STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395570	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MILTON REHABILITATION AND NURSING CENTER	**743 MAHONING STREET MILTON, PA 17847**

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and resident and staff interview, the facility failed to have sufficient nursing staff, with the appropriate competencies and skills sets, to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident on one of two nursing units (West). Findings include: Interview with Employee 3 (nurse aide) on August 14, 2020, at 9:58 AM revealed that the shift started with four nurse aides at 7:00 AM, that breakfast was served at 8:00 AM, and that breakfast is typically not completed until 10:30 AM. Employee 3 stated that it is impossible to have resident care done in the one hour between 7:00 AM and 8:00 AM; which means that resident care cannot resume until approximately 10:30 AM. Employee 3 also indicated that the little time between residents finishing breakfast at 10:30 AM and the noon lunch delivery makes providing morning care and transferring residents out of bed difficult before lunch. The interview also indicated that all residents currently on the unit had the [DIAGNOSES REDACTED].g. such as at the nurse's station or assigned 1:1 supervision) due to fall risks. Observation of Resident 58 (who resides on the West nursing unit) first identified her call bell as activated on August 14, 2020, at 9:49 AM. Continued observation of Resident 58's room on August 14, 2020, at 10:23 AM, revealed that Employee 3 stated to Resident 58 that she would get (her) to the toilet as soon as she found one of the other girls. Observation of Employee 3 on August 14, 2020, at 10:26 AM revealed she was collecting trash from the hallway bin. Employee 3 stated that there is a float nurse aide that is supposed to give additional assistance to the three hallways as needed; however, that float is on the other hallway assisting another nurse aide. Employee 3 obtained the assistance of another staff member and assisted Resident 58 with her toileting needs on August 14, 2020, at 10:33 AM (at least 44 minutes after Resident 58 activated her call bell). Observation of Resident 78 on August 14, 2020, at 10:13 AM revealed she was in bed. Interview with Resident 78 (in the presence of Employee 3) revealed that she intended to get out of bed before lunch. Observation of Resident 78 on August 14, 2020, at 12:33 PM revealed that Resident 78 had her lunch tray delivered while her breakfast tray remained on her overbed table. During this observation, Employee 3 stated that she did not have time to collect her breakfast tray. Interview with Employee 3 on the date and time of the observation revealed that Resident 78 did not get out of bed before lunch because she did not have a partner to assist her in transferring the resident. Observation of the West nursing unit on August 14, 2020, at 11:00 AM revealed two nurse aides arrived on the unit to begin their shift. The two nurse aides reported to Employee 3 to determine their work assignment. Continued observation of the West nursing unit revealed that a conversation continued amongst three nurse aides (including Employee 3) until 11:10 AM, when an interview with Employee 3 revealed that there was no supervisor on this unit to direct the workforce (deciding work and break assignments); requiring them to figure out amongst themselves how to split the workload. The observation indicated that the call bells for Resident 58, 74, and 9's rooms were activated during this time. The interview with the three staff revealed that they did not feel comfortable determining staff assignments; and confirmed that this task distracted their attention from resident care needs (e.g. call bells). During observation of the West nursing unit on August 14, 2020, at 12:20 PM Employee 3 returned from lunch, approached the surveyor, and indicated that three nurse aides errantly went to lunch at the same time. Employee 3 indicated that she believed only two were to go, which would have resulted in four more nurse aides on the unit; however, that did not happen. Employee 3 reiterated that she did not believe that the nurse aides should be responsible for dividing up work and break assignments; however, there were no supervisory staff on the unit to assume the responsibility. The interview indicated that all staff on the unit (except Employee 3) were from agency or contracted companies. Observation of the West nursing unit on August 14, 2020, at 12:17 PM revealed staff transported two residents (one of which was Resident 27) from the East unit to the West unit. Observation of Resident 77 on August 14, 2020, at 12:43 PM, revealed her call bell activated (Employee 3 continued to discuss the room assignment for a transferred resident with Employee 12, licensed practical nurse). Interview with Employees 3 and Employee 12 on August 14, 2020, at 12:45 PM revealed that housekeeping informed them that they needed to make the beds in two resident rooms in order to complete the transfers of the two residents from the East unit to the West unit. Employees 3 and 12 indicated that the rooms did not appear cleaned by housekeeping following the deaths of the previous residents in those rooms; therefore, they would not make the beds or place those residents in those rooms. The interview indicated that they did not know what supervisory staff authorized these room moves during lunch hours; however, there was no supervisory staff on the unit to make these decisions. Employee 3 also stated, (Resident 77) has to pee (use the bedside commode to urinate). The staff positioned Resident 27 at the end of the hallway, in front of Resident 77's door, with her lunch meal on an overbed table. Resident 77's call bell remained activated on August 14, 2020, at 1:00 PM. Interview with Employee 3 on August 14, 2020, at 1:00 PM confirmed that she was assigned two tasks at one time: assist residents with lunch meal trays and make beds on her hallway. Employee 3 indicated that she believed she could not assist residents with their lunch meal when two residents were in the hallway without a room assignment. Employee 3 confirmed that she was unable to assist Resident 78 out of bed as desired before lunch because she did not have a partner to assist her. Employee 3 also confirmed that no one had assisted Resident 77 to the bedside commode yet (at least 17 minutes after her activated call bell) because she did not have a partner. The facility failed to assign and coordinate sufficient nursing staff, with the appropriate competencies and skills sets, to provide nursing and related services to assure resident safety and attain or maintain the highest practicable care for residents on the West nursing unit. 28 Pa. Code 211.12(d)(1)(3)(5)(l) Nursing services
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies and procedures, observation, infection control surveillance documentation, and staff interview, it was determined that the facility failed to implement measures to prevent and/or contain COVID-19 on two of two nursing units (West and East). Findings include: The facility policy entitled, Covid-19 Guidance, version May 18, 2020, Section 1.1d Guidance for Staff Screening for COVID-19 upon Entrance and Exit of Facility, revealed that if team members answer yes to any of the above or have a temperature greater than 100.0 degrees Fahrenheit, they should be provided with a face mask and advised to exit the facility. They should contact their primary care physician and supervisor for testing options as soon as possible. Section 1.1e addresses when an employee can return to work. Section 1.1e Guidance for Health Care Providers (HCP) with Presumed or Confirmed COVID-19 revealed that the symptom based strategy for a symptomatic HCP who has had a suspected or confirmed COVID-19 [DIAGNOSES REDACTED]. HCP who were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive [MEDICAL CONDITION] diagnostic test. The guidance stipulated that staff were to hang used respirators in a designated storage area or keep them in a clean, breathable container, such as a paper bag, between uses. To minimize potential cross-contamination, store

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) respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly. Isolation unit best practices for staff instructed that at the end of the shift, staff should refresh personal protective equipment (PPE: gowns, gloves, masks, and face shields). PPE guidelines should be posted in key areas of the unit. Per Employee 1 (infection control program coordinator), Employee 2 (nurse aide), reported on August 2, 2020, that she had not been feeling well for about one week. Employee 1 stated that upon review of the symptoms indicated to her, that the reported concerns were not the, common, traditional, symptoms of Covid, but she advised Employee 2 to go to her primary care physician or urgent care for testing and potential treatment. Employee 1 indicated that the facility received notification on August 7, 2020, that Employee 2 tested positive for COVID-19 (contagious [MEDICAL CONDITION] infection typically causing respiratory disease). Review of the facility's infection control surveillance line listing revealed that Employee 2 noted as having symptoms on July 25, 2020 (fever, headache, and body aches); and that a test collected August 3, 2020, was positive for COVID-19. Review of Employee 2's Time Card documentation revealed that she worked regular hours on July 26, 27, 29, 30, and 31, 2020, and August 2, 2020. Further review of the facility's infection control surveillance line listing indicated several other staff worked while experiencing known signs and symptoms of potential COVID-19 infection: Employee 3 (nurse aide) noted as having symptoms onset July 25, 2020 (fever, cough, sore throat, and headache); and that a test collected August 1, 2020, was positive for COVID-19. Review of Employee 3's Time Card documentation revealed that she worked eight hours on July 25, 2020 and 7.5 hours on July 26, 2020. Employee 4 (nurse aide) noted as having symptom onset (headache and head congestion) on August 1, 2020; and that a test collected August 4, 2020, was positive for COVID-19. Review of Employee 4's Time Card documentation revealed that she worked 10.25 hours on August 4, 2020, 10 hours on August 5, 2020, 10.25 hours on August 6, 2020, and 10.5 hours on August 8, 2020. Employee 5 (discipline not identified) noted as having symptom onset August 7, 2020 (fever, sore throat, headache); and that a test collected August 10, 2020, was positive for COVID-19. Review of Employee 5's Time Card documentation revealed that she worked 6.5 hours (specified as overtime) on August 8, 2020, and 7.5 hours on August 9, 2020. The facility had not alerted the Department of any staffing crisis/shortages to warrant staff working while symptomatic, or known positive for COVID-19, until August 7, 2020. Centers for Disease Control (CDC) guidelines in effect at the time of the onsite visit stipulated that healthcare providers with mild to moderate illness who are not severely immunocompromised may return to work after at least 10 days have passed since symptoms first appeared, at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) have improved. Healthcare providers who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive [MEDICAL CONDITION] diagnostic test. An entrance conference interview with the Nursing Home Administrator and Employee 1 on August 11, 2020, at 9:15 AM, revealed that the facility converted the West nursing unit to Red isolation zone (highest level of isolation precautions for nursing units with known COVID-19 positive residents requiring the use of gloves, gowns, masks, and face shields) on August 7, 2020. The interview indicated that the facility has initiated the extended use of isolation gowns; and that staff assigned to the West nursing unit utilize a rear exit door to leave and/or re-enter the West nursing unit during their shift. Observation of the West nursing unit (Red zone) on August 11, 2020, at 9:20 AM revealed isolation gowns hanging from the doors of resident rooms 40, 51, 53, and 74. Interview with Employee 7 (registered nurse unit manager) on August 11, 2020, at 9:40 AM revealed that staff were not to store isolation gowns on resident room doors, she did not know if the gowns were clean or had been used, and the shift and staff who utilized the gowns were unknown. Employee 7 removed the gowns identified during the observation. Observation of the West nursing unit rear exit door (designated as the nursing unit's PPE donning and doffing area during the entrance conference interview) revealed a table with gloves and gowns. The area did not have a supply of face shields or facemasks (neither KN95, N95 (face mask designed to achieve a very close facial fit and very efficient filtration of airborne particles), nor surgical masks). The area did not have any signage to indicate that it was the designated area for PPE donning or doffing; or instructional material for staff regarding its use. The area did not include storage (e.g. brown paper bags) for reused PPE such as face shields or respirator masks. The area contained a cardboard box lined with a plastic bag on the floor without any signage to indicate its intended use. The area did not have any readily visible alcohol-based hand sanitizer (ABHS) or handwashing materials. Interview with Employees 3 (nurse aide) and 6 (nurse aide) during the above observation on August 11, 2020, at 9:30 AM, revealed that they were, .winging it. The interview confirmed that staff were to exit and reenter the West nursing unit from this area as needed during the shift. The interview indicated that staff are to wash their hands as needed at the sink in the common lounge/dining room accessible from the PPE donning and doffing area. Observation of the common lounge/dining room on August 11, 2020, at 9:33 AM revealed an empty paper towel dispenser. A shelf above the common lounge/dining room sink contained an unlabeled and uncovered face shield and KN95 mask. Interview with Employee 7 during the above observation on August 11, 2020, at 9:40 AM confirmed that the nursing unit's designated PPE donning and doffing area was not equipped with face shields, face masks, paper bags for storage of reused PPE, paper towels, or signage. The interview confirmed that the facility converted the West nursing unit to a Red zone on Friday, August 7, 2020 (four days earlier); however, she did not have an opportunity to equip the area appropriately. The interview revealed that the intended use for the cardboard box on the floor was for staff to dispose of isolation gowns for laundering as they removed them; however, there was no sign to indicate this. Employee 7 readjusted the plastic bag to reveal the word, Gowns. The interview confirmed that this method allowed aerosolization of the gowns as they were not contained in bins with lids until the housekeeping or laundry department staff collected them for processing. The interview also confirmed no alcohol-based sanitizer (ABHS) in one of two dispensers in the common lounge/dining room. Employee 7 was not aware of any PPE or ABHS supply shortages. Observation during the above interview with Employee 7 on August 11, 2020, at 9:40 AM, revealed Employee 6 utilized the sink in the common lounge/dining room to wash her hands. As Employee 6 identified the absence of paper towels for hand drying, she obtained a wash cloth from an open cart stored in the common lounge/dining room. The washcloths and towels contained on the open cart did not have a covering to protect the items from potential contamination during storage. Observation of the East nursing unit on August 11, 2020, at 10:05 AM revealed Employee 8 (nurse aide) utilizing an electronic wall kiosk device for documentation. Employee 8 did not have gloves on. A sign with the handwritten word, Gowns, was positioned on the wall below the kiosk. Two cardboard boxes lined with a plastic bag were on the floor on the opposite side of the hallway from Employee 8. Neither box had signage to indicate their intended use. Interview with Employee 11 (housekeeping) on August 11, 2020, at 10:05 AM revealed that if she turned one unmarked box around, she exposed the handwritten word, Trash; and if she adjusted the plastic bag on the other unmarked box she exposed the handwritten word, Gowns. Interview with Employee 8 at this time indicated that staff who utilize the kiosk do not want to reach over the cardboard boxes, so, they reposition them on the other side of the hallway. The interview confirmed that staff may doff PPE in this area before leaving the nursing unit. Observation of this area confirmed no visible signage regarding the appropriate use of PPE. Continued observation of the East nursing unit on August 11, 2020, at 10:13 AM revealed Employee 8 completed her task at the kiosk and went directly to the shower room area to retrieve trash and linen bins. Employee 8 walked past three wall mounted ABHS dispensers before pushing the bins onto the nursing unit hallway. The shower room door was equipped with an electronic keypad; however, Employee 8 did not have to enter a code as another staff member entering the room had the door propped open for her. Interview with Employee 8 on August 11, 2020, at 10:13 AM revealed that she did not believe that she needed to perform hand hygiene after touching the kiosk surface because she was only going to retrieve laundry and garbage bins which she considered dirty. The interview confirmed that she would typically need to enter a code on the shower room door keypad to enter the shower room. Continued observation of the East nursing unit on August 11, 2020, at 10:22 AM revealed a linen cart stocked with washcloths, towels, and resident gowns. The cart was equipped with a front flap for covering the cart during storage; however, the front flap was folded on top of the cart. No staff were observed accessing the cart for supplies; however, Employee 8 walked past the cart at 10:24 AM and 10:26 AM. Interview with Employee 8 on August 11, 2020, at 10:26 AM regarding the open linen cart, revealed that it was her opinion that the cart should be covered, that she was assigned center hall, and that her cart is covered there. Employee 8 did not reposition the front flap of the cart to protect the supplies on the linen cart before leaving the hallway. Continued observation of the East nursing unit on August 11, 2020, at 10:31 AM revealed a yellow isolation gown hanging on resident room [ROOM NUMBER]'s door. No staff were available to interview regarding the storage and use of this yellow gown. Observation of the West nursing unit on August 11, 2020, at 2:02 PM revealed a blue isolation gown hanging from resident room [ROOM NUMBER]'s door. Interview with Employee 7 on August 11, 2020, at 2:05 PM confirmed that staff were not to store isolation gowns on resident room doors, she did not know if the gown was clean or had been used, and the shift and staff who utilized the gown was unknown. Interview with Employee 1 on

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) August 11, 2020, at 2:35 PM confirmed that staff are not to store isolation gowns on resident room doors. The interview reiterated that the facility discontinued the practice of intermittent reuse of isolation gowns during a shift on Friday, August 7, 2020; and that the facility had initiated extended use of isolation gowns during a shift. Observation of the Red zone outside entrance/exit located on the East nursing unit side of the facility on August 11, 2020, at 11:17 AM revealed no signage regarding the appropriate use of PPE. Interview with Employee 9 (licensed practical nurse) at the time of the observation confirmed that the area is designated as the PPE donning/doffing location for staff working this Red zone. Employee 9 could not identify any area on this Red zone that was equipped with signage; however, confirmed that the facility positioned signage on the opposite side of dividing plastic, which was not visible when in the area. Employee 9 confirmed that staff are not to cross the dividing plastic to either enter or exit the area. 483.80(a)(1)(2)(4)(e)(f) Infection Prevention Control Previously cited deficiency 3/22/19 and 4/20/18 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's newsletters, facility's website, and staff interview, it was determined that the facility failed to disseminate cumulative updates for residents, their representatives, and families following confirmed staff infections of COVID-19 ([MEDICAL CONDITION] infection typically causing respiratory disease). Findings include: Interview with the Nursing Home Administrator on August 11, 2020, at 9:15 AM and electronic communication with the Nursing Home Administrator on August 12, 2020, at 1:40 PM, requested evidence of the mechanism used to inform residents, their representatives, and families of confirmed or suspected COVID-19 activity (for both residents and staff) in the facility. The Nursing Home Administrator indicated that residents/representatives were informed via a newsletter that they can independently obtain the updated information via a website address which directs the user to the corporate website. The website is updated daily by an outside website manager based on numbers that the facility provides them. Review of the information available on the corporate website on August 12, 2020, revealed the number of facility residents who tested positive for COVID-19; however, did not indicate that the facility had 30 staff also test positive for COVID-19. The facility failed to take reasonable efforts to make it easy for residents, their representatives, and families to obtain the information regarding confirmed staff cases of COVID-19 as required. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights