STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395414	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LACKAWANNA HEALTH AND REHAB CENTER	108 TERRACE DRIVE OLYPHANT, PA 18447

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** Based on observation, clinical record review and staff interview, it was revealed that the facility failed to provide necessary services to maintain adequate personal grooming and hygiene for residents unable to carry out activities of daily living for eight of 16 residents reviewed (Residents 11, 12, 13, 14, 15, 16, 17, 18). Findings include: Observations conducted on the D (dementia) nursing unit on September 22, 2020, at approximately 12:45 PM revealed that Residents 17 and 18 were observed with unclean/greasy hair. Interview with nursing staff, who did not wish to be identified, at the time of these observations revealed that the nursing staff members stated that they do not have time to provide showers to these dependent residents as scheduled. The nursing staff members interviewed stated that no residents scheduled to be showered during the day tour of duty on September 22, 2020, had received their showers as scheduled during that shift. According to the facility's shower schedule for Tuesday September 22, 2020, Residents 11, 12 and 13 were scheduled to have showers on the day tour of duty on that Tuesday, but they were not showered and the nursing staff interviewed stated that the residents would not be showered during that shift or on that day. A review of the residents' ADL (activity of daily living) and clinical records revealed the following: Resident 11 was totally dependent on staff for showers and was scheduled to receive showers on Tuesdays and Saturdays. According to the resident's ADL record documentation for September 1, 2020 through September 22, 2020, the resident was scheduled to receive six showers during that time period, but was only showered twice (on September 5, 2020 and September 19, 2020); Resident 12 required staff assistance for showers and was scheduled to receive showers on Tuesdays and Saturdays. According to resident's ADL record documentation for September 1, 2020, through September 22, 2020, the resident was scheduled to receive six showers during that time period, but received only two showers (on September 5, 2020 and September 12, 2020); Resident 13 required extensive assistance to totally dependence on staff for showers. The resident was scheduled to receive showers on Tuesdays and Saturdays. The resident's ADL records for September 1, 2020 through September 22, 2020, revealed that she was scheduled to receive a total of six showers, but received only two showers during that time period (on September 5, 2020 and September 19, 2020); Resident 14 was totally dependent on staff for showers and was scheduled to receive showers on Mondays and Fridays. The resident's ADL records for September 1, 2020 through September 22, 2020, revealed that the resident was scheduled to receive six showers during that time frame. The resident was only showered twice (on September 11, 2020 and September 14, 2020; Resident 15 was totally dependent on staff for showers and was scheduled to receive showers on Mondays and Fridays. According to facility ADL record documentation for September 1, 2020, through September 22, 2020, the resident was scheduled for a total of six showers during that time frame. The resident received only two showers, on September 7, 2020 and September 11, 2020; Resident 16 required extensive assistance to total dependence for showers. The resident was scheduled to receive showers on Mondays and Thursdays. A review of the resident's ADL records for September 1, 2020 through September 22, 2020, the resident was scheduled for a total of six showers during that time period, but received only two showers (on September 10, 2020 and September 17, 2020, The facility failed to ensure that residents dependent on staff for assistance with showers were provided the necessary care and services, at the necessary frequently to maintain good grooming and personal hygiene. 483.24(a)(2) ADL Care Provided for Dependent Residents 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services. 28 Pa. Code 201.29 (j) Resident rights
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 a review of select facility policy, staff interviews and observations it was determined that the facility failed to implement COVID-19 infection control practices to promote social distancing between residents, failed to fully screen individuals entering the facility and failed to contain soiled linens and personal care items to prevent the spread of infection on two of four nursing units (B2 and D). Findings include: At the time of the onsite visit to the facility on [DATE], the facility had not identified any residents as COVID positive or begun its universal testing of all residents and staff. A review of the the facility's Emergency Management Policy and Procedure Manual- Interim COVID-19 Visitation Policy dated as effective 3/11/20, revealed that the facility was to restrict the visitation of visitors and non-essential health care personnel for the duration of the declared national and public health emergency related to COVID-19. For those individuals allowed to visit and facility employees various interventions were to be utilized prior to allowing entrance to the facility. The facility's procedures included screening for fever or respiratory infection(fever, cough, shortness of breath or sore throat), requiring visitors to perform hand hygiene and to remind frequent hand hygiene during their visit. Visitors were to told to monitor for signs and symptoms of respiratory illness for 14 days after the visit, and were to report any issues to the facility. Special considerations for State Agency surveyors included informing them of the facility's standard and transmission based policies. A review of the facility Emergency Management Policy and Procedure Manual-Coronavirus Surveillance dated as effective 3/5/20 and revised 5/28/20, revealed that heightened surveillance activities were to be implemented including screening of allowed visitors and staff. Interventions consisted for screening visitors and staff for signs and symptoms of respiratory infection, such as fever, cough, shortness of breath or sore throat. Determining if any contact occurred, with individuals with confirmed [DIAGNOSES REDACTED]. A determination was to be made, if international travel had occurred within the past 14 days to countries with sustained community transmission as identified from the CDC's website or for those residing in a community where community based spread of COVID-19 was occurring. Any visitor who met any of this criteria was to be denied access to the facility. Observations conducted at the facility on July 2, 2020, at 8:27 a.m., revealed the facility had signs on the main entrance exterior doors leading to the alcove. The signs stated that visiting was restricted and only one person at a time, should be in the area for screening. Once in the alcove, a table was set up and staff member was seated there. The staff member took the surveyor's temperature and instructed the surveyor to sign in and placed a pen on top of the binder. The pen was not observed to be sanitized prior to use by the surveyor. The staff member at the door did not ask the surveyor any screening questions. There were questions on the left side of the paper related to screening, but the staff member did not instruct the surveyor to review/answer the questions. The staff member did not instruct or ensure that the surveyor had sanitized her hands prior to leaving the screening area and entering the lobby. The staff member was not observed to sanitize the pen after the surveyor had used it in preparation for handing the pen to the next person. Continued observations revealed that the three individuals stood in the alcove together although there was signage instructing individuals to maintain social distancing. The staff member did not request that these three individuals wait , at least 6 feet apart, to allow each person to be screened while maintaining social distancing. Continued observations also revealed that the staff member did not instruct the next individual to sanitize her hands prior to entering the lobby. To access the nursing units in the facility staff

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) and visitors utilized an elevator. There was no signage posted explaining the need to social distance in this confined area, or the maximum capacity of people allowed in the elevator to safely maintain social distancing. A review of the facility policy Emergency Management Policy and Procedure Manual- Interim COVID -19 Visitation Policy, effective 3/11/20, revealed that all communal dining and group activities were cancelled. Residents were to be reminded to practice social distancing and perform frequent hand hygiene. The facility Emergency Management Policy and Procedure Manual- Communal Dining Guidance Covid-19, (which included the statement that the policy was based on CMS memo dated March 13, 2020, which offered guidance to cancel communal dining and all group activities,) revealed that the facility was to practice social distancing and infection control practice for communal dining. Social distancing was defined as residents staying at least six feet apart, if in a common area for meals, with as few other residents as feasible in this common area. If residents needed to be brought to the common area for dining, it was to be done in intervals to maintain social distancing. Tables were to be as far apart as possible with at least six feet. The number of meal services was to increased, meals were to offered in shifts, and the number of staff was to be increased to assist with resident dining to allow fewer residents in common areas at one time. Ideally residents were to sit at tables by themselves to ensure that social distancing could be maintained, or depending on table and room size. If necessary, it was to be arranged for two residents to be seated at a table, with the focus on maintaining existing social relationships, if necessary. Residents who needed assistance with feeding were to be spaced as far apart as possible, ideally six feet or more, or no more than one person per table. Observations completed on the D unit, the facility's designated dementia unit, beginning at 11:30 AM on July 2, 2020, revealed that residents were assembled in the large dining room near the entrance to the unit and in the small dining room near the nurses station. Nine tables were set up in the large dining room with a total of 31 residents seated at various tables. Four residents were observed seated together at all but three tables in the dining room. Two residents were observed in geriatric chairs in the back of the room, but the chairs were not positioned at least six feet apart. Six tables were observed in the small dining room with 15 residents seated at the tables, one table had four residents seated at it and two tables with three residents seated at the tables. The tables were arranged in a configuration and residents positioned in a manner that did not allow for at least six feet between residents. The residents were seated seated back to back and for those with four at a table, seated face to face. As this unit, was the facility's dementia unit, the residents observed were not consistently social distancing and none were observed wearing masks prior to the meal service. Only one staff member was in the large dining room to supervise the 31 residents and attempt to maintain social distancing prior to meal service at 11:30 AM. At 11:40 AM Resident 4 was observed ambulating down the corridor of the D unit, holding hands with Resident 5. Resident 4 directed Resident 5 into the large dining room, went to the counter and obtained a clothing protector and fastened it around his neck. When she finished, she placed both hands on his shoulders, from behind, bent down and said something to him and left. Resident 4 then proceeded back to the small dining room and sat a table with two other residents. Staff members did not redirect the Resident 4, encourage her to social distance, wear a mask or to sanitize her hands after touching her peer, Resident 5. When the Director of Nursing and licensed Nursing Home Administrator were interviewed on July 2, 2020, at 2:45 p.m., they stated that they had tried to moved the tables and adjust the meal times at one point, but the residents kept moving the tables back and coming into the dining room. The DON and NHA stated that the facility had made no modifications in deployment or increases to the staffing levels on this dementia unit, in response to Covid-19 precautionary measures to assist with maintain social distancing between residents. According to PA Health Update Notice dated May 12, 2020, provided by the PA Department of Health to all skilled nursing facilities residents need to be cohorted to separate units in three zones, based on test results; COVID positive test (Red Zone): resident with a positive [DIAGNOSES REDACTED]-CoV-2 PCR test and still within the parameters for transmission-based precautions. COVID- test potentially exposed (Yellow Zone): resident with a negative [DIAGNOSES REDACTED]-CoV-2 PCR test who remain asymptomatic but are within 14 days of possible exposure to COVID-19. Unexposed (Green Zone): any resident in the facility who was not tested and is thought to be unexposed to COVID-19. Interview with the licensed nursing home administrator on July 2, 2020 at 8:45 a.m., revealed that the facility had designated the B2 unit as the yellow unit for those residents who had been out of the facility for various reasons or who were newly admitted to the facility. The purpose of this unit, was to segregate these residents from the rest of the facility population, in the event they had been exposed to COVID-19, and to deter possible transmission between residents on other units as well as this unit. A tour of the B2 unit on July 2, 2020, at 10:20 a.m., revealed that some of the resident room doors were closed, with the residents inside the rooms. However, other residents were observed out of their rooms, ambulating or self-propelling about the unit and not all the residents were wearing masks while out of their rooms. The facility had placed the bins for soiled resident care items in the resident rooms on the B2 unit. Observations completed on this unit at 12:45 p.m. revealed that the red bins designated for disposal of soiled items in Resident 3 and Resident 1's rooms were overflowing and uncovered. In Resident 3's room, the soiled items were observed touching the wall of the room. Observations on the B2 unit on July 2, 2020, at 10:20 AM revealed rolled up linens and gowns thrown on the floor of Resident 6's room. When observed again at 2:45 p.m., they had not been removed. When interviewed on July 2, 2020, at 2:45 p.m., the Director of Nursing Services confirmed that linens and soiled items were to be contained in bins to deter the spread of infection. 28 Pa. Code 211.12 (a)(c)(d)(4)(5) Nursing Services. 28 Pa. Code 211.10(a)(d) Resident care policies