STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366436	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND AT PROMEDICA FLOWER HOSPITAL CAMPUS	5360 HARROUN SYLVANIA, OH 43560

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 0573 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, review of the facility medical records request forms, review of email correspondence, and review of facility policy, the facility failed to follow their policy to timely release requested medical records timely for one (#100) of two residents reviewed for record requests. The facility census was 66. Findings include: Review of the medical record for Resident #100 revealed an admission date of [DATE] and a discharge date of [DATE]. [DIAGNOSES REDACTED]. Review of the authorization for the release of health information records for Resident #100, dated 06/15/20, revealed a legal representative of the resident requested a copy of the medical records to be picked up in person. Review of email correspondence between the facility and Resident #100's legal representative, dated 07/04/20, revealed the legal representative had not yet received the records requested and again requested the records be released to them. Further review of the email correspondence revealed confirmation from the legal representative that the records were released to them on 07/07/20. Interview on 09/16/20 at 3:56 P.M. with the facility Administrator confirmed Resident #100's medical record was not released to the representative in accordance with the facility policy. The Administrator stated the office staff responsible for processing those requests was off of work during that time causing a delay in releasing the records. Review of the undated facility policy titled Release of Medical Records revealed the patient or legal representative can receive copies of the records, full or partial, upon request and provision of 2 working days advance notice and applicable cost for copies. This deficiency substantiates Complaint Number OH 847 and Complaint Number OH 332.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and review of facility policy, the facility failed to ensure interventions to prevent falls were in place for one (#110) of five residents reviewed for falls. The facility census was 66. Findings include: Review of the Resident #110's medical record revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed for Resident #110, dated 07/06/20, revealed the resident was fully dependent on staff for repositioning and transfers, and was severely cognitively impaired. Review of the care plan for Resident #110, dated 07/20/20, revealed the resident was at risk for falls due to weakness, unsteadiness, cognitive impairment, and immobility. Interventions for this concern included frequent checks from staff, call light within reach, bed in lowest position, and a perimeter mattress in place. Review of the fall assessment dated [DATE] for Resident #110 revealed the resident was at risk for falls due to difficulty maintaining a standing position, impaired balance during transitions, impulsivity, and poor safety awareness. Review of the nurse progress notes for Resident #110 revealed on 07/02/20 the resident was found on the floor by a nurse. Further review of the nurse progress notes for 07/03/20 revealed the resident was found laying on the floor at the bedside. Observation on 09/16/20 at 9:56 A.M. revealed Resident #110 in bed with one bolster on the left side of the resident's bed and a regular mattress in place. The right side of the bed was absent for any type of perimeter or safety devices. The resident was on the right side and notably leaning toward the edge of the bed. Her right arm and head were hanging off the right side of the bed. Interview with Unit Manager (UM) #20 at the time of observation on 09/16/20 at 9:56 A.M. verified Resident #110 was in a compromised position that posed a risk for a fall and the resident had fallen out of bed in the past. UM #20 stated the resident was on a regular mattress but should have had a perimeter mattress in place. Review of the facility policy titled Falls, dated 12/2011, revealed the facility will assess residents for fall risk, develop and revise initial or interdisciplinary care plans, and implement ongoing fall prevention strategies. This deficiency substantiates Complaint Number OH 943 and Complaint Number OH 507.
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 record review, observation, staff interview, review of facility policy, review of the facility isolation tracking worksheet, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to mitigate the transmission of COVID-19 when staff were observed providing care to residents in transmission-based precautions without the use of required personal protective equipment (PPE). This deficient practice had the potential to affect 25 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25) who resided in areas assigned to the observed staff. The facility census was 66. Findings include: 1. Review of the medical record for Resident #2 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessment, dated 09/19/20, revealed the resident was moderately cognitively impaired. Observation on 09/15/20 at 8:29 A.M. revealed an isolation cart outside of Resident #2's room next to the door. A sign displayed on the resident's door read Stop and see the nurse prior to entering. State tested Nursing Assistant (STNA) #40, who was passing resident breakfast trays, entered Resident #16's room with a breakfast tray wearing a face shield and a standard face mask that was not an N95. While in the resident room, STNA #40 assisted the resident with setting up his meal by moving the tray table over the resident's bed. STNA #40 then leaned over the top of Resident #16 to the other side of his bed to grab the telephone, making direct contact with the resident bed and placing herself in a position less than three feet from Resident #2. STNA #40 then performed hand hygiene, exited the resident room, and continued passing trays to residents throughout the hall. Interview on 09/15/20 at 8:55 A.M., STNA #40 verified she entered Resident #2's room without an N95, gown, or gloves. STNA #40 stated she knew the resident was in transmission-based precautions but did not think she needed to don all the required PPE if she was just passing a meal tray. Interview on 09/15/20 at 3:15 P.M., with the Director of Nursing (DON) revealed the facility policy dictates new admissions are to be kept in airborne-droplet isolation precautions for 14 days, even if the resident received a negative test during the admission process. The DON indicated the facility follows the CDC guidelines for PPE and staff must wear, upon entry to the resident room, an N95 facemask, a face shield, gown, and gloves for all new admissions in transmission-based precautions. Review of the facility isolation worksheet which identified new admissions and exposures in the facility that require 14-day isolation, revealed Resident #2 was to maintain isolation precautions from 09/12/20 to 09/25/20. 2. Review of the medical record for Resident #20 revealed an admission date of [DATE]. [DIAGNOSES REDACTED]. Review of the (MDS) 3.0 assessment dated [DATE] revealed the resident was moderately cognitively impaired. Observation on 09/15/20 at 8:10 A.M. revealed an isolation cart outside of Resident #20's room next to the door. A sign displayed on the resident's door read Stop and see the nurse prior to entering. Licensed Practical

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) Nurse (LPN) #30 entered Resident #20's room with his medication wearing an N95 respirator and a face shield. She did not stop at the isolation cart to don any additional PPE prior to entering. LPN #40 then assisted Resident #20 with adjusting his tray table, stood at the bedside within three feet of the resident, and handed the resident his medications. The resident took the medication cup and placed it to his mouth to take the medication and handed it back to LPN #30's ungloved hand. Interview on 09/15/20 at 8:21 A.M., LPN #30 verified Resident #20 was in transmission-based precautions for his new admission status. LPN #30 stated she should have donned a gown and gloves prior to entering the resident's room but forgot to don the additional PPE. Review of the facility isolation worksheet which identified new admissions and exposures in the facility that require 14-day isolation, revealed Resident #20 was to maintain isolation precautions from 09/11/20 to 09/25/20 Review of the facility policy titled COVID-19 Admission Criteria, dated 08/13/20, revealed any newly admitted residents regardless of testing status are to be placed in a private room in airborne-droplet isolation precautions for 14 days. Review of the CDC website guidance titled Responding to COVID-19 in Nursing Homes, dated 04/30/20, revealed newly admitted residents should be monitored in observation for 14 days and cared for using all recommended COVID-19 PPE. Recommended COVID-19 PPE includes an N95 respirator or higher, an isolation gown, gloves, and eye protection. The facility identified 25 residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25) who resided in areas assigned to STNA #40 and LPN #30. This deficiency substantiates Complaint Number OH 708 and OH 196.