STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195562	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREEN MEADOW HAVEN	**1110 RINGGOLD AVENUE COUSHATTA, LA 71019**

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

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to ensure a resident's assessment accurately reflected the resident's status for 1 (#2) of 16 (#1-16) total sampled residents reviewed for accuracy of assessment. The facility failed to identify a left heel pressure ulcer upon admission for Resident #2. Findings: Review of Resident #2's Medical Records revealed admitted [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's MDS (Minimum Data Set) assessment dated [DATE] revealed: - Section M: Skin Conditions - at risk for pressure ulcers YES; (1) unhealed pressure ulcer - unstageable present upon admission - Section N: Medications - Received Insulin injections 7 out of 7 days of look back period. Review of Resident #2's Transferring Facility's Medical Records revealed the following: - July 2020 physician's orders [REDACTED]. - Resident Transfer Form dated 07/27/2020 - Nursing assessment and recommendations: wounds bilateral heels - heel protectors Review of Resident #2's Admitting Facility's Clinical Note dated 07/28/2020 revealed the following: - Chief complaint: admission assessment to establish care - History of present illness: Resident #2 is an [AGE] year old male seen today after admitting to _____ on 7/27 from_____Nursing Facility He has a chronic unstageable wound to his R (right) heel which is compromised due to PAD ([MEDICAL CONDITION]) and diabetic [MEDICAL CONDITION] . Review of Resident #2's Wound Care Assessments failed to reveal assessments or wound care for left heel pressure ulcer from 07/27/2020 - 08/06/2020. Further review of left heel pressure ulcer revealed: unstageable due to slough, 100% (percent) eschar and measuring 5 cm (centimeters) x 5 cm. During an interview on 08/19/2020 at 11:30 AM S6 LPN (licensed practical nurse)/Treatment Nurse reported she was out with COVID-19 from 07/14/2020 - 07/29/2020 and S2 DON (Director of Nursing) or the RN (registered nurse) would have performed wound care. LPN indicated the left heel pressure ulcer was found on 08/07/2020 after Resident #2 hit his heel on the wheelchair. LPN reported that when she was staffing and couldn't get to Resident #2's wound care she could smell it and she stated she was pretty sure it deteriorated from the time of admission until 08/07/2020. During an interview on 08/19/2020 at 12:50 PM S6 LPN/Treatment Nurse confirmed that Resident #2 had 2 pressure ulcers on admission from _____ Nursing & Rehab Center on 07/27/2020 and the pressure ulcer on the left heel was found by her on 08/07/2020. LPN confirmed the left heel wound did not receive wound care from admission on 07/27/2020 until 08/07/2020 and if the wound was new it would not be unstageable. During an interview on 08/19/2020 at 3:00 PM S18 Therapy Director reported therapy was notified Resident #2 had 1 pressure ulcer on his right heel upon admission and was not aware of a pressure ulcer on the left heel until 08/07/2020 when it was discovered. During an interview on 08/20/2020 at 11:15 AM S2 DON acknowledged the left heel pressure ulcer was not assessed on admission and is unable to produce documentation that wound care was administered to the left heel from 07/27/2020 to 08/07/2020.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the written plan of care was followed for 1 (#6) out of 16 (#1-#16) sampled residents reviewed. The facility failed to administer [MEDICATION NAME] 30mg (milligram) injections daily as ordered by the physician. Findings: Review of Resident #6's medical records revealed [DIAGNOSES REDACTED]. Review of Resident #6's physician's orders [REDACTED].) Review of the progress note dated 07/14/2020 by the nurse practitioner revealed the visit's chief complaint was Readmission assessment status [REDACTED]. The history of present illness revealed Resident #6 was readmitted on [DATE] with history significant for [DIAGNOSES REDACTED]. It further stated Resident #6 was determined by the orthopedic surgeon to not be a candidate for surgery and elected non-operative management. A further review revealed the assessment and plan stated: Closed intertrochanteric fracture of right femur, non-surgical candidate per orthopedics. Weight bearing as tolerated. On LMH (low molecular [MEDICATION NAME]) x 2 weeks for [MEDICAL CONDITION] ([MEDICAL CONDITION] [MEDICATION NAME]. Review of Resident #6's July and August 2020 Medication Administration Records revealed no documentation of [MEDICATION NAME] being given. In an interview on 08/18/2020 at 12:10PM, Resident #6 confirmed she fell and broke her right leg in July. She stated she is paralyzed because she had broken her other leg previously. She stated she never leaves her room. In an interview at 11:15AM on 08/20/2020, S2 Director of Nurses reviewed Resident #6's medical record and confirmed she did not receive the [MEDICATION NAME] as ordered on July 11th.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, record review, and interview, the facility failed to have sufficient nursing staff to provide services to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 4 (#2, #7, #8, and #9) out of a total of 4 sampled residents reviewed with wound care orders. The facility failed to ensure wound care was provided as ordered. According to the Resident Census and Conditions of Residents form completed by the facility, there were 5 residents in the facility with pressure ulcers, excluding Stage 1. Findings: A list was provided by the Administrator on 08/17/2020 of staff who tested positive for COVID-19 and it was noted that 30 employees have tested positive and 13 remain still off work or have quit and are not expected to return. . Resident #2 Review of Resident #2's current physician's orders [REDACTED]. Left heel pressure ulcer, unstageable: Clean with wound cleanser, apply Santyl ointment, followed by saline moistened Mesalt gauze. Cover with ABD pad, wrap with kerlix and secure with tape every day and as needed if soiled or dislodged. Left heel abrasion: clean with wound cleanser, cover with ABD pad, wrap with kerlix and secure with tape every day and as needed if soiled or dislodged. Review of the August 2020 eTAR (electronic treatment administration record) revealed wound care was not performed for Resident #2 on 08/15/2020 or 08/16/2020 on the two pressure ulcers or the left heel abrasion. Resident #7 Review of Resident #7's current physician's orders [REDACTED]. Review of Res #7's August 2020 eTAR revealed wound care was not performed on August 15th or August 16th. Resident #8 Review of Resident #8's current physician's orders [REDACTED]. Review of the August 2020 eTAR revealed the wound care was not completed on 08/15/2020 or 08/16/2020, as ordered. Resident #9 Review of Resident #9's current physician's orders [REDACTED]. Apply silver calcium alginate, and cover with ABD pad and wrap with kerlix every other day and as needed if soiled/dislodged. Review of the eTAR for August 2020 revealed Resident #9 did not receive wound care as ordered on [DATE]. In an interview on 08/18/2020 at 5:10PM, S3 ADON (Assistant Director of Nurses) confirmed the facility was short staffed and it has gotten worse. She stated the facility has about 10 CNAs (Certified Nursing Assistants) that have quit either because they were scheduled to work with COVID residents or in a different place than their usual assignmentt. She further stated they have two nurses that have quit and another nurse who is out and hasn't decided if she is coming back or not.

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) She stated they have not been using agency staff but is 99% sure they have signed a contract with a staffing agency but they have not started yet. She said two housekeepers have quit, also. In an interview on 08/20/2020 at 10:27AM, S4 LPN (Licensed Practical Nurse), stated she had spoken with S5 LPN, who worked this past weekend, who told her she didn't think the scheduled wound care nurse came in to do wound care. In an interview at 11:15AM on 08/20/2020, S2 DON (Director of Nurses) was notified of the missing wound care documentation and stated the weekend nurse responsible for doing wound care must not have been here. In an interview on 08/20/2020 at 12:20PM, S1Administator confirmed the facility has been short staffed due to the number of employees who are off work due to COVID-19. He further stated many of those employees have quit after becoming positive. In an interview with on 08/20/2020 at 2:15PM, S1Administrator acknowledged the wound care was not done because the nurse who was scheduled for the weekend called in and didn't come to work.
F 0835 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** Based on record review and interview, the facility failed to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 35 COVID-19 negative residents currently residing in the facility out of a total census of 70 residents. An Immediate Jeopardy situation was identified by the survey team on 08/17/2020 when they observed that there were systemic failures in the facility's Infection Prevention and Control Program to identify and implement measures to help prevent the development and transmission of communicable diseases and infections. The facility allowed residents that tested positive for Covid-19 to remain cohorted in rooms with residents that tested negative for Covid-19, and did not immediately isolate residents that tested positive for Covid-19 from other residents and staff. The facility did not ensure that residents wore masks when out of their rooms, and allowed staff that tested positive for Covid-19 to return to work less than 10 days after receiving the results. The designated Covid-19 unit and rooms outside of the Covid-19 Unit were not identified with transmission based precaution signage. S1 Administrator was notified of the Immediate Jeopardy on 08/18/2020 at 6:55 PM. The Immediate Jeopardy was removed on 08/19/2020 at 3:30PM when the facility submitted the following I.J. Plan of Removal which included: -S1 Administrator and S2 Director of Nurses will conduct twice daily follow up on all COVID test results in the lab portal until the facility has 14 days without any positive cases. -On 08/17/2020 new results were obtained from testing agency. Upon those findings six residents were relocated to a different part of the facility. The Covid unit and Non Covid unit. By doing this we are able to keep positive residents and negative residents separate. -Certified Nursing Assistants (CNAs) responsible for Resident #16 and Resident #3 will monitor their use of front smoking area. A new smoking area for COVID positive residents was created. Monday 08/17/2020 they are both now using the back smoking section located in the COVID positive area. CNAs responsible for their supervision will be listed on schedule. -All Nursing staff on each shift will continue to monitor Resident #15, #16, #3, and #14 for non-compliance and reiterate the importance of social distancing, mask wearing, and hand washing. As listed above there designated CNAs will also continue to monitor while in smoking areas. -On 08/18/2020 staff was in serviced on proper signage on resident's doors that are COVID positive. Attachments were provided to staff for proper use of PPE (personal protective equipment), the importance of PPE that is provided, proper PPE donning and doffing. If COVID positive residents leave their room, make sure they have a mask and please direct them to the appropriate smoking areas. Employee return to work policy which states that employees will be off at least 10 days for quarantine and that all staff will be notified promptly of any positive test results. In servicing will be completed 08/20/2020. -Since the onset of COVID-19 April 10, 2020 Director of Nurses and nursing staff met with residents to explain the importance of wearing mask while in the hallways, social distancing, and hand washing. Nurses and CNAs are continuing to encourage all residents to wear masks anytime they are outside their room or outside around other residents and staff. -The DON, ADON, and Administrator will monitor room assignments daily with the goal of keeping negative rooming together and positives rooming together. -DON, ADON, or designee will monitor notifications daily to NP and MD of positive results as soon as they are received by the facility. -Logs will be created for Administrator, DON, ADON or designee to use daily to ensure proper signage is in place to notify staff and other residents of precaution requirements. The log will be used daily document employee's participation in proper use of PPE and disposal. It will also include a notification section where MD/NP were informed about new cases to residents. This log will continue for the next 4 weeks. -ADON, DON, or designee will conduct all surveillance tracking and trending daily as new cases occur for residents and staff. The purpose of the tracking will be to assist in determining exposure for proper quarantine application. DON and Administrator have revised the return to work policy that states any positive employee will self-quarantine for 10 days with mild cases, 20 days with severe cases. -DON, ADON, and Administrator will continue daily review for updated CDC guidelines to help with quality improvement and to update polices. Policies will be updated based on current information. -In-services will continue to be conducted weekly to inform staff of any changes. QA will be conducted twice weekly for the next four weeks and once weekly until the end of the COVID pandemic. DON, ADON, or designee will conduct daily rounds to ensure staff are hand washing and using gel in between patients and that masks and PPE are used properly. This deficient practice continued at a potential for more than minimal harm for 35 COVID-19 negative residents who resided in the facility. Findings Cross reference findings at F880. A review of the Emergency Plan for Contagion updated 08/01/2020 revealed in part: 5. Per CDC guidelines, mild to moderate symptoms will require a 10 day self-quarantine with return to work on the 11th day. Severe cases will require a 20 day self-quarantine with return to work on the 21st day. 6. Any resident testing positive for COVID-19 will be isolated in the COVID unit. During an interview on 08/17/2020 at 3:20 PM, S2 DON (Director of Nurses) verified that there are negative and positive COVID-19 residents residing on the 400 Hall and no transmission based precaution signage posted. She stated she assumes the nurses are communicating with the CNAs to let them know what the residents' COVID-19 statuses are. In an interview with S1 Administrator on 08/18/2020 at 6:55 PM, S1 Administrator acknowledged these negative residents were cohorted with COVID positive residents. S1 Administrator verbalized he had no place to put them and didn't want to move negative residents who would become positive. He further indicated they had been cleaning the 300 hall since Saturday, August 15, 2020, and it was not ready for use. Also, S1 Administrator acknowledged staff were returning to work before their 10 day self-quarantine was over because they received some bad information and thought the employees could come back to work in 24 hours after testing positive if they were asymptomatic. In a phone interview on 08/20/2020 at 1:30PM, S16 Medical Director confirmed he was unaware COVID-19 negative and positive residents were cohorted in the same room. He acknowledged he was unaware staff were returning to work without waiting the proper quarantine period. He confirmed he would keep COVID-19 positive residents in the COVID area and the negative residents should be separated from the positive residents.
F 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure an effective Infection Prevention and Control Program, including the establishment and implementation of measures to prevent the development and transmission of communicable diseases and infections. This deficient practice had the potential to affect any of the 35 COVID-19 negative residents currently residing in the facility out of a total census of 70 residents. An Immediate Jeopardy situation was identified by the survey team on [DATE] when they observed that there were systemic failures in the facility's Infection Prevention and Control Program to identify and implement measures to help prevent the development and transmission of communicable diseases and infections. The facility allowed residents that tested positive for Covid-19 to remain cohorted in rooms with residents that tested negative for Covid-19, and did not immediately isolate residents that tested positive for Covid-19 from other residents and staff. The facility did not ensure that residents wore masks when out of their rooms, and allowed staff that tested positive for Covid-19 to return to work less than 10 days after receiving the results. The designated Covid-19 unit and rooms outside of the Covid-19 Unit were not identified with transmission based precaution signage. S1 Administrator was notified of the Immediate Jeopardy on [DATE] at 6:55 PM. The Immediate Jeopardy was removed on [DATE] at 3:30PM when the facility submitted the following I.J. Plan of Removal which included: -S1 Administrator and S2 Director of Nurses (DON) will conduct twice daily follow up on all COVID test results in the lab portal until the facility has 14 days without any positive cases. -On [DATE] new results were obtained from testing agency. Upon those findings six residents were relocated to a different part of the facility. The COVID-19 unit and Non-COVID-19 unit. By doing this we are able to keep positive residents and negative residents separate. -Certified Nursing Assistants

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) (CNAs) responsible for Resident #16 and Resident #3 will monitor their use of front smoking area. A new smoking area for COVID positive residents was created. Monday [DATE] they are both now using the back smoking section located in the COVID positive area. CNAs responsible for their supervision will be listed on schedule. -All Nursing staff on each shift will continue to monitor Residents #15, 16, 3, and 14 for non-compliance and reiterate the importance of social distancing, mask wearing, and hand washing. As listed above there designated CNAs will also continue to monitor while in smoking areas. -On [DATE] staff was in serviced on proper signage on resident's doors that are COVID positive. Attachments were provided to staff for proper use of PPE (personal protective equipment), the importance of PPE that is provided, proper PPE donning and doffing. If COVID positive residents leave their room, make sure they have a mask and please direct them to the appropriate smoking areas. Employee return to work policy which states that employees will be off at least 10 days for quarantine and that all staff will be notified promptly of any positive test results. In servicing will be completed [DATE]. -Since the onset of COVID-19 [DATE] Director of Nurses and nursing staff met with residents to explain the importance of wearing mask while in the hallways, social distancing, and hand washing. Nurses and CNAs are continuing to encourage all residents to wear masks anytime they are outside their room or outside around other residents and staff. -The DON, ADON, and Administrator will monitor room assignments daily with the goal of keeping negative rooming together and positives rooming together. -DON, ADON (Assistant Director of Nurses), or designee will monitor notifications daily to NP (Nurse Practitioner) and MD (Medical Director) of positive results as soon as they are received by the facility. -Logs will be created for Administrator, DON, ADON or designee to use daily to ensure proper signage is in place to notify staff and other residents of precaution requirements. The log will be used daily document employee's participation in proper use of PPE and disposal. It will also include a notification section where MD/NP were informed about new cases to residents. This log will continue for the next 4 weeks. -ADON, DON, or designee will conduct all surveillance tracking and trending daily as new cases occur for residents and staff. The purpose of the tracking will be to assist in determining exposure for proper quarantine application. DON and Administrator have revised the return to work policy that states any positive employee will self-quarantine for 10 days with mild cases, 20 days with severe cases. -DON, ADON, and Administrator will continue daily review for updated CDC (Centers for Disease Control) guidelines to help with quality improvement and to update polices. Policies will be updated based on current information. -In-services will continue to be conducted weekly to inform staff of any2 changes. QA (Quality Assurance) will be conducted twice weekly for the next four weeks and once weekly until the end of the COVID pandemic. DON, ADON, or designee will conduct daily rounds to ensure staff are hand washing and using gel in between patients and that masks and PPE are used properly. The deficient practice continued at a potential for more than minimal harm for 35 COVID-19 negative residents who resided in the facility. Findings: A review of the Emergency Plan for Contagion updated [DATE] revealed the following in part: 5. Per updated CDC guidelines, mild to moderate symptoms will require a 10 day self-quarantine with return to work on the 11th day. Severe cases will require a 20 day self-quarantine with return to work on the 21st day. 6. Any resident testing positive for COVID-19 will be isolated in the COVID unit. Cohorted Residents Review of Facility's Room Assignment Logs, Medical Records and Lab Results revealed Resident #1 remained in the same room with Resident #12 who was reported COVID-19 positive on [DATE] at 4PM. Review of Resident #1's room assignments revealed they remained in the same room from [DATE] through [DATE]. On [DATE] Resident #1 moved out of the room with Resident #12 and into the room of Resident #4. Resident #1's lab results revealed COVID-19 positive results were reported on [DATE] at 2PM. Resident #1 remained in the same room with Resident #4 until [DATE] at 4:23PM when Resident #1 was sent to the hospital. Resident #4 became ill and was sent to the hospital on [DATE] at 2:39AM. Resident #4 expired on [DATE] at 6:50AM with [DIAGNOSES REDACTED]. Review of Facility's Room Assignment Logs and Lab Results revealed Resident #3 remained in the same room with Resident #14 who was reported COVID-19 positive on [DATE]. Resident #3 was not moved to a room with a negative resident until [DATE] at approximately 2:25PM. Resident #3 subsequently reported positive on [DATE]. Review of Facility's Room Assignment Logs and Lab Results revealed Resident #6 remained in the same room as Resident #13 who was reported positive for COVID-19 on [DATE] at 1:07PM. These two residents were never separated and Resident #6 subsequently was reported positive on [DATE] at 3:36PM. In an interview on [DATE] at 12:10PM, Resident #6 stated she was never offered to be moved to a different room after Resident #13 tested positive. Review of Facility's Room Assignment Logs, Medical Records and Lab revealed Resident #10 remained in the same room with Resident #11 who was reported positive on [DATE] at 3:52PM. Resident #11 was not moved out of the room with Resident #10 until [DATE]. Resident #10 subsequently was reported positive on [DATE] at 2:02PM. Resident #10 expired on [DATE]. Review of Facility's Room Assignment Logs, Medical Records and Lab revealed Resident #15 remained in the same room with Resident #16 who was reported positive for COVID-19 on [DATE] at 1:07PM. Resident #15 was not moved out of the room until [DATE] at 2:25PM. During an interview on [DATE] at 2:00 PM, S6 LPN/Treatment Nurse confirmed Resident #1 was negative for COVID-19 when Resident #1 shared a room with Resident #12 who was COVID-19 positive. During an interview on [DATE] at 2:00 PM, S5 LPN confirmed residents who were COVID-19 positive were sharing rooms with COVID-19 negative residents on the COVID-19 unit. Resident #2 During an interview on [DATE] at 11:00 AM, S1 Administrator and S2 DON (Director of Nursing) reported all of the residents on the 200 Hall had been negative for COVID-19 until this morning when Resident #2's COVID-19 results came back positive. S1 Administrator confirmed he became aware of Resident #2's COVID-19 positive results the morning of [DATE] and confirmed he was not immediately relocated to the COVID-19 unit upon becoming aware of the resident's results. S1 Administrator verified Resident #2's COVID-19 positive results were reported on [DATE] at 7:12PM but no one checked the portal until [DATE]. During an interview on [DATE] at 11:30 AM, S9 CNA reported she was not aware that Resident #2 tested positive for COVID-19. During an interview on [DATE] at 11:35 AM, S10 LPN (Licensed Practical Nurse) reported she was working the 200 Hall and had not been notified that Resident #2 tested positive for COVID-19. During an interview on [DATE] at 11:35 AM, S2 DON confirmed that she became aware of Resident #2's positive test results on this morning and staff caring for Resident #2 had not been made aware of the positive results. Observation on [DATE] at 11:40 AM revealed Resident #2 in wheelchair sitting outside his room on the 200 hall not wearing a mask and no transmission based precaution signage on Resident #2's door. Observation on [DATE] at 3:00 PM revealed S1 Administrator moving Resident #2 without a mask from 200 Hall to the COVID-19 unit. Staff with COVID-19 Positive Results Review of Facility's Employee COVID positive list, Employee Timecard Reports, and Lab Results revealed the facility allowed S7 CNA (Certified Nursing Assistant) and S8 CNA who tested COVID-19 positive and returned to work before the 10 day quarantine requirement was met. S7 CNA tested positive on [DATE], was sent home on [DATE] and returned to work on [DATE]. S8 CNA tested positive on [DATE] and returned to work on ,[DATE] and [DATE]. S7 CNA and S8 CNA were observed working in the facility on [DATE]. During an interview on [DATE] at 2:05 PM, S8 CNA reported she received COVID-19 positive test results on [DATE] and was sent home. S8 CNA indicated later the same day S2 DON called her and told her to come back to work the next day, [DATE] from 2pm-10pm. S8 CNA reported she called before she came on [DATE] and spoke with S2 DON at 12:40 PM and told S2 DON she would do her 10 days off and come back the following Monday. S8 CNA confirmed S2 DON told her to come in on [DATE] as she is on the schedule and S8 CNA came to work at 1:30 PM. Resident #16 Observations on [DATE] at 2:20 PM revealed Resident #16, a COVID 19 positive resident, on the hallway in her wheelchair not wearing a mask Observation on [DATE] at 2:50 PM revealed Resident #16 sitting in her room. Resident #16 was alert and oriented, pleasant and talkative. In an interview with Resident #16, she reported her roommate Resident #15 tested negative and she tested positive. During an interview on [DATE] at 3:00 PM, S12 CNA reported Resident #16 leaves to go smoke all the time. S12 CNA further indicated she did not know negative residents were in rooms with positive residents and that the residents do not always wear a mask in their rooms. During an interview on [DATE] at 3:25 PM, S13 LPN and S14 LPN verified Resident #16 (COVID-19 positive) goes out to smoke passing through the ,[DATE] Hall to the smoking patio and does not always wear her mask. COVID-19 Positive Unit - 400 Hall During an interview on [DATE] at 2:05 PM, S11 CNA on COVID-19 unit reported she assumes everyone is COVID-19 positive on the 400 Hall because she does not know who is negative and who is positive. Observations on [DATE] at 2:15 PM revealed COVID-19 unit with Resident #3 COVID-19 negative) sharing a room with Resident #14 (COVID-19 positive), Resident #15 (COVID-19 negative) sharing a room with Resident #16 (COVID-19 positive), and Resident #6 (COVID-19 negative) sharing a room with Resident #13 (COVID-19 positive). Observation on [DATE] at 3:00 PM revealed the COVID-19 unit with no transmission based precaution signage on the entrance doors. An area directly outside the COVID-19 unit had one side of the hall with COVID-19 positive residents with no transmission based precaution signage on the doors. During an interview on [DATE] at 3:20 PM, S2 DON verified that there are negative and positive COVID-19 residents residing on the 400 Hall and she assumes the nurses are communicating with the CNAs to let them know what the residents' COVID-19 statuses are. During an interview on [DATE] at 12:10PM, Resident #6 stated she was never offered to be moved to a different room after Resident #13 tested positive. During an interview on [DATE] at 3:23 PM, Resident #15 reported that she was moved out of room on the 400 Hall on [DATE].

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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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) During an interview on [DATE] at 3:25 PM, S14 LPN reported she did not know which residents were positive or negative on the 400 Hall, but there is a list they give her each day. S14 LPN indicated she does not know if residents wear masks in their rooms. During an interview on [DATE] at 3:34 PM, S2 DON reported she was aware that Resident #3 was negative and shared a room with COVID-19 positive Resident #14. S2 DON further reported she does not know why there was a delay in moving Resident #3 out of the COVID-19 unit and that S1 Administrator is in charge of moving residents. During an interview on [DATE] at 4:00 PM, S1 Administrator indicated the delay in moving negative residents out of the COVID-19 unit was because he didn't have anywhere to move them and he didn't want to move negative residents who would become positive. During an interview with S1 Administrator on [DATE] at 6:55PM, S1 Administrator acknowledged these negative residents were cohorted with COVID positive residents. S1 Administrator verbalized he had no place or rooms to put them. He further indicated they had been cleaning the 300 hall since Saturday and it was not ready for use. Also, S1 Administrator acknowledged staff were returning to work before their 10-day self-quarantine was over because they received some bad information and thought the employees could come back to work in 24 hours after testing positive if they were asymptomatic. During an interview on [DATE] at 9:35AM, Resident #15 reported she did not know Resident #16 was COVID-19 positive when they were roommates. Resident #15 indicated they did not wear face masks in their room. Resident #15 reported she found out Resident #16 was positive on Monday when they moved her to the 300 Hall with Resident #3. During a telephone interview on [DATE] at 1:30 PM, S16 MD reported that he was not aware that negative residents were being cohorted with COVID-19 positive residents. S16 MD further indicated he would not agree with placing negative residents with COVID-19 positive residents.