STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365267	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
O'NEILL HEALTHCARE LAKEWOOD	13900 DETROIT AVE LAKEWOOD, OH 44107

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(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** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to take required steps to prevent and/or contain the spread of COVID-19. The facility failed to ensure the creation and implementation of a plan for managing new admissions and readmissions whose COVID-19 status was unknown. Eleven of 11 residents (Resident (R) 2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12) reviewed for admission and/or readmission to the facility, whose COVID-19 status was unknown, failed to have transmission-based precautions implemented. In addition, the facility's policies for new admissions/readmissions, facility COVID-19 testing for residents and staff, and resident and resident representative notification of COVID-19 were not in accordance with current regulations and based on national standards for COVID-19. The failure to have current COVID-19 policies regarding these areas has the potential to affect all residents in the facility. Findings include: 1. Review of the Centers for Disease Control and Prevention (CDC) policy titled Responding to Coronavirus (COVID-19) in Nursing Homes - Considerations for the Public Health Response to COVID-19 in Nursing Homes, updated 04/30/20, directs, Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE (personal protective equipment) should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Review of the facility's policy titled, COVID-19 Segregation and Infection Control Practices for New Admissions/Readmissions during Pandemic dated 03/20/20, directs that Specific rooms will be designated for all new admission/readmissions to the facility for the first 14 days of their stay A sign reminding staff that a mask must be worn when entering resident rooms beyond this point will be placed at the start of section rooms. Only residents who are admitted with a known illness that requires contact or droplet precautions will have individual infection control signs placed outside their rooms. The policy was not revised to include the information that residents whose COVID-19 status is unknown require the use of all COVID-19 PPE as defined in the CDC policy titled Responding to Coronavirus (COVID-19) in Nursing Homes-Considerations for the Public Health Response to COVID-19 in Nursing Homes, updated 04/30/20. Review of the facility's policy titled Admission Monitoring Unit, dated 04/20/20, directs that Residents in this area are being monitored for the first 14 days of admission for potential COVID-19 exposure prior to or during their hospital stay. Staff should wear a surgical mask AT ALL TIMES. Other PPE (personal protective equipment) is only required if the individual room has an isolation sign indicating the need. The policy was not revised to include the information that residents whose COVID-19 status was unknown required the use of all COVID-19 PPE as defined in the CDC policy titled Responding to Coronavirus (COVID-19) in Nursing Homes -Considerations for the Public Health Response to COVID-19 in Nursing Homes, updated 04/30/20. Review of a new admission report detailed in an Action Summary Report from the Electronic Medical Record (EMR) for resident admissions/readmissions from 08/28/20 - 09/14/20, revealed 12 residents were admitted to the facility in the past 14 days prior to the survey; however only 11 residents, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12, remained in the facility. Observation on 09/16/20 at 8:00 AM revealed R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, and R12 resided on the 1 North Hall. None of the resident's rooms had isolation/transmission-based precautions signage and there were no isolation carts/supplies in the hall. Observation on 09/16/20 at 8:00 AM revealed State tested Nursing Assistant (STNA) 4 exited R5's room wearing a surgical mask, then re-entered the room wearing a surgical mask, stating she was going in to assist the resident with toileting. STNA4 transferred R5 from the bed to a wheelchair, placed a blanket on the resident's lap and wheeled the resident into the bathroom. STNA4 remained in the room, straightening the resident's bed linens. At 8:05 AM, STNA4 wheeled the resident from the bathroom to the bedside, put the foot pedals on the wheelchair and positioned the resident to sit upright. STNA4 next exited the room and obtained R5's meal tray from the food cart in the hall and re-entered the room, delivered the meal tray to the resident, then exited the room and used alcohol-based hand rub (ABHR). STNA4 then obtained another meal tray from the food cart and delivered a meal tray to R12. At 8:10 AM, STNA4 delivered a meal tray to R7, adjusted the bedside table, left the room, used ABHR, and then delivered a meal tray to R10, who was admitted on [DATE] and no longer on observation status. STNA4 then delivered a meal tray to R3. Throughout these observations, STNA4 wore only a surgical mask and no other PPE was used while performing care for these residents. Observation on 09/16/20 at 8:02 AM revealed STNA1, wearing a surgical mask, delivered a meal tray to R2, then delivered a meal tray to R6. In each room, she adjusted the bed to an upright position. STNA1 failed to wear any PPE other than the surgical mask while performing these routine resident care tasks. Observation on 09/16/20 at 8:02 AM revealed Licensed Practical Nurse (LPN) 1 entered R10's room wearing a surgical mask and adjusted the bed to an upright position, performed a temperature check and blood pressure reading, then washed her hands in the resident's bathroom prior to exiting the room. LPN1 then prepared medications for another resident, and at 8:14 AM entered R7's room, administered the medications, took the resident's blood pressure and temperature, and then exited the room and used ABHR to cleanse her hands. LPN1 failed to wear any PPE other than a surgical mask while performing these routine resident care tasks. During an interview on 09/16/20 at 8:30 AM, STNA4 stated she just came back from vacation and that she knew none of the residents were on isolation precautions because there were no isolation signs or isolation carts in the hall. STNA4 stated that if any of the residents were on isolation, she would wear a gown and gloves; however, none of the residents she provided care for this morning were on isolation. During an interview on 09/16/20 at 8:50 AM, Registered Nurse (RN) 2, who served as the Unit Manager (UM), stated that prior to each new admission/readmission, the resident's information was reviewed by the Director of Nursing (DON). RN2 stated that ideally, the residents should have a negative COVID test, and upon admission were placed on the observation hall and monitored every 4 hours with vital signs and pulse oximetry. RN2 stated that if a resident required transmission-based precautions, the DON would set up signage and an isolation cart and staff would wear full PPE for resident care. During an interview on 09/16/20 at 9:55 AM, LPN1 stated that she did not know why the new admission residents were not on isolation precautions. LPN1 stated that if the residents were on isolation precautions, there would be signage and isolation carts for the individual residents. During an interview on 09/20/20 at 10:30 AM, the DON, who also served as the Infection Control Preventionist (DON/ICP) was interviewed with the Corporate Quality Assurance (QA) Nurse present. The DON/ICP stated that the 1 North and 1 West Units were used for new admissions. The DON/ICP stated the she reviewed the pre-admission medical information for each resident

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** - Many	(continued... from page 1) which may or may not include a negative COVID test. The DON/ICP stated that new admission/readmissions were placed on admission monitoring for signs & symptoms of COVID-19, and staff were required to wear a surgical mask; however, no other PPE was required for staff use. If a resident developed any signs and symptoms of COVID-19, they were placed on isolation/transmission-based precautions. The DON/ICP stated this process was in accordance with facility policy. In addition, the DON/ICP stated it was the intention of the facility to follow CDC guidance for COVID-19. When asked how the facility was following CDC policy for admission/readmissions, the DON/ICP and Corporate QA Nurse stated they were not aware of the CDC policy for nursing home admission/readmission. 2. QSO-20-38-NH, issued 08/26/20 and effective immediately, directs that, Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents should be tested , and all staff and residents that tested negative should be retested every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. Review of the facility's COVID19 Testing Policy Per QSO-20-38-NH, dated 09/04/20, which was provided by the Director of Operations, directs the use of a Point of Care [MEDICATION NAME] testing machine to test all residents and staff at a frequency determined by our county positivity rate for COVID tests . any positive results for the Point of Care [MEDICATION NAME] test . will verify results by swabbing the resident/staff and having a PCR (polymerase chain reaction - a type of COVID-19 test) test run by the Cleveland Clinic Lab .If a PCR test confirms the results from the Point of Care [MEDICATION NAME] test .then test all previously negative residents and staff with the Point of Care [MEDICATION NAME] tester every 3-7 days until 14 days have passed without a confirmed positive result. Once 14 days without a positive result has passed then revert to the testing frequency as dictated by our county specific positivity rate. The facility policy failed to accurately relay the requirements set forth in QSO 20-38-NH regarding staff and resident testing requirements for COVID outbreak testing. (Please refer to F886.) 3. Review of QSO-20-29- NH dated 05/06/20 directs that Facilities must .Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. During the Entrance Conference on 09/15/20 at 9:20 AM, the DON/ICP stated the facility performed resident and family notification for COVID-19 resident and staff occurrences within 24 hours and she would provide the policy for COVID-19 notification. Review of the COVID-19 Policies provided on 09/15/20 revealed no directive for resident and resident representative notification regarding COVID-19 occurrence(s). (Please refer to F885.) During an interview on 09/16/20 at 4:00 PM, the DON/ICP reiterated that family notification for a positive resident and/or staff COVID-19 result required resident and family notification within 24 hours as directed by facility policy; however, neither she nor the Corporate QA Nurse could find a policy for resident and family notification. During the interview, the DON stated that she relied on corporate staff for policy updates, and in addition, she monitored the CDC website for new information. The Corporate QA nurse stated she assisted with policies; however, it had been challenging to keep policies current due to rapidly changing information.
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 record review, policy review and interviews, the facility failed to ensure that all residents, their representatives and families were informed by 5 PM the next calendar day following an outbreak in which there was a single confirmed COVID-19 infection. Three of three residents (Resident (R) 19, R20, and R22) were reviewed for resident and family notification. The facility received notification of a COVID positive resident on 08/28/20; however, the facility did not notify these three residents and their resident representative until 08/31/20. Findings include: Review of QSO-20-29-NH dated 05/06/20 revealed that Facilities must .Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. During the Entrance Conference on 09/15/20 at 9:20 AM, the Director of Nursing/Infection Control Preventionist (DON/ICP) stated the facility performed resident and family notification for COVID-19 resident and staff occurrences within 24 hours and she would provide the policy for COVID-19 notification. Review of the COVID-19 Policies provided on 09/15/20 at 5:00 PM revealed no directives for resident and resident representative notification regarding COVID-19 occurrence(s). Review of R1's Clinical Resident Profile in the Electronic Medical Record (EMR) revealed the resident was admitted on [DATE]. Review of R1's COVID Laboratory Result obtained from the print copy of the medical record dated 08/28/20 revealed the resident had a nasopharyngeal swab collected on 08/26/20 and on 08/28/20 the facility was informed of the positive COVID19 ([DIAGNOSES REDACTED] CoV2) result via telephone to Registered Nurse (RN) 4 at 2:19 AM. Review of R1's EMR revealed the resident had never previously tested positive for COVID-19, indicating this positive COVID result constituted a new outbreak. a. Review of R22's Health Status Note under the Progress Notes tab in the EMR dated 08/31/20 revealed the Minimum Data Set (MDS) Registered Nurse (RN) notified the resident and responsible party of the COVID 19 status in the facility. During an interview on 09/16/20 at 2:05 PM, the MDS RN verified that on 08/31/20, she spoke to R22 and called the resident's responsible party to inform them of the 8/28/20 COVID-19 outbreak. The MDS RN stated that she made this notification when she was informed to do so by the Administrator. b. Review of R20's Health Status Note under the Progress Notes tab in the EMR dated 8/31/20 revealed the Administrative Assistant notified the resident and responsible party of the COVID-19 status in the facility. During an interview on 09/16/20 at 2:07 PM, the Administrative Assistant verified that she had notified R20 and the resident's responsible party on 8/31/20 that there had been a positive COVID-19 test result received on 08/28/20. c. Review of R19's Health Status Note under the Progress Notes tab in the EMR dated 8/31/20 revealed the Activities Director notified the resident and responsible party of the facility's COVID 19 status at this time. During an interview on 09/16/20 at 2:21 PM, the Activities Director verified that she had notified R19 and the resident's responsible party of the 08/28/20 positive COVID-19 result. Interview on 09/16/20 at 2:05 PM with the MDS RN revealed that at the time of the 08/28/20 COVID-19 outbreak, she was responsible for the facility in the DON/ICP's absence. The MDS RN stated that she did not think about assuring notification to all residents and families/resident representatives at the time the outbreak occurred. During an interview on 09/16/20 at 4:00 PM, the DON/ICP confirmed she was not in the facility on 8/28/20 when the facility was notified of the COVID positive resident; the MDS RN was in charge of the facility in her absence. The DON/ICP stated that family notification for a positive resident and/or staff COVID-19 result required resident and family notification within 24 hours as directed by facility policy, and that staff should have performed timely notification for the 08/28/20 outbreak. Further interview with the DON/ICP revealed that neither she nor the Corporate Quality Assurance (QA) Nurse were able to find a policy for resident and family notification. On 09/16/20 at 4:30 PM, the DON/ICP provided a document titled COVID19 Family Notification Policy dated 09/16/20 which stated that the Ohio Department of Health Director .is ordering all long-term care facilities in the state to notify residents and their families within 24 hours of a resident or staff member being diagnosed with [REDACTED].
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and policy review, the facility failed to conduct staff and resident testing as required after an outbreak of COVID-19. The facility failed to retest staff in accordance with regulatory time frames after the outbreak. Residents were not tested after the outbreak unless they displayed symptoms which could be attributed to COVID-19. The failure to immediately test all residents after an outbreak, as well as the failure to repeatedly test all COVID-19 negative staff every three to seven days until there were no new positive cases for at least 14 days, had the potential to affect all residents of the facility. Findings include: QSO-20-38-NH, issued 08/26/20 and effective immediately, directed that, Upon identification of a single new case of COVID-19 infection in any staff or resident, all staff and residents should be tested , and all staff and residents that tested negative should be retested every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. An untitled document was provided and identified by the Director of Nursing/Infection Control Preventionist (DON/ICP) as the Staff and Resident COVID-19 line listings. The facility's last COVID-19 outbreak occurred effective 08/28/20. On that date, the facility received COVID positive test results for Resident (R) 1, from a sample taken on 08/26/20. Review of R1's Clinical Resident Profile in the Electronic Medical Record (EMR) revealed R1 was admitted on [DATE]. Review of R1's COVID Laboratory Result dated 8/28/20 revealed R1 had a nasopharyngeal swab collected on 08/26/20, and on 08/28/20 the facility was informed of the positive COVID19 ([DIAGNOSES REDACTED] CoV-2) result via telephone call to Registered Nurse (RN) 4 at 2:19 AM. Review of R1's EMR revealed R1 had never previously tested positive for COVID-19, indicating this COVID result constituted a new outbreak. a. Resident Testing - Review of the Daily Census report from the EMR dated 08/28/20 revealed the facility census was 74. A review of the untitled resident COVID-19

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F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) line listing provided by the DON/ICP revealed that, as of 09/15/20, 66 of those 74 residents were not tested after the 08/28/20 COVID-19 outbreak. Two residents (R13, R14) were tested on [DATE] and were negative. Neither of the two residents were retested within three to seven days and had not been retested as of the survey date of 09/15/20. Four additional residents (R2, R5, R15, R16) were not tested until 09/09/20 and were negative. Two additional residents (R4 and R17) were not tested after the 08/28/20 outbreak until 09/13/20 and were negative. b. Staff Testing - A review of the Quest laboratory results for 08/31/20 revealed all 121 staff were tested with the PCR [MEDICATION NAME] test and found to be negative for the COVID-19 virus. However, the COVID-negative staff were not then retested three to seven days later. Testing did not reoccur until 09/14/20, when all 112 current staff were retested . A random sample of three staff - RN 2, State tested Nursing Assistant (STNA) 4, and Licensed Practical Nurse (LPN) 1 were chosen for review. The COVID-19 staff testing downloaded from the facility's scheduling software and provided by the DON/ICP confirmed that these staff were tested on [DATE] and their laboratory results were all negative. The COVID-19 staff testing downloaded from the facility's scheduling software and provided by the DON/ICP confirmed that RN2, STNA4, and LPN1 were not retested until 14 days later, on 09/14/20. Results from these tests were not received as of 11:00 AM on 09/16/20. During an interview on 09/15/20 at 12:10 PM, the DON/ICP confirmed that the last COVID positive resident result was received on 08/28/20, from a sample taken on 08/26/20. She stated COVID-19 resident testing is currently performed based on exposure and/or symptoms. Staff testing is performed every two weeks and was performed on 08/31/20 and 09/14/20. During an additional interview on 09/15/20 at 1:20 PM, the DON/ICP stated that she was currently aware of a COVID-19 testing requirement for staff and residents that specified testing every three to seven days for a new outbreak; however, the DON/ICP stated that requirement did not apply to the 08/28/20 outbreak, because it happened before she was made aware of the new federal requirement. During this interview, the DON/ICP confirmed the facility was testing all staff every two weeks, rather than every three to seven days until 14 days had elapsed with no new positive cases. During an additional interview on 09/15/20, at 3:40 PM, the DON/ICP stated she was on vacation from 08/28/20 and was unaware of the new requirements until after returning to work on 09/01/20. The DON/ICP stated that the Minimum Data Set (MDS) RN filled in during her absence. During an interview on 09/15/20 at 5:00 PM, the MDS RN stated she found out about the facility's current COVID-19 testing policy last week; however, she did not know about it on 08/28/20 when she filled in for the DON as the ICP. She stated she did not assure testing of all staff and residents at the time of the outbreak because she was unaware of the directive. During an interview on 09/15/20 at 4:00 PM, the Corporate Quality Assurance (QA) Nurse stated that she received QSO-20-38-NH on 08/28/20 but she did not have a conversation about the directive with the MDS RN who filled in for the DON/ICP while she on vacation. During an interview on 09/15/20 at 1:34 PM, the Medical Director stated that according to the protocol, once a resident tested COVID positive, facility staff follow the protocol and test everybody that should be tested according to the new memo released the end of August (QSO2-38-NH). Review of the facility's COVID-19 Testing Policy titled, COVID19 Testing Policy Per QSO-20-38-NH, dated 09/04/20, which was provided by the Director of Operations, directs the use of a Point of Care [MEDICATION NAME] testing machine to test all residents and staff at a frequency determined by our county positivity rate for COVID tests . any positive results for the Point of Care [MEDICATION NAME] test .will verify results by swabbing the resident/staff and having a PCR (polymerase chain reaction - a type of COVID-19 test) test run by the Cleveland Clinic Lab .If a PCR test confirms the results from the Point of Care [MEDICATION NAME] test .then test all previously negative residents and staff with the Point of Care [MEDICATION NAME] tester every 3-7 days until 14 days have passed without a confirmed positive result. Once 14 days without a positive result has passed then revert to the testing frequency as dictated by our county specific positivity rate. The facility policy failed to address the requirements set forth in QSO 20-38-NH which require the testing of all staff and residents after an outbreak.