STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395554	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOREST CITY NURSING AND REHAB CENTER	**915 DELAWARE STREET FOREST CITY, PA 18421**

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 -** 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 and staff interview, it was determined that the facility failed to maintain infection control practices to prevent spread of infection COVID-19. Findings include: Review of facility Coronavirus (COVID-19) Policy (undated) revealed that the facility will stay current with CDC, State and Local Health Department guidance and recommendations. The policy further indicated that the facility will manage a confirmed, suspected or patient under investigation, confirmed COVID-19 individual by placing the individual in a private room (if available) with a closed door and dedicated bathroom. They may also be cohorted with other resident with the same infection status and signs would be posted on the door or outside of the patient room that described the type of precautions needed and required PPE (personal protective equipment). Observations conducted during a tour of the facility on June 10, 2020, at approximately 10:15 a.m. in the presence of Employee 1, Licensed Practical Nurse (LPN), revealed that the second floor of the facility was designated as a Yellow Zone (residents exposed or quarantined for potential COVID-19) Unit. Signage was posted outside the entrance to the unit which noted, Yellow Zone Full PPE (personal protective equipment) Required; N95, eye protection, gowns, gloves. Employee 1, instructed the surveyor to don full PPE prior to entering the unit through the double doors. However, observation upon entering the unit revealed facility staff walking in the hall near nurse's station without wearing full PPE Employee 1 confirmed during interview at the time of the observation that that the observed staff did not apply Full PPE prior to entering the unit, but instead staff enter the unit wearing an N95 mask and then proceed to the medication room, which is located behind the nurse's station to don (put on) the additional required PPE. At 10:30 a.m. two staff members were observed entering resident room [ROOM NUMBER] without Full PPE. Staff failed to wear gloves and eye protection as directed by the precaution signage posted upon entering the unit. Interview with Employee 2, Nurse Aide and Employee 3, Nurse Aide at that time revealed that they did not think Full PPE was required if resident care was not being provided. Interview with Employee 1, LPN at 10:32 a.m. confirmed that Full PPE was required to be worn while on the Yellow unit. Observation of the facility's soiled utility room, a facility designated location for staff to doff/ remove their PPE revealed three large yellow barrels on wheels blocking access to the biohazard bin in which the contaminated PPE was to be disposed. During observation, the moved barrels out of the way with a foot and only then was the appropriate disposal bin accessible. Further observation of the area designated for the doffing of PPE revealed that the paper towel dispenser was empty and lacked paper towels to dry hands after washing. Employee 1, LPN, was observed opening the door to exit the soiled utility room with wet hands. According to the CDC guideline for Hand Hygiene in Healthcare Settings, when cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands and rub your hands together for at least 15 seconds, covering all surfaces of the hands and fingers; rinse your hands with water and use disposable towels to dry; use towel to turn off the faucet; avoid using hot water to prevent drying of skin. Employee 1, LPN, requested that the surveyor to don a new gown and gloves to re-enter the Yellow Zone unit and then proceed to the elevator to access the first floor Red Zone (COVID positive residents). Signage inside the elevator indicated that the elevator went to the Red Zone and that Full PPE was required; N95, eye protection, gowns and gloves. However, upon entering the Red Zone unit staff again were observed with only a N95 mask on as they entered the unit. The staff were required to go behind the nurse's station and into the medication room to don the necessary PPE. At 11:00 a.m. during tour on the Elm hallway located on the Red Zone unit, Employee 4, housekeeper (HK) was observed performing floor cleaning in resident room [ROOM NUMBER] without Full PPE. Employee 4, HK, was wearing only an N95 mask. Interview with Employee 4 at that time revealed that she didn't think she needed Full PPE since the residents on that unit were considered recovered. Interview with Employee 1, LPN at approximately 11:05 a.m. confirmed that Full PPE was required to be worn while on the unit. During a tour of the first floor Red Zone, which continued to the Pine hallway revealed the unit housed active COVID-19 positive residents. The double doors to access the residents in this hallway were closed. A donning station for PPE was located outside the double doors. Upon inspection the donning station lacked gowns, protective eyewear and masks. Interview with Employee 1, LPN, revealed that the nursing staff and housekeeping are responsible to stock the station and that if the station was missing items, the staff would need to go behind the nurse's station into the medication room to retrieve what they needed. Employee 1, LPN, confirmed during interview that the PPE donning station should always be fully stocked. Employee 1 also verified that the facility did have the necessary PPE supplies on hand in the facility. Observation as the tour proceeded through the double doors, a area housing active COVID-19 residents, revealed that upon entering the hallway, all resident room doors were observed to be open and a resident, Resident 1, was in the hallway outside her room. This resident was in a geri-recliner and was not wearing a mask. According to Health Update dated March 24, 2020, provided by the PA Department of Health to all facilities, patient/resident with known or suspected COVID-19 is to be placed in a single-person room with door closed. The patient/ resident should have a dedicated bathroom. Interview with Employee 1, LPN revealed that residents were encouraged to wear a mask when out of their room and that Resident 1 was a COVID-19 recovered and continued to reside on the active COVID-19 hallway. According to Health Update dated May 12, 2020 provided by the PA Department of Health to all facilities residents need to be cohorted to separate units in three zones, based on test results; COVID positive test (Red Zone): resident with a positive [DIAGNOSES REDACTED]-CoV-2 PCR test and still within the parameters for transmission-based precautions. COVID- test potentially exposed (Yellow Zone): resident with a negative [DIAGNOSES REDACTED]-CoV-2 PCR test who remain asymptomatic but are within 14 days of possible exposure to COVID-19. Unexposed (Green Zone): any resident in the facility who was not tested and is thought to be unexposed to COVID-19. The tree types of resident residents listed should not share common areas such as communal bathrooms and showers with other types of residents. The three zones should remain separate on the unit. Interview with Employee 5, LPN, at approximately 11:00 a.m. revealed that Employee 5 was unable to state if Resident 1 had been offered a mask or why the resident was out of her room. Employee 5, LPN, did confirm that she was the assigned nurse for the active COVID-19 hallway. Observation of the location in which staff are required to remove/ doff their contaminated PPE revealed an overfilled biohazard bin. Employee 1, LPN, confirmed that the bin was too full to fully contain the disposed PPE. Further observation revealed that there was no hand sanitizer in the dispenser closest to the exit and there was no hand washing station readily accessible, therefore; staff were not able to perform hand hygiene prior to leaving the active COVID-19 hallway. Interview with Nursing Home Administrator and Director of Nursing on June 10, 2020, at approximately 12:00 p.m. confirmed that the facility failed to consistently maintain supplies readily available for staff and implement appropriate infection control practices to prevent the spread of the COVID-19 infection. 28 Pa. Code 211.12 (a)(c)(d)(4)(5) Nursing Services. 28 Pa. Code 211.10(a)(d) Resident care policies

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.