2020 at 10:19am S5ADON (assistant director of nursing) reported that all staff should enter the facility using the front door and participate in the COVID-19 screening process that consists of taking their temperature and completing a screening questionnaire. S5ADON also reported that the therapy staff should know to use the front door entrance and participate in the COVID-19 screening process prior to reporting to their work area.