STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395398	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIEMONS' LAKEVIEW MANOR NURSING AND REHAB CTR	**228 SIEMON DRIVE SOMERSET, PA 15501**

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were stored in a secure manner on one of four medication carts (Yellow Unit cart). Findings include: The facility's policy regarding medication storage, dated July 17, 2020, included that staff were to ensure that all medications were secured in a locked cabinet/cart. Observations on July 31, 2020, at 11:00 a.m. revealed that a medication cart on the Yellow Unit was unlocked and unattended by staff until 11:35 a.m. when Licensed Practical Nurse 5, who was passing medications from another cart on the other wing, but who was also responsible for the Yellow Unit medication cart, was asked if the Yellow Unit's medication cart was locked. She then went down the Yellow hall to find that the cart was unlocked. During the time the cart was unattended and unlocked, several staff members were in close proximity to the cart. Interview with Licensed Practical Nurse 5 on July 31, 2020, at 11:37 a.m. confirmed that the medication cart was unlocked and unattended, and that she was on the other hall giving medications and thought she had locked it. Interviews with the Director of Nursing and the Nursing Home Administrator on July 31, 2020, at 3:45 p.m. confirmed that the medication cart on the Yellow Unit should not have been left unlocked and unattended. 28 Pa. Code 211.9(a)(1) Pharmacy services.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Pennsylvania Department of Health guidelines, facility policies and education records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed while doffing personal protective equipment while in an isolation area. Findings include: Pennsylvania Department of Health - Health Alert Network (PAHAN) - 509 regarding testing for COVID-19 (a contagious [MEDICAL CONDITION] disease that has caused a global pandemic and which can cause fever, cough, shortness of breath and/or fatigue and other symptoms) in Long-term Care Facility Residents and Healthcare Personnel, dated June 1, 2020, revealed that residents needed to be cohorted to separate units in three zones, based on test results: 1. COVID-19 positive residents (Red Zone) were residents with a positive test and still within the parameters for transmission-based precautions. 2. Potentially exposed residents (Yellow Zone) were residents with a negative COVID-19 test who remained asymptomatic but were within 14 days of possible exposure to COVID-19. 3. Unexposed (Green Zone) were any resident in the facility who was not tested and was thought to be unexposed to COVID-19. Zones should be clearly marked with limited access signs or temporary barriers to prevent unnecessary foot traffic to the area, and full PPE (gown, gloves, mask and face shield) must be used to care for residents in Red and Yellow zones. The facility's policy regarding Personal Protective Equipment (PPE) for COVID-19, dated April 10, 2020, indicated that prior to removing PPE, hand hygiene was to be performed. Then, the gown was to be untied and folded with the outside of the gown folded into a tight ball to contain the contaminated side, then gloves were to be removed in the resident's room prior to exiting the room and closing the door. Hand hygiene was to be performed, clean gloves put on, then the surface of the face shield was to be cleaned with a disinfectant wipe prior to properly removing the face and placing it with the straps down and shield facing up. A donning (putting on) and doffing (taking off) compentency for Unit Clerk 6, dated June 5, 2020, revealed that she was competent to properly don and doff PPE. Observations in the facility's Yellow Zone on July 31, 2020, at 10:20 a.m. revealed that there were six residents quarantined in the zone. Unit Clerk 6 put on PPE to enter the quarantined area, entered a resident's room, and then exited the resident's room. She removed her face shield and laid it down on an area of the donning station (where PPE is put on), removed her mask and disposed of it, changed her gloves, used hand sanitizer, applied new gloves, got a wipe from the donning station, wiped the shield, opened several drawers in the doffing station (where PPE is removed) to find a bag, placed the shield into the bag and placed the bag into a brown wooden set of drawers, then removed her gown and gloves and performed hand hygiene. Interview with Unit Clerk 6 on July 31, 2020, at 10:25 a.m. revealed that she was trained regarding donning and doffing PPE. She usually does not enter the Yellow Zone, but she had to speak to a resident. She confirmed that she laid her dirty shield on the counter and used the same gloves to open drawers to look for a bag and did not properly remove her PPE. Observations in the Yellow Zone on July 31, 2020, at 10:58 a.m. revealed that a yellow tape line was on the floor and there was a sign near it to advise staff entering the unit that a face shield, mask, gown and gloves were required to enter the quarantine area. Observations at 11:05 a.m. revealed that Nurse Aide 4 entered the Yellow Unit with only a mask on. She knocked on each resident's door and partially entered the threshold to each resident's room in that area without full PPE on. She then used hand sanitizer and left the unit. Interview with the Infection Control Nurse on July 31, 2020, at 11:25 a.m. revealed that signs were in place to help with donning and doffing PPE properly. She confirmed that there were donning and doffing stations in the same area, that doffing was not occurring in the residents' rooms, that it was all still new, and that staff were still getting used to it all. She confirmed that Unit Clerk 6 should not have laid her dirty shield down, that she should have cleaned the area after removing the shield, and that she should not have used dirty gloves to open the drawers. She stated that Nurse Aide 4 did not wear full PPE because the fire alarm had been sounding for seven minutes on another wing and she needed to check on the residents. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policies, as well as observations and staff interviews, it was determined that the facility failed to maintain a clean and sanitary environment for residents and staff in seven of 14 resident bathrooms reviewed (Rooms 127, 208, 214, 215, 221, 226, 229) and in one of three bath area reviewed (C Wing). Findings include: Observations in resident bathroom [ROOM NUMBER] on July 31, 2020, at 8:48 a.m. revealed that there was a large amount of a splattered, dried, brown substance on the top and inside of the toilet and the elevated toilet seat. The area under the front on the sink lip had a moderate amount of a removable, brown substance, and there were dark specks of removable debris scattered over the floor of the bathroom. Observations in resident bathroom [ROOM NUMBER] on July 31, 2020, at 9:00 a.m. revealed that there was a red X made from tape placed over the raised toilet seat. Several bath blankets that had dried,

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

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) brown stains on them were wrapped around the base of the front of the toilet. Observations on July 31, 2020, at 9:02 a.m. revealed that in resident bathroom [ROOM NUMBER] there was a build-up of dried, removable, brown debris under the front lip of the sink. In resident bathroom [ROOM NUMBER] there were multiple dark specks of removable debris on the bathroom floor. In resident bathroom [ROOM NUMBER] there were brown splatters under the front lip of the sink. In resident bathroom [ROOM NUMBER] there was a large, yellowish stain in the sink bowl. Observations on July 31, 2020, at 9:40 a.m. revealed that in resident bathroom [ROOM NUMBER] the toilet was heavily soiled with a black/brown, splattered, dried, removable substance on the inside top of the toilet and the elevated toilet seat. Observations in the C wing bath area on July 31, 2020, at 10:40 a.m. revealed that there were multiple areas of a smeared, dried, brown substance in the bucket of a bedside commode, and there was a white, powdery substance over the front railing near the toilet seat. Interview with Housekeeper 1 on July 31, 2020, at 14:25 p.m. revealed that it takes her all day to get through cleaning her resident rooms and if she is not told that an area is heavily soiled, she may not get to it for a while. She confirmed that the sinks, toilets, floors and the bedside commode in the C wing shower room needed to be cleaned. Interview with Housekeeping Manager 2 on July 31, 2020, at 9:40 a.m. confirmed that the resident bathrooms and the bedside commode should have been cleaned after use. 28 Pa. Code 207.2(a) Administrator's responsibility.