| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **105237** | A. BUILDING _____ B. WING _____ | **07/15/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **WEST BROWARD REHABILITATION AND HEALTHCARE** | **7751 W BROWARD BLVD PLANTATION, FL 33324** |

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) |
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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews and record reviews, the facility failed to provide supervision to ensure the safety of residents for 1 of 3 sampled residents reviewed for supervision, Resident #1, as evidenced by failing to monitor the whereabouts of Resident #1, and failing to reassess for elopement risk, resulting in Resident #1 eloping from the facility. The facility also failed to adequately supervise the Observation unit and random residents, including Resident #18, who were observed wandering the hallway. The findings included: Review of the facility policy Elopements and Wandering Residents dated reviewed and revised on 06/21/20 states in part, 'This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .Elopement occurs when a resident leaves the premises or a safe area without authorization and/or any necessary supervision to do so .The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks and implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary . Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: Adequate supervision will be provided to help prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly . Tips for Prevention of Elopements; Never assume everyone knows the resident is a wanderer; make it clear to dining room aides, new staff and whoever is involved in the resident's care even for a short period of time.' Review of the clinical record for Resident #1 revealed he was admitted to the facility on [DATE] from the hospital with pertinent [DIAGNOSES REDACTED]. Resident #1 had a left upper arm shunt in place for [MEDICAL TREATMENT] treatment access. Resident #1 was mobile independently with a wheelchair and also utilized a right leg prosthetic. The resident's Brief Interview for Mental Status (BIMS) was documented as a 12 of 15, indicating the resident was moderately impaired for cognition. Review of the initial nursing assessment dated [DATE] at 11:26 PM, the Licensed Practical Nurse (LPN) documented Resident #1 was admitted under contact isolation [MEDICAL CONDITION] (Methacillin Resistant Staphylococcus Aureus) pneumonia. Due to being admitted from the hospital, Resident #1 was admitted to the facility's Observation unit on the West Wing where new admissions are placed to observe for any signs or symptoms of the COVID-19 virus. Review of a Elopement Risk Evaluation assessment dated [DATE] completed by a Licensed Practical Nurse (LPN) documents under Evaluation Factors: Is the resident cognitively impaired with poor decision making skills? -No; Does the resident have a [DIAGNOSES REDACTED].? - No. Resident #1 was deemed not an elopement risk. Review of a psychiatric consultation dated 05/27/20 documents Resident #1's thought process is disorganized; thought content delusional; disoriented to time; insight limited; judgement poor; reliability poor; mood anxious. The [DIAGNOSES REDACTED]. Resident #1 was on an antianxiety medication twice daily and an antipsychotic medication daily at bedtime. Review of a Nursing Progress Note dated 05/28/20 at 9:52 PM, the LPN documents, 'Resident observed screaming loudly, talking to himself . Medicated as ordered, tolerated well.' Review of a Nursing Progress Note dated 05/31/20 at 1:30 AM, the LPN documents, 'Resident call 911 at 11:47 PM. 911 arrive at facility at 11:55 PM. Resident stated that [MEDICATION NAME] 325 milligrams did not work. Resident claimed he want to go to the hospital because he needed [MEDICATION NAME] for pain on his right hand. 911 took resident to the hospital at 12:00 AM.' Review of a Nursing Progress Note dated 05/31/20 at 2:07 AM, the LPN documents, 'Hospital call facility and said they are going to send resident to facility. Hospital stated that resident is ok and they are going send resident with prescription medication.' Review of a Nursing Progress Note dated 06/11/20 at 2:00 AM, the Registered Nurse (RN) documents, 'Resident was complaining of chest pain this AM, he did not activate his call bell to call for the nurse and he proceeded to call 911. Resident was transported to hospital via stretcher accompanied by EMT.' Further review of the Nursing Progress Notes revealed Resident #1 was readmitted to the facility to the same Observation unit and bed assignment on 06/12/20 at 3:50 PM. Review of the Medication list revealed Resident #1 was now on 2 antianxiety medications, one administered twice daily and one administered at bedtime and the antipsychotic medication administered at bedtime. Review of a Elopement Risk Evaluation assessment dated [DATE] completed by a LPN when Resident #1 was readmitted from the hospital after he self initiated a 911 call, documents under Evaluation Factors: Is the resident cognitively impaired with poor decision making skills? -No; Does the resident have a [DIAGNOSES REDACTED].? - No. Resident #1 was deemed not an elopement risk. Review of an Infection Progress Note dated 06/17/20 at 3:07 PM documents, 'COVID-19 prevention in place as well as quarantine status [REDACTED].' Review of a psychiatric consultation dated 06/24/20 documents Resident #1's thought process is less disorganized; thought content/[MEDICAL CONDITION] less delusional; disoriented to time; insight fair; judgement fair; reliability fair. The [DIAGNOSES REDACTED]. The treatment plan continued to include the 2 antianxiety medications and antipsychotic medication. Review of a Nursing Progress Note dated 06/28/20 at 12:45 PM the LPN documented, 'Resident observed out of bed, agitated. Throw away lunch tray, broke the phone. Attempted to get out of his room and get in the dining room. Resident redirected.' Further review of the Nursing Progress Notes revealed no documentation the physician was notified of the change in Resident #1's behavior. Review of a Nursing Progress Behavior Note dated 06/28/20 at 3:48 PM, the RN documented, 'Patient was very agitated and angry, punch the wall, broke the phone in the room, throw his tray and food on the floor. Patient then went into (another resident's room) and attempting to use his phone, this created a screaming match between both residents. By the time I got there both patient was very angry. Spoke to both patient, eventually they calm down. Resident (#1) stated he wants to leave .' Further review of the Nursing Progress Notes revealed no documentation the physician was notified of the change in Resident #1's behavior. Review of the clinical record revealed no Elopement Risk Evaluation was conducted when the resident was now expressing 'He wants to leave.' Review of a Nursing Progress Note dated 06/28/20 at 4:42 PM, the LPN documented, 'On initial round observed resident in his room with signs of agitation, screaming, talking to himself. Resident went to the courtyard, nurse on duty educates resident that he is not allowed to be either in the hallway or the courtyard. Resident went back to his room.' Further review of the Nursing Progress Notes revealed no documentation the physician was notified of the change in Resident #1's behavior. Review of a Nursing Progress Note dated 06/29/20 at 7:25 AM, the LPN documents, 'Resident up all night and out of bed back and forth in the hallway stated he can't sleep. No distress or discomfort noted.' Further review of the Nursing Progress Notes revealed no documentation the physician was notified of the change in Resident #1's behavior. Review of a Nursing Progress Note dated 06/29/20 at 6:42 PM, the RN documents, 'Resident was seen by ARNP (Advanced Registered Nurse Practitioner) new order for psych consult received and carry out.' Further review of the Nursing Progress Notes from 06/29/30 through 07/03/20 revealed no evidence of a psychiatric consult conducted. Review of the clinical record revealed no evidence of any psychiatric evaluation conducted since the last documented assessment of 06/24/20. There was no evidence in the clinical |

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 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>record an Elopement Risk Evaluation was conducted when the resident expressed 'He wants to leave' as documented by the RN on 06/28/20 at 3:48 PM. Further review of the clinical record revealed Resident #1 attended [MEDICAL TREATMENT] treatments on 06/30/20 and 07/02/20. Review of Resident #1's clinical record revealed the following care plans: I am using [MEDICAL CONDITION] medications related to behavior management, date initiated 06/08/20. Intervention to include: Monitor/document/report as needed any adverse reactions to [MEDICAL CONDITION] medications, to include behavior symptoms not usual to the person. I am on anti-anxiety medications related to anxiety disorder, date initiated 06/08/20. Interventions to include: Monitor for safety. Unexpected side effects - mania, hostility, rage, aggressive or impulsive behavior. I exhibit behaviors of yelling and screaming unprovoked. Resident is non-adherent to staff's directives. Resident is self directed and is difficult to redirect at times, date initiated 05/29/20. Interventions to include: Provide consistent caregivers if available. Report to physician changes in behavior status. My cognition is impaired as evidenced by short term memory problems possibly related to multiple comorbidities, date initiated 05/27/20. Interventions to include: Safety checks. On 07/03/20, Resident #1 eloped from the facility. Review of a Nursing Progress Note dated 07/03/20 at 9:00 AM, RN Staff 'N' documents, 'During medication pass, Administrator informed nurse that doors to quarantine areas needs to be closed at all times. No quarantined residents are allowed to come out of quarantine area. Nurse continued working. Shortly thereafter approximately 9:30 AM nurse noticed a resident coming through doors. Nurse asked resident what he needed. Resident stated he needed to speak to the social worker. Nurse advised resident to go back to his room. Nurse also advised that he's not suppose to leave quarantine area unless it's for appointment or [MEDICAL TREATMENT]. Resident went to room. When resident approached nurse resident did not appear upset. Nurse came to room to check vital signs and to give medication. Resident not in room. Nurse asked unit manager about resident. Unit manager informed nurse that resident is noncompliant and he comes out of his room all the time. After medication pass finished, nurse went to accu-checks (blood sugar monitoring test). Nurse went to check resident's roommate. Nurse asked where is your roommate? Resident stated he never stays in room. He's probably rolling around somewhere. Nurse went to therapy room to look for resident. Resident not there. Nurse came to nursing station to report that she cannot find resident still. Staff assisted nurse to look for resident. Nurse search room to room then nurse went to East wing searched rooms. DON (Director of Nursing) notified ' Review of the July 2020 Medication Administration Record [REDACTED]. For each 9:00 AM medication slot, RN Staff 'N' initialed and circled her initials indicating the medications were not administered. On the back of page one of the MAR, RN Staff 'N' documented on 07/03/20 at 9:40 AM 'No 9 AM meds given. Resident OOF (out of facility)'. Resident #1 did not receive any of his 9 AM medications which included his insulin to control high blood sugars. Review of the Diabetic Record for 07/03/20 at 6:00 AM documented Resident #1's blood sugar level was 124 (normal range 70-100). Resident #1 had consumed his breakfast at 9:00 AM which would have increased his blood sugar level. Resident #1's next blood sugar level check was due at 11:30 AM. Further review of the MARs for the day shift on 07/03/20, revealed no documentation of vital signs, oxygen saturation or assessment of the resident's left arm shunt [MEDICAL TREATMENT] access. Review of the Analysis of Investigation completed by the DON after the elopement of Resident #1 on 07/03/20, documents in part, 'Based on the review of the record and staff interviews, it was determined at no time did Resident #1 demonstrate any exit seeking behaviors. On the day, he did not voice to staff a desire to leave. There were no reasons or indications for staff to believe that he would leave unauthorized and therefore Resident #1's unauthorized departure was unforeseeable. Based on the resident's care plan, Resident #1 was being monitored as per his care plan in place. Resident was alert and oriented and based on his mental assessment identified, Resident #1 was able to make his own decisions and therefore was not identified as an elopement risk. The door was checked and found to be functional and locked. Resident #1 pushed the back door and left. Resident #1 remains out of the facility . Resident #1 was found at a local gas station by law enforcement and brought to a local hospital in the early morning of Saturday July 4, 2020.' Further review of the investigation included 'Immediate Interventions to include - Based on the internal analysis Resident #1 was on the empiric based COVID-19 unit per CDC (Centers for Disease Control and Prevention) guidelines. He was able to push the fire door within the unit to escape Immediate action implemented is a staff member assigned to the area to monitor resident's activity within the unit ensuring their safety until alternate interventions are implemented.' On 07/13/20 at 11:00 AM, an observation was conducted of the Observation unit located on a hallway of the West Wing separated by double fire doors. Signs on the door read Droplet Precautions. Looking through the glass window in the door revealed an empty hall with no staff members present. Double fire exit doors were observed at the end of the hall. Observed upon entering the hallway, there was no nursing station, no place for staff to sit or chart and no medication cart. The doors to resident rooms were wide open. There were no staff members present in any of the rooms. On 07/13/20 at 2:30 PM, an observation was conducted of the Observation unit. Upon walking through the double doors, an alarm could be heard coming from a resident's room however with the doors closed to the West Wing, the alarm was not audible from the other side of the doors. No staff members were present in the Observation unit. Observed in a resident's room half way down the hall was a resident laying horizontal across his bed with the bed alarm going off. The resident's torso was in the middle of the bed with his legs hanging off the left side of the bed. Fall mats were observed on the floor on either side of the bed. Observed from inside the Observation unit looking through the glass window in the door, staff were walking back and forth on the other side however no staff were walking towards or coming into the Observation unit through the double doors. It was not until 2:38 PM, 8 minutes later did a Certified Nursing Assistant (CNA) enter the Observation unit, heard the bed alarm and entered the resident's room to address it. On 07/13/20 at 3:20 PM, an interview was conducted with RN Staff 'L' at her medication cart on the West Wing. An inquiry was made if residents from the Observation unit were allowed to leave the unit to which she stated no, those residents are new admissions so they stay there for 14 days to be monitored for any signs or symptoms of COVID. She further stated all [MEDICAL TREATMENT] residents reside on that unit also because they go out of the facility 3 times a week so they are treated as new admissions every time they leave and come back. An inquiry was made where the medication cart used for the Observation unit is kept to which she stated all medication carts are kept here, at the West Wing nursing station, confirming there is not a dedicated medication cart for that hallway. RN Staff 'L' confirmed the West Wing nursing station is the only nursing station and is used by the nurses working in the Observation unit. Staff L also stated all charting and calls are conducted at the West Wing nursing station and there is not a dedicated nursing station for the Observation unit. On 07/13/20 at 3:25 PM, an interview was conducted with the Administrator and Infection Control Preventionist RN outside of the Observation unit. Entering the double doors with the sign on door reading Droplet Precautions, the Administrator stated residents are not allowed to leave this unit. The Administrator stated the census today on this unit was 12 and there was one nurse and one aide assigned. He confirmed the nursing station on the West Wing was the nursing station for this Observation unit which was delineated by the closed fire doors to the West Wing. A request was made to the Administrator to test the double exit doors which led outside at the end of the hallway to activate the door alarm. The Administrator pushed on the door handle bar and the door opened and a very loud piercing alarm was activated. The Administrator reset the alarm on a touch key pad on the wall and the alarm stopped. He stated the alarmed exit doors are checked by maintenance daily. An inquiry was made to the Administrator how Resident #1 managed to elope through these doors with such a loud alarm to which the Administrator stated the staff did not hear any alarms going off. There were no staff members present in the Observation unit during the interview and demonstration conducted by the Administrator. On 07/14/20 at 11:05 AM, an attempt was made to interview Resident #5 who was Resident #1's roommate on 07/03/20. Resident #5 was no longer residing in the room of the Observation unit that he shared with Resident #1. Reviewing the facility census revealed Resident #5 now resided on the West Wing and had been transferred out of the Observation unit. While on the Observation unit, it was noted there were no staff members present. Resident #18, who now currently resided in the same room that Resident #1 and #5 had, was observed wandering around her room, then out to the hallway, then back into her room, then back out to the hallway. An alarm was going off in her room, undetermined if it was a bed alarm or chair alarm. There were no staff present to redirect the resident back to her room or address the alarm going off in her room. Exiting the Observation unit to locate Resident #5, staff seated at the West Wing nursing station were alerted by this surveyor that an alarm was going off in a resident's room on the Observation unit. On 07/14/20 at 11:10 AM, an interview was conducted with Resident #5, the former roommate of Resident #1, in his room on the West Wing. He stated he moved out of the other room on the other side of the doors a couple of days ago. An inquiry was made about what happened with Resident #1 to which he stated Resident #1 was never in the room, he was always wandering around in his wheelchair. He stated one time Resident #1 threw a chair and broke a phone. He stated he thinks it was around 8:00 AM when the resident left but he was not sure how he got out. Resident #5 stated he does not remember if there were any alarms going off, stating again he was not sure how Resident #1 did it. Review of RN Staff 'N's written statement dated 07/03/20 documented, 'Approximately around 9:30 AM writer noticed a resident, writer asked what he |

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>needed. Resident stated he wanted to speak to the Social Worker (SW). Writer advised resident to go back to his room and writer will notify SW. Resident did not appear agitated or in distress. Resident followed direction and verbalized understanding. Writer watched resident go towards his room. Writer unsuccessful with finding the SW. Writer came to resident's room approximately 9:45 AM to check vital signs and administer medications. Resident not in room. 9:45-10 AM writer asked UM (Unit Manager) about resident. UM informed nurse that is his normal behavior. He likes to self-propel in wheelchair and then he will come back to his room. No alarms heard this shift. With that being said no need for alarm. Writer started accuchecks 11-11:25 AM. Writer went to resident's roommate and asked where's your roommate? Resident (roommate) stated he always leaves. He likes to roll around. Writer looked for resident in therapy room, the bubble room and the atrium. Writer informed UM that she cannot find resident. UM delegated to look on east and west wing. 12-12:15 writer saw DON (Director of Nursing) and informed her about resident. DON assisted writer in rounds to get resident ready for lunch.' On 07/15/20 at 12:44 PM, an interview was conducted with RN Staff 'N' who stated it was her first day working with Resident #1. She stated she was working on her medication cart and Resident #1 stated he wanted to speak to the SW. She told him to go back to his room and she would send the SW to his room. She stated she finished with another resident's medications and then went to the nursing station on the West Wing to look for the SW. She stated when she got back to the resident's room at 9:45 AM, he was no longer there and asked his roommate where he was to which the roommate stated he did not know. She stated she went to the nursing station and the UM said he likes to get around, he'll come back to his room, so she continued with her medication pass. She stated she finished the 9:00 AM medication pass about 11:15 AM. She stated it was her first time working with all those patients and she had only been working in the facility about 2 weeks. She stated she then went to start on her accuchecks and she went to Resident #1's room and he was still not there so she checked therapy, activities, courtyard, then back to the nursing station and told the UM again Resident #1 was still not in his room. She stated she looked everywhere, then saw the DON and told her Resident #1 was not in his room and she said he will be somewhere in the building. RN Staff 'N' stated she checked the gas station next door and everybody was looking around for him. She stated she asked the aide when she last saw him and she was not sure as the resident looked after himself. She stated she did not know the resident was difficult and they know the resident better than her and I was told he will be back to his room. She further stated she knows anyone on that hallway is to stay in their rooms because of [MEDICAL CONDITION] monitoring that is why she let the UM know right away when she found that he was not in his room. An inquiry was made if she knew residents were not allowed to leave the Observation unit because in that unit residents are being monitored for signs and symptoms of COVID and should not be commingling with other residents in the facility, why did she not search for the resident at 9:45 AM when he was not in his room to which she stated she was new and not used to this assignment and she was focused on getting her medication pass done. RN Staff 'N' confirmed she finished her 9 AM medication pass at around 11:15 AM and Resident #1 did not receive his 9 AM medications to include his insulin, because as she documented on the back of the MAR indicated [REDACTED]. She stated it was her first time with Resident #1 and did not know he was capable of eloping, however did confirm Resident #1 was independent with getting around in his wheelchair because she saw him in the hall and wheeling himself back towards his room. An inquiry was made again to RN Staff 'N' had she looked for Resident #1, who should not have been out of his room and commingling with other residents at 9:45 AM, they might have been able to locate him before he went too far, to which she again stated, the UM told her he liked to wander so she was not alarmed. Review of a written statement completed by UM RN Staff 'O' dated 07/03/20 documented, 'Assigned nurse to Resident #1 stated the resident was not in his room. Writer replied resident is encourage to remain in his room and explained to the nurse the resident like to leave his room and is not the first time he like to be out in his wheelchair. Approximately 11:20 AM-11:25 AM writer was informed by assigned nurse she went to do accucheck for the resident roommate the resident was still not in the room. Immediately writer assisted primary nurse to locate the resident. We continue to do extensive search unable to locate resident within the facility.' On 07/15/20 at 1:01 PM, an interview was conducted with UM RN Staff 'O' who stated that day she was at the nursing station doing her usual UM duties and the nurse came up and told her Resident #1 was not in his room and she knew that he sometimes would come to the nursing station or wheel around and you would have to redirect him. When the nurse told me, I said it was not unusual that he was not in his room. Later on, when the nurse went to do accuchecks, she came back and said Resident #1 was still not in his room and she could not find him anywhere. An inquiry was made if she was aware residents residing on the Observation unit should not be allowed to roam about the facility to which she stated the residents on the Observation unit have to be quarantined. An inquiry was made if the residents are quarantined, why did nobody search for Resident #1 at 9:45 AM when RN Staff 'N' alerted her the resident was not in his room, to which she stated Resident #1 was noncompliant no matter how hard we try, he left his room quite often, a couple of times a day. A third inquiry was made if Resident #1 should not have been out of his room or out of the Observation unit, why was there no sense of urgency to locate the resident when he was not in his room at 9:45 AM, to which she stated with some residents no matter how hard you try you can not get through to them. On 7/15/20 at 1:41 PM, a telephone interview was conducted with a family member of Resident #1 who stated Resident #1 was found by the police the next day who took him to the hospital. She stated Resident #1 does not recall anything that happened and has no idea of what went on. She stated Resident #1 was currently living with a family member. On 07/15/20 at 2:30 PM, Resident #18 was observed through the glass window of the fire doors leading to the Observation unit. She was wandering up and down the hallway and walking into other resident's rooms. Upon entering the Observation unit, an alarm was audible and noted to be coming from Resident #18's room. There were no staff present in the unit at this time. Looking out through the glass window from inside the Observation unit, staff were observed walking back and forth in the West Wing hallway, however, no staff were coming into the Observation unit. At 2:35 PM, 5 minutes later, CNA Staff 'Q' entered the Observation unit, and escorted Resident #18 back to her room. On 07/15/20 at 2:37 PM, after CNA Staff 'Q' settled Resident #18 in her room, an interview was conducted. CNA Staff 'Q' stated her assignment today was the Observation unit. An inquiry was made what measures are taken to prevent a resident from eloping to which she stated you have to keep an eye on residents, make sure they are safe and do not wander around and do not try to leave the building. She stated sometimes you have to stay with your residents and check on them more often if they like to wander. On 07/15/20 at 3:30 PM, an interview was conducted with CNA Staff 'R' on the West Wing and an inquiry made what measures are taken to prevent a resident from eloping. CNA Staff 'R' stated you have to make sure residents are safe and do not let them wander. She stated sometimes you have to stay with them and check on them more to make sure they are alright. On 07/15/20 at 3:40 PM, an interview was conducted with RN Staff 'P' working on the West Wing and an inquiry made what measures are taken to prevent a resident from eloping. RN Staff 'P' stated for some residents they use bed and chair alarms to ensure their safety and if you hear an alarm going off, check it immediately. She further stated if a resident is on medications that could affect their thinking, like antipsychotics and antianxiety, those residents have to be checked more often because their behavior could change quickly. On 07/15/20 at 3:45 PM, a further observation was conducted of the Observation unit. Resident #18 was again observed through the glass window of the fire doors leading to the Observation unit. She was wandering up and down the hallway and walking into other resident's rooms. Upon entering the Observation unit, an alarm was again audible and noted to be coming from Resident #18's room. There were no staff present in the unit at this time to attend to Resident #18 and redirect her to her room. Looking out through the glass window from inside the Observation unit, staff were observed walking back and forth in the West Wing hallway, however, no staff were coming into the Observation unit. At 3:53 PM, 8 minutes later, CNA Staff 'R' entered the Observation unit, and escorted Resident #18 back to her room. On 07/15/20 at 4:15 PM, during the exit with the Administrator and Infection Control Preventionist RN, Resident #1's elopement was reviewed. The Administrator was apprised after speaking with RN Staff 'N', had she searched for Resident #1 at 9:45 AM when he was not in his room, and not wait until after 11:00 AM, there would have been a better chance of discovering the resident wheeling around outside. Further, the UM RN Staff 'O' failed to take the resident's disappearance seriously at 9:45 AM when she was informed by the RN Staff 'N'. Resident #1 was allowed to leave his room despite the fact that he was on the Observation unit and should not have been wandering around the facility. The Infection Control Preventionist RN confirmed residents on the Observation unit are not allowed to leave that unit. The double doors to the observation unit have Droplet Precaution signs posted, yet it is not a dedicated unit, there is no place for staff to be able to monitor or supervise the residents, nurses use the West Wing nursing station and the medication cart is stored at the West Wing nursing station. Further, observations of residents in the Observation unit with bed or chair alarms activated with no staff around to address the alarms or redirect the residents. Additionally, when the Observation unit doors are closed you cannot hear what is going on behind them unless you are located in the Observation unit was relayed. The Administrator had no comment. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.** |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, record reviews and review of the Centers for Disease Control and Prevention (CDC) infection prevention guidance, the facility failed to implement proper infection prevention and control practices to prevent the development and transmission of the COVID-19 virus when 4 confirmed cases of COVID-19 of staff testing positive were identified in the facility, as evidenced by failing to follow CDC guidance to ensure face masks are covering the mouth and nose; and failing to identify the need to implement isolation precautions for persons under investigation (PUI) for those 25 residents identified as being cared for by the staff members who tested positive. Further, by permitting residents to congregate throughout the facility without wearing face masks covering their mouths and noses, increases the risk of potential transmission and contracting the COVID-19 virus for residents residing in the facility and the staff members who work in the facility. The facility census on 07/13/20 was 103. The findings included: Individuals who are [AGE] years and older, those with chronic underlying medical conditions, and those living in nursing homes are at high risk for developing serious complications from COVID-19 illness. Individuals who are infected could develop serious disease with difficulty breathing, and might require intensive care for the treatment of [REDACTED]. COVID-19 infection can lead to death. COVID-19 is a new disease, caused be a new Coronavirus that has not previously been seen in humans. Currently, there is no vaccine and no approved treatment for [REDACTED]. Review of the CDC guidance for use of Personal Protective Equipment (PPE) updated June 9, 2020 documents under Face Mask Do's and Don'ts for Healthcare Personnel (HCP): When putting on a face mask clean your hands and put on your face mask so it fully covers your mouth and nose. When wearing a face mask, don't do the following - Don't wear your face mask under your nose or mouth; Don't touch or adjust your face mask without cleaning your hands before and after. Review of the CDC guidance titled 'Implement Source Control (use of a cloth face covering or face mask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they are talking, sneezing or coughing) Measures' updated June 25, 2020 states - HCP should wear a face mask at all times while they are in the facility. Residents should wear a cloth face covering or face mask (if tolerated) whenever they leave their room, including for procedures outside the facility. Review of the CDC guidance Clinical Questions and Answers updated as of 07/07/20 states 'If a HCP at the facility was recently diagnosed with [REDACTED].' A Focused Infection Control survey and complaint survey was conducted at the facility on 07/13/20 through 07/15/20. Upon entering the facility on 07/13/20 at approximately 9:30 AM, the receptionist conducting the COVID-19 screening process and obtaining essential visitor temperatures upon entry to the facility, was wearing her face mask positioned under her nose. When she was reminded to ensure her nose and mouth are covered by the face mask, she immediately repositioned her face mask to cover her nose. She did not perform hand hygiene before or after doing so. On 07/13/20 at 9:45 AM, during the entrance meeting with the facility Infection Control Preventionist Registered Nurse (RN), observed through the conference room door was a Certified Nursing Assistant (CNA) Staff 'A' pulling a wheelchair behind her and walking Resident #3 in front of her down the hallway. Resident #3's mask was observed positioned below his nose. An inquiry was made to the Infection Control Preventionist RN what the resident was doing walking in the hallway. She confronted CNA Staff 'A' who stated she is a restorative nursing aide and she assists the resident walking every other day. CNA Staff 'A' and Resident #3 were reminded the face mask needs to be positioned over the mouth and nose. Resident #3 repositioned his face mask to cover his nose. He was not provided with hand hygiene after doing so. Further during the entrance meeting on 07/13/20 at 9:55 AM with the Infection Control Preventionist RN, and now joined by the Administrator, she stated they have been notified of 4 staff members who have tested positive for the COVID-19 virus. She stated 2 day shift CNAs and 1 evening shift CNA who worked on the East Unit tested positive on 07/09/20 and one other staff member who has no direct hands on care with residents, tested positive on 07/11/20. She further stated they will be testing all 177 staff on 07/14/20 and 07/15/20 and all residents on 07/16/20. The Administrator stated they do not have a dedicated COVID unit, however, are using a hallway on the West Wing as their 'Observation unit' for all new admissions to the facility and 5 [MEDICAL TREATMENT] residents. The Administrator stated the new admissions will be under observation and monitored for 14 days for any signs or symptoms of [MEDICAL CONDITION] as they were admitted from the hospital, and the [MEDICAL TREATMENT] residents now reside on this unit because they go out of the facility 3 times a week. Review of the CNA Assignment Sheets from July 6 through July 9 revealed the 2 day CNAs and 1 evening CNA who tested positive for COVID-19 as of July 9, cared for residents residing on the East Wing in rooms 107 through 114 and 118 through 128. Review of the facility resident census for July 13, revealed a total of 25 residents reside in these rooms on the East Wing. On 07/13/20 at 10:05 AM, a facility tour commenced starting on the East Wing. Most doors to resident rooms were open, in particular rooms 107 through 114 and 118 through 128. Of the resident rooms potentially exposed, there is one private room, 9 semi-private rooms and 2 rooms that houses 4 beds. Some of the residents in the rooms were wearing a face mask, some were wearing their masks below their noses and some were not wearing a mask at all. The 25 residents residing in these rooms should have been treated and considered as persons under investigation (PUI) and placed under isolation conditions when the facility was informed on 07/09/20 that 3 CNAs who tested positive for COVID-19 cared for these 25 residents. On 07/13/20 at 10:10 AM, Resident #4 who resides on the West Wing, was observed off the main dining room seated in a wheelchair next to the sliding doors to the patio. Her face mask was positioned below her nose. This hallway is a main thorough fare between the East and West Wings, activity room, the main dining room area and therapy gym. Nursing and therapy staff were observed walking past Resident #4 with no staff reminding or assisting the resident to reposition her mask over her nose. Seated against the wall next to the activity room was Resident #5. His face mask was positioned below his nose. An interview was conducted with Resident #5 who stated he is just sitting here waiting for his ride to the [MEDICAL TREATMENT] center. To the right of Resident #5 was the activity room. Inside the activity room, Resident #6 was observed reading a newspaper. Her face mask was positioned below her nose. Resident #6 resides on the East Wing. Also, in the activity room was Resident #7 seated in a wheelchair a couple of feet away from Activity Aide Staff 'B'. His face mask was positioned slightly below his nose and there was not six foot distancing between them. Resident #7 resides on the East Wing in one of the rooms which had potential exposure from the CNAs who tested positive. An interview was conducted with Activity Aide Staff 'B' inquiring why these residents were out of their rooms to which she stated the residents are allowed to be out of their rooms if they are wearing a face mask. It was pointed out to Activity Aide Staff 'B' Resident #6's face mask is positioned below her nose. Activity Aide Staff 'B' did not make any attempt to remind the resident to reposition her face mask or assist the resident with repositioning her face mask over her nose. On 07/13/20 at 10:15 AM, an interview was conducted with Registered Nurse (RN) Unit Manager Staff 'C' on the East Wing. She stated residents are allowed to be out of their rooms if they are wearing a mask. She was wearing her face mask below her nose while speaking with a nurse at the nurse's medication cart. The medication cart was situated next to Resident #10's room, which is one of the rooms which had potential exposure from the CNAs who tested positive. Resident #10 was seated in his wheelchair at the door threshold to the hall and right next to the nurse's medication cart that she was working at. Resident #10 was wearing his face mask positioned under his nose. The nurse at the medication cart and the RN Unit Manager did not remind the resident to reposition his face mask or assist the resident with repositioning his face mask over his nose or encouraging the resident to go back into his room. On 07/13/20 at 10:18 AM, a kitchen tour observation was conducted with the Food Service Director (FSD) who was wearing his face mask below his nose. The FSD was reminded to ensure his face mask was covering his nose. He proceeded to reposition his face mask over his nose and after doing so did not perform hand hygiene. An observation was made of Dietary Aide Staff 'D' at the 3 compartment sink washing pots with her face mask positioned below her nose. Dietary Aide Staff 'E' was observed cleaning the breakfast food carts with her face mask positioned below her nose. The FSD concurred these dietary staff needed to ensure their face masks were positioned properly on their faces. On 07/13/20 at 10:20 AM, observation was made of the therapy gym. Two residents were observed seated in wheelchairs wearing face masks. One of the residents who was working on the omnicycle periodically would reposition her face mask with her right hand then would grasp the handlebar again. Resident #8, who resides on the East Wing, was observed seated in a wheelchair against the middle wall wearing her face mask below nose. She was observed to pull up her right pant leg to reveal a right lower shin wound with the dressing barely attached to her leg with her wound oozing purulent yellow drainage. She was observed to touch around the oozing wound, then touched her pants then her wheelchair armrest. A therapy staff member observed the resident doing this and stated to the resident she needed to go back to her room to have the dressing replaced and directed Rehabilitation Technician Staff 'F' to take the resident back to her room before she had her therapy session. The resident proceeded to pull her right pant leg back down. Rehabilitation Technician Staff 'F' donned a pair of gloves and proceeded to take the resident back to her room. Resident #8 was not offered hand hygiene after coming in contact with the oozing purulent yellow drainage from her leg wound. Rehabilitation Technician Staff 'F' wheeled Resident #8 out of the therapy gym to return her to her room on the East Wing. Resident #8 was |

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|---|---|---|---|
| | 105237 | A. BUILDING _____ B. WING _____ | 07/15/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>not reminded to reposition her face mask or assisted with repositioning her face mask over her nose before she was wheeled out of the therapy gym. On 07/13/20 at 10:23 AM, while in the therapy gym, an interview was conducted with the Director of Rehabilitation who was wearing his face mask positioned below his nose. He was reminded to ensure his face mask was covering his nose and mouth. He proceeded to reposition his face mask over his nose and did not perform hand hygiene after doing so. He stated they clean all therapy equipment after each use with disinfectant wipes and housekeeping does periodic cleaning in the therapy area. He could not provide specifics as to how often housekeeping cleaned the therapy gym which was a high traffic area as therapy was still being conducted in group settings. On 07/13/20 at 10:30 AM, an observation was conducted in the laundry room. Laundry Aide Staff 'G' was observed in the dryer area folding clean linens. Her face mask was positioned below her nose. A request was made to see the washer area. She opened the door leading to the washer area, then proceeded to open the door to the dirty linen delivery area. She then opened the door back into the clean area, then went back to folding clean linen. At no point did she perform hand hygiene after touching the doorknobs or touching her face mask after several times repositioning her face mask over her nose. An inquiry was made if there is any hand sanitizer available, and looking around the room she stated usually there is a bottle on the table but they must have run out over the weekend and have not replaced it yet. On 07/13/20 at 11:00 AM, observation was made of the West Wing Observation unit. The Observation unit was a hallway of the West Wing cordoned off by double fire doors. A sign on each door read 'Droplet Precautions'. Inside the double doors, all resident doors were wide open. The census on this unit was 12. There were no staff members present. There were no supply of gowns, additional masks or red biohazard trash bags to be seen anywhere. There was no charting or resting area to accommodate nursing staff. There was no medication cart in the hall indicating the medication cart was stored at the nursing station on the West Wing and not dedicated to this cordoned off hallway. Review of the facility Coronavirus (COVID-19) Infection Control policy dated reviewed and revised on 03/12/2020 states in part, 'Policy: follows the CDC's recommendations to protect our residents from respiratory disease including Coronavirus disease 2019 (COVID-19). Patient Placement: When a resident is positive or suspected to be positive for COVID-19, the resident should be in a private room unless this is not possible. Personnel entering the room will use PPE (personal protective equipment), including respiratory protection. Only essential personnel will enter the resident's room. The facility will consider caring for these residents with dedicated HCP (healthcare personnel) to minimize risk of transmission and exposure to other residents and other HCP. On 07/13/20 at 11:10 AM, Resident #9 residing on the East Wing was observed seated in her wheelchair outside her room. Her face mask was positioned below her nose. The resident room across the hall from Resident #9's was observed to have a PPE (personal protective equipment) caddy hanging over the resident's door indicating the resident was under isolation precautions. The resident's door was wide open. On 07/13/20 at 11:12 AM, observation was made of Laundry Aide Staff 'H' on the East Wing go into a resident's room delivering resident clothes. She was observed in the room with her face mask positioned below her nose. When she came to the doorway an interview was conducted with her, with her face mask still positioned below her nose. An inquiry was made how often resident clothes are laundered. As she started to talk, she took her face mask right off her face holding it in her right hand, and stated resident clothes are washed and delivered daily. When she was finished talking, she put the mask back on her face, went to the clothes cart and proceeded to deliver hangers of clothes to resident rooms down the East Wing hallway. At no point did she perform hand hygiene after touching her face and mask and continued to deliver resident clothes room to room. On 07/13/20 at 11:15 AM, an interview was conducted with Unit Manager RN Staff 'C' and an inquiry made about what kind of isolation was across from Resident #9's room. Unit Manager RN Staff 'C' was wearing her face mask positioned below her nose while talking. She stated the resident is in isolation for ESBL (Extended-spectrum beta-lactamases) in the urine so the door does not need to be closed unless they are working with her for privacy. On 07/13/20 at 11:16 AM, Resident #10, residing on the East unit in one of the rooms potentially affected by the positive CNAs, was observed still seated in his wheelchair at his door threshold. His face mask continued to be positioned below his nose. A couple of nursing staff walked by and an aide walked by pushing a hoyer lift and nobody directed or assisted the resident to place his mask up over his nose or encourage the resident to stay inside his room. On 07/13/20 at 11:17 AM, Rehabilitation Technician Staff 'F' was observed wheeling a resident in a wheelchair down the hallway past the glass sliding doors leading to the patio and past Resident #4, who was still seated there with her mask positioned below her nose. Rehabilitation Technician Staff 'F"s face mask was positioned below his nose. Stopping next to Resident #4, he was then observed to reposition his mask over his nose then kept on wheeling the resident in the wheelchair down the hall to the therapy gym. He did not perform hand hygiend before or after touching his mask, then touched the resident's wheelchair and doorknob into the therapy gym. On 07/13/20 at 11:18 AM, a resident seated in a wheelchair was greeted in the hallway across from the therapy gym. He identified himself as Resident #11. Resident #11 resides on the East Wing. His face mask was positioned below his nose. Therapy staff were observed walking by and not directing or assisting the resident to reposition his face mask properly. On 07/13/20 at 11:19 AM, observation was made of Occupational Therapist (OT) Staff 'J' in the therapy gym with gloves on wiping down an omnicycle with a wipe, disposed of the wipe in the trash, went to a resident seated in a wheelchair next to the omnicycle, touched his hand, arm and wrist bracelet then took off her gloves. She was not observed to perform hand hygiene after cleaning the omnicycle, touching resident or after taking her gloves off. The OT then proceeded to put on gloves and start working with the same resident. On 07/13/20 at 11:20 AM, an additional observation was conducted in the kitchen. Dietary Aide Staff 'D' who was observed earlier washing pots with her face mask positioned below her nose, was now observed pouring cooked mixed vegetables into a large square metal container for the steam line. Her face mask was again positioned below her nose. At this time the FSD arrived into the kitchen wearing his face mask below his mouth. He was reminded to place his face mask over his mouth and nose which he did immediately however did not perform hand hygiene before or after doing so. The FSD observed Dietary Aide Staff 'D' wearing her face mask positioned below her nose and told her to put her mask above her nose. She removed her oven mitts, repositioned her face mask over her nose, put the oven mitts back on then carried on, putting the vegetable container into the steam line. The FSD was advised by this surveyor that Dietary Aide Staff 'D' needed to perform hand hygiene after touching her face and face mask. The FSD stopped Dietary Aide Staff 'D' from continuing on with the vegetables and told her she needed to wash her hands. In the presence of the FSD, she removed her oven mitts, went to the sink, turned on the water, spritzed soap into her right palm and immediately rinsed her hands under the water for 3 seconds, pulled out 3 paper towels, dried her hands and turned off the tap, then lifted the lid of the trash can with her right hand, then realized there was a foot pedal, then used the foot pedal to dispose of the used paper towel. She then proceeded back to the steam table to carry on working. An inquiry was made to the FSD if he was satisfied with the way Dietary Staff 'D' washed her hands to which he indicated he was not and directed her to wash her hands again. She went back to the sink and spritzed soap in her hands, then immediately rinsed her hands under the water for 10 seconds. She then took 3 paper towels, turned off the tap and then dried her hands with the paper towels she used to turn off the tap. She then proceeded back to the steam table. An inquiry was made again to the FSD if he was satisfied with the way she washed and dried her hands to which he stated 'No'. The FSD went over to Dietary Aide Staff 'D' and directed her to wash her hands for the third time. On 07/13/20 at 11:23 AM, Resident #12 was observed in a wheelchair in the activity room with her face mask positioned below her nose. There were 2 activity staff present and asking her to put the face mask on her face however they were not physically getting up to assist the resident. There were 2 other residents present in the activity room with face masks on however they were seated less than 6 feet apart from each other. The Activity Director then arrived to the activity room and he was advised that Resident #12 should not be in the room with others without her face mask on properly and not 6 feet apart. He proceeded to remove the resident from the activity room and placed her outside the activity room door. He did not attempt or assist the resident with putting her face mask above her nose. He did not perform hand hygiene after touching the resident's wheelchair. On 07/13/20 at 12:55 PM, observation was made of a resident wheeling himself down the East Wing hallway with his mask positioned under his chin. Staffing Coordinator Staff 'J' was observed walking down the East Wing hall with her mask positioned under her nose. An inquiry was made to her who this resident was to which she identified the resident as Resident #13 who resides on the East Wing. Staffing Coordinator Staff 'J' stopped in front of Resident #13 with her face mask below her nose and his face mask under his chin and told him to put his face mask over his nose, which he did while making comments. Resident #13 was not offered hand hygiene after touching his face mask. Staffing Coordinator Staff 'J' carried on down the hall with her face mask below her nose. On 07/13/20 at 12:57 PM, observation was made of rooms 107 to 114 and 118 to 128 on the East Wing, the rooms potentially affected by the 3 positive CNAs. All residents residing in those rooms had their doors wide open. Some residents were in their rooms, some were not, some were wearing masks, some were not. On 07/13/20 at 1:00 PM, observation was made of a staff member at the West Wing nursing station desk with her face mask positioned down and off her mouth while she was flipping through some papers and talking to |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 5)<br>other 2 nurses who were less than 6 feet away. She continued to talk in the surveyors presence, then after approximately 30 seconds finally put her mask over her face to cover her mouth and nose, then continued flipping through some papers and talking to the 2 other nurses. The staff member did not perform hand hygiene after replacing her face mask on her face. The staff member identified herself as Restorative Licensed Practical Nurse Staff 'K'. On 07/13/20 at 2:00 PM, a walk- through of the East Wing was conducted. All the doors to resident rooms 107 to 114 and 118 to 128 remained wide open. Some residents were not in their rooms. Of the residents observed in their rooms, some residents were wearing face masks, some were not. On 07/13/20 at 3:00 PM, a resident residing on the East Wing in one of the rooms between 118 and 126 was seated in her wheelchair at the threshold to her room. Her face mask was below her nose. Staff were observed walking back and forth in front of her seated at the threshold to her room, with no staff stopping to remind or assist the resident with repositioning her face mask above her nose. The resident was observed to swipe and scratch under her nose with her right hand, then touched the arm of the wheelchair, then scratched her left arm. The resident did not perform hand hygiene after swiping under her nose and continued to wear the face mask under her nose. On 07/13/20 at 3:18 PM, a second visit was conducted in the laundry room at change of shift. 3 Laundry Aides were observed seated in the clean linen area next to the dryers. 2 Laundry Aides had their face masks positioned below their noses. Upon seeing this surveyor, the 2 Laundry Aides immediately pulled their face masks above their noses. Not observing any hand sanitizer bottle in the area or on the side table, an inquiry was made if they had hand sanitizer available. One Laundry Aide stated We need one. He's looking for it. She could not provide specifics of who He was, but confirmed there was still no hand sanitizer available for use in the clean laundry dryer/folding area. On 07/13/20 at 3:20 PM, an interview was conducted with RN Staff 'L' at the West Wing nursing station. RN Staff 'L' confirmed this nursing station was used by the nurses assigned to residents residing on the West Wing Observation unit. An inquiry was made if residents from the Observation unit are allowed to leave the unit to which she stated the residents stay there for 14 days if they are new admissions from the hospital and are being observed for any signs or symptoms of [MEDICAL CONDITION] and the [MEDICAL TREATMENT] residents are on that unit too as they go out<br>of the facility 3 times a week. She stated because they go out 3 times a week they have to be on isolation. On 07/13/20 at 3:25 PM, observation of the Observation unit was conducted with the Administrator and Infection Control Preventionist RN. The signs on the 2 double fire doors read Droplet Precautions. The Administrator stated the staffing on this Observation unit is generally one nurse and one aide, stating the census today was 12. The Administrator confirmed the nurse assigned to the Observation unit used the West Wing nursing station and there was not a dedicated nursing station for this hallway. In addition, the medication cart is housed at the West Wing nursing station when not in use. He confirmed residents are not allowed off this unit or out of their rooms as they are monitored for 14 days for signs and symptoms of illness.<br>Observations revealed there were still no gowns, additional gloves or red biohazard trash bags available anywhere. The Infection Control Preventionist RN stated if there was going to be any wound care dressing changes or any splashing of bodily fluids, the nurses would bring in a reusable washable gown and would bring in a red biohazard trash bag into the room. Despite the Droplet Precaution sign posted on the double fire doors, the Observation unit was essentially observed as just a hallway with the doors closed with no other infection control measures implemented to include the availability of gowns, gloves, face shields or red biohazard trash containers to dispose of potentially contaminated items. On 07/13/20 at 3:28 PM, an observation was made of the Activity Director talking to a resident, who was not wearing a mask, seated in her wheelchair at the door of her room on the West Wing. The Activity Director's face mask was positioned as the tip of his nose. On 07/13/20 at 3:30 PM, observation was made of Physical Therapy Assistant (PTA) Staff 'M' bring in a resident to the therapy gym in a wheelchair. She set the resident up by the omnicycle, touched his shoulder and hand and then retrieved a pair of gloves which she donned. She did not perform hand hygiene prior to putting on the gloves and after having touched the resident and his wheelchair. An inquiry was made to PTA Staff 'M' about the different therapies and she confirmed all Physical Therapy and Occupational Therapy is conducted for all residents in the therapy gym with the exception of those residents residing on the Observation unit on the West Wing as they are under observation for 14 days, so therapy is conducted in the resident rooms on that unit. On 07/14/20 at 10:55 AM, Resident #10, was observed seated in his wheelchair at the threshold of his room door on the East Wing. Resident #10's face mask was positioned below his nose. Staff and residents were observed passing by back and forth with some staff wearing masks over their noses and some with their masks below or at their noses. On 07/14/20 at 11:00 AM, the list obtained on 07/13/20 at 3:30 PM of residents receiving therapy was reviewed. Of the 44 residents listed as actively receiving skilled therapy services, 8 of those residents resided on the Observation unit on the West Wing therefore therapy services would be conducted in the resident's rooms. Of the 36 remaining residents on the therapy case load that were not residing on the Observation unit on the West Wing, 8 of those 36 residents resided in rooms 107 through 114 or 118 through 128 and were actively receiving physical therapy or occupational therapy services provided in the therapy gym in the presence of other residents and therapy personnel. On 07/14/20 at 11:10 AM, 2 of the 8 residents identified receiving therapy services in the therapy gym and residing in rooms 107 through 114 or 118 through 128 were observed in their rooms, Resident #14 and Resident #15. The other 6 residents were not observed in their rooms. On 07/14/20 at 11:14 AM, Resident #14, residing in a potentially exposed room between 107 and 114, was observed in his semi-private room with the door wide open. The resident's eyes were closed so he was not interrupted. Resident #14 was identified as receiving physical therapy services 3 times a week. On 07/14/20 at 11:16 AM, Resident #15, residing in a potentially exposed room between 107 and 114 was observed in his room with the door wide open. The room was semi-private however Resident #15 was the only resident residing in the room. Resident #15 was wearing a face mask positioned below his nose. An interview was conducted with him and he confirmed he goes to therapy 3 times a week stating, They come and get me and take me down there. Resident #15 was identified as receiving Occupational Therapy services 3 times a week. On 07/14/20 at 11:40 AM an interview was conducted with the Director of Rehabilitation. He confirmed that all residents receiving therapy services have been receiving their therapy in the therapy gym with the exception of those residents residing on the Observation unit on the West Wing who receive their therapy in their rooms. Briefly going over the list with the Director of Rehabilitation, it was additionally confirmed Resident #16 receives occupational therapy in the therapy gym 3 times a week and Resident #17 receives occupational therapy 5 times a week in the therapy gym. Both residents reside in rooms 107 through 114. Further, Resident #17 resides in a room with 4 other residents. During the interview with the Director of Rehabilitation, an inquiry was made if he was aware the residents in rooms 107 through 114 and 118 through 128 had possible exposure to the [MEDICAL CONDITION] from their CNAs to which he had no comment. On 07/14/20 at approximately 12:45 PM, during an interview conducted with the Administrator, he stated he hoped there were less observations of residents outside of their rooms. He stated they are working on it but have a way to go yet. On 07/14/20 at 2:50 PM, a representative from the Broward County Department of Health (DOH) was conducting an onsite Infection Control visit at the facility. She identified herself as an epidemiologist. During an interview conducted with her and the facility Infection Control Preventionist RN, the issue of observations of staff and residents wearing their masks under their noses or chins was discussed. The DOH epidemiologist stated when she arrived the woman who did her screening was wearing her mask under her nose. She stated that staff person is the first person you see and is not an example of the correct way to wear a mask. She further stated it does not protect you and it does not protect others if your nose is uncovered. Further, the issue of residents with possible exposure to the [MEDICAL CONDITION] were being allowed to leave their rooms and attend therapy in the therapy gym was discussed. The DOH epidemiologist stated all residents with potential exposure should be kept in their rooms and are considered persons under investigation (PUIs) until such time they can be tested for [MEDICAL CONDITION]. The Infection Control Preventionist RN indicated she was not aware of this guideline. She further stated they will be testing all residents on 07/16/20 to include the resi |