STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145847	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STEARNS NURSING & REHAB CENTER	**3900 STEARNS AVENUE GRANITE CITY, IL 62040**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to immediately notify the resident, resident's physician and/or the resident's representative of any significant change in condition, a transfer to the hospital for medical treatment, room assignment changes or notification of infection for 6 of 24 residents (R5, R7, R12, R17, R25, R41) reviewed for notification of changes in the sample of 45. Findings include: 1.On 08/04/20 at 2:29 PM, R41's Nurse's Note, written by V29, Register Nurse (RN) documented R41 had an oxygen saturation level of 84% (normal reading is typically between 95% and 100% with values under 90% are considered low) and was not feeling well or eating. There was no documentation of physician or family representative notification at that time. On 08/04/20, R41's Nurse's Note, written by V8, Licensed Practical Nurse, with no time, documented R41 had a change in condition which included lethargy, malaise (general feeling of discomfort/illness), diarrhea and poor skin turgor. It documented R41 was alert and oriented to one and was normally alert and oriented to person, place and time. Vital signs were documented as blood pressure 152/80, pulse 99, respirations 26, temperature 101.5 degrees Fahrenheit (F) and oxygen saturation level of 80%. It documented that V28, Advanced Practice Register Nurse (APRN) was called and R41 was sent to the hospital for treatment. There was no documentation that V48, R41's family representative was notified of the transfer. On 08/25/20 at 7:57 AM, V48, R41's family member, stated the family was notified by the hospital on [DATE] at 2:00 PM that R41 had been transferred for care. V48 stated she was not notified by the facility of R41's transfer to the hospital. On 08/25/20 at 2:00 PM, V29, stated she did not notify the physician or family representative of R41's change in condition on 8/4/20. On 08/25/20 at 2:15 PM, V8 stated she did not remember if she called the family regarding R41's transfer to the hospital. After multiple attempts to acquire documentation from the facility staff, there was no documentation provided that R41 had been tested for COVID-19 while at this facility. There was no documentation in the medical record or on the Facility's Line list for COVID-19 positive residents, entitled IDPH Line List for COVID-19 Outbreaks in Long Term Care Facilities provided by the facility on 08/26/20 that indicated R41's family representative or physician was notified that there were positive cases of COVID-19 in the facility as of July 22, 2020. 2. R5's Hospital Record, dated 8/11/20 at 10:09 AM, documented R5 was admitted from the facility after falling. The record documented R5 was COVID-19 positive per facility staff. The Hospital records documented R5 was diagnosed with [REDACTED]. At 11:52 AM, hospital records documented R5 was transferred to a trauma center for treatment. On 08/19/20 at 5:55 AM, during a tour of the Memory Unit, a name plate for R5 was observed on a room door. V14, Certified Nursing Assistant (CNA) stated R5 was on the unit until she had a fall. V14 stated after R5 returned from the hospital, she was placed on the North Hall (COVID-19 positive unit). On 8/19/20, at 6:05 AM, V30, LPN stated she was not working at the time R5 fell and did not know who the nurse was that sent her out to the hospital. On 8/19/20, at 9:00 AM, V8, LPN stated she was not working when R5 fell and did not know who the nurse was that sent R5 to the hospital. When requested, V8, V14 and V30 could not present any documentation (i.e. nurse's notes or transfer orders) regarding R5 from that day. There was no documentation in R5's Facility medical record that R5's facility physician or family representative were notified of any transfer. Multiple attempts were made to facility staff to present documentation regarding any transfer notification for R5. There were none provided. The Facility's COVID-19 Positive list, entitled IDPH (Illinois Department of Public Health) Line List for COVID-19 Outbreaks for Long Term Care Facilities presented on 08/26/20 documented R5 tested positive for COVID-19 infection on 08/07/20. There was no documentation in R5's medical record that R5's physician or family representative was notified of this result. The Facility's Policy, Notification of Change of Resident's Status, undated, documented Procedure: 1. Guideline for notification of physician/responsible party (not all inclusive): a. Significant change in or unstable vital signs (temperature, blood pressure, pulse, respiration); b. emesis/diarrhea; e. symptoms of any infectious process; i. change in level of consciousness. 2. Document in the notes: a. resident change in condition; b. physician notification; c. Notification of responsible party. 3. On 8/17/2020, R7 was observed on the North Hall (COVID-19 positive unit). She resided in a room with R4. On 8/20/2020, at 12:22 PM, V34, R7's family, stated R7 had previously been roommates with a certain resident for a long period of time, but the facility has moved her twice since then. On 8/25/2020, staff were in the process of moving R7 to another room down the same hall. R4 was also moved to different room. On 9/1/2020, at 2:15 PM, V34 stated, No one ever contacted us about room changes. I had to find out when I went to visit. I went to visit at her window (where she had previously been) and neither her nor her roommate (R4) were in there. I told my sister, 'Mom is missing again.' It took us 3 or 4 times to get ahold of someone at the facility. On 9/3/2020, at 9:51 AM, V46, Social Service Director stated, Since the outbreak, we have had to make a lot of movement. It depends on who is in the building, but usually it's my job or the nurses to notify resident's family if they come back from the hospital or must move to an isolation room. I give written statements to the patient or family. I spoke with (R7's) family on the 8th (August 8th, 2020) that was the last communication I had with them and that was not about a room move. 4.R25's Face Sheet, not dated, documents R25 has a Power of Attorney (POA), V52. R25's Minimum Data Set (MDS), dated [DATE], documents R25 is severely impaired cognitively. R25's Laboratory Result, dated 8/09/2020, documents R25 tested positive for COVID-19. R25's Care Plan, dated 08/10/2020, documented R25 had a positive COVID-19 test. It documented an intervention update/educate resident/family/responsible party as needed regarding COVID-19 and condition. There is no documentation in R25's August 2020 Progress Notes or medical record that V52 was notified of R25 testing positive for COVID-19. 5.R17's Face Sheet, not dated, documents R17 has a POA, V51. R17's Laboratory Result, dated 8/09/2020, documents Positive for COVID-19. R17's Care Plan, dated 08/10/2020, documented R17 had a positive COVID-19 test. It documented interventions, in part as, update/educate resident/family/responsible party as needed regarding COVID-19 and condition. R17's MDS, dated [DATE], documents R17 is severely impaired cognitively. There is no documentation in R17's medical record or August Progress Notes documenting V51 was notified R17 tested positive for COVID-19. 6.R12's Face Sheet, not dated, documents R12 has a Guardian, V50. R12's MDS, dated [DATE], documents R12 is severely impaired cognitively. R12's Care Plan, dated 08/08/2020, documented R12 had a positive COVID-19 test. It documented interventions, in part as, update/educate resident/family/responsible party as needed regarding COVID-19 and condition. There is no documentation in R12's August Progress notes or medical record that V50 was notified R12 tested positive for COVID-19. On 8/19/2020 at 11:00 AM V8, Licensed Practical Nurse (LPN), stated, We document in the progress notes in the computer. There are nurses that don't have computer access. They have to document on paper. If it is not in the nurses notes in the computer or on paper, then it wasn't done.

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to assist resident with dressing for 1 of 4 residents (R7) reviewed for assistance with Activities of Daily Living (ADLs) in a sample of 45. Finding includes: R7's August 2020 physician's orders [REDACTED]. The Care Plan interventions documented Observe me frequently to anticipate and meet my needs. On 8/18/2020, at 9:50 AM, V34, R7 family member, stated her mother (R7) has been wearing the same outfit and she has pictures of this. V34 stated her mom's new roommate (R4) has been complaining that staff aren't taking care of them. On 8/19/2020, at 11:30 AM, R4 stated, She (R7) is in here because of her memory. She has been in those clothes since she came to this room from the other end of the hall, which was 2 days ago. She is not eating. At, 12:00 PM, R7 was wearing the brownish shirt and gray pants with a red stain all down the length of the right pant leg. At this time, R4, R7's roommate stated, She spilt Kool-Aid on her pants two days ago. R4's Brief Interview for Mental Status (BIMS), dated 8/18/2020, indicates R4 is cognitively intact. On 8/20/2020, at 12:22 PM, V34, verified that R7 was wearing the brown shirt and gray pants on 8/18/2020. On 8/25/2020, at 11:45 AM, R7 was wearing the same brown shirt and gray pants with the stain down the pant leg, as she was observed wearing on 8/19/2020.
F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to complete timely assessments, to notify the physician of a change in condition and to provide medical treatment in a timely manner for 2 of 2 residents (R17, R41) reviewed for care and services in the sample of 45. This failure resulted in R17 and R41experiencing a medical decline in condition without timely treatment. Findings include: 1. R17's August 2020 physician's orders [REDACTED]. R17's Laboratory Result, dated 8/09/2020, documented she had tested Positive for COVID-19. R17's Care Plan, dated 08/10/2020, documented R17 had a positive COVID-19 test. It documented R17 was placed on isolation/droplet precautions, staff were to monitor vital signs and oxygen saturations levels (SPO2) as ordered. R17's Nurse's Note, dated 8/13/2020 at 4:07 PM, documents Resident decrease SPO2 to 84% room air. Oxygen applied at 3 liters by nasal cannula increased to 98%. Temperature of 99.2 at 4:07 PM down to 97.7. Resident fatigued, complained of extreme pain to back and all over. Continue routine pain meds and prn narcotics slightly effective. No SOB (Shortness of Breath) noted. Respirations even non labored at this time. Added to report sheet, to be monitored every shift. POA (Power of Attorney) contacted and message left. R17's Departmental Nursing Notes, dated 8/14/2020 at 1:04 AM, documents T99.7 (temperature)-80 (pulse)-20 (respirations)-106/68(blood pressure). Oxygen saturation 94% on oxygen at 2 liters. HOB (Head of Bed) elevated-lungs clear with no cough or SOB. There was no documentation in R17's medical records that the facility staff was monitoring R17's vitals on 8/15, 8/16 and 8/17/20. R17's Departmental Nursing Notes, dated 8/18/2020 at 12:17 AM, documents T (temperature) 99.1-72 (pulse)-20 (respiration)-114/68 (blood pressure). O2 sat 97% no distress noted. There was no documentation in R17's medical records on 8/18/20 for the 6:00 AM-2:00 PM shift and the 2:00 PM -10:00 PM shift that the facility was monitoring R17's vital signs. On 8/19/2020 at 8:40 AM R17 was lying in bed. V14, Certified Nurse's Aide/CNA, placed R17's tray on the over bed table. R17's face was red in color. R17 was taking slow shallow breathes. Her oxygen tubing was lying on the bed and not on her face. At 8:43 AM, V14 stated This is not normal for her. She has changed. She (R17) feels hot. She says she doesn't feel good. She (R17) is positive for COVID 19. This is not like her. She used to get up out of the bed, transfer herself to the wheelchair and roll herself out in the hallway. She would eat pretty good. She has not been eating at all. She drinks her drinks sometimes. She has been coughing, sneezing and has had fever. She hasn't been getting up. This has been going on about 2 weeks. I have reported it to the nurse. I tried to get her temperature, but I was told the thermometer wasn't working and they would get me a new one. On 8/19/2020 at 9:28 AM V8, Licensed Practical Nurse, entered R17's room. V8 applied R17's oxygen tubing to her nose. V8 did not attempt to get R17's oxygen saturation level prior to putting the O2 on R17. V8 then left the room and proceeded off the unit. V8 returned approximately 10 minutes later and performed an oxygen saturation test. R17's results were 92% with oxygen being delivered per nasal cannula at 2 liters. On 08/19/20 at 10:10 AM, V14, CNA stated none of the residents have had their SPO2 (oxygen saturation level) levels checked. She stated vital signs were taken once per shift and normal vital signs taken are blood pressure, temperature, and pulse. On 8/19/20, at 10:12 AM, V30, LPN stated vital signs are only done once per shift. On 8/19/20, at 10:15 AM, V14 stated there were no vitals taken for the day shift. The Vital Sign sheet had no documentation that R17's vitals were being monitored. There was no documentation in R17's medical record on 8/19/20 from 8:40 AM until 4:52 PM the facility was monitoring R17's vital signs. R17's Departmental Nursing Notes, dated 8/19/2020 at 4:52 PM, documents R17's temperature was 97.5 degrees F, her respirations were 20, her blood pressure was 208/92 and her pulse was 72. The Note documented resident resting comfortably in bed with eyes closed. Medications administered per MAR (Medication Administration Record) and resident tolerated meds well. This nurse notified (V28), Nurse Practitioner, about residents elevated BP (blood pressure), he stated to recheck in 1 hour after medications given. NP (sic) 142/78 assessment complete, lung sounds clear and bowel sounds present x4. No s/s of distress noted. Will continue to monitor and observe. The Note did not document at what time staff rechecked R17's blood pressure. There is no documentation in R17's medical record from 8/19/20 at 4:52 PM until 8/20/20 at 5:25 PM regarding if facility staff were monitoring R17's condition and her vital signs. R17's COVID 19 Assessment, dated 8/20/2020 at 5:25 PM, documents Temperature-Fever-yes 99.5 pulse ox 96%/RA (Room air). There is no documentation in R17's medical record from 8/20/20 at 5:25 PM until 8/21/20 at 8:30 PM that facility was monitoring R17 condition and her vital signs. R17's COVID 19 Assessment, dated 8/21/2020 at 8:30 PM, documents R17 displayed the following COVID 19 symptoms: Malaise, loss of appetite and loss of taste or smell with oxygen in use. R17's vital signs were documented as follows: Temperature 96.6 Respiratory Rate 22. Pulse Ox 94% with oxygen at 2 liters per nasal cannula. R17's heart rate 100 beats per minute. Blood Pressure 133/73. There is no documentation in R17's medical record from 8/21/20 at 8:30 PM until 8/22/20 evening shift (2:00 P-10P) that the facility was monitoring R17's condition and her vital signs. R17's COVID 19 Assessment, dated 8/22/2020 2-10p, documents R17 displayed the following COVID 19 symptoms: Malaise, loss of appetite and aches all over. R17's vital signs were documented as follows: Temperature 97.3 pulse ox 94%. R17's heart rate 105 beats per minute. Blood pressure 124/58. There is no documentation in R17's medical record from 8/22/20 evening shift until 8/23/20 at 1:39 PM the facility was monitoring R17's condition and her vital signs. There was no documentation V28 had been notified of R17's condition. R17's Departmental Nursing Notes, dated 8/23/2020 at 1:39 PM, documents At approximately 10:30 A.M. Writer was on hall passing meds when a member of CNA staff reported to writer that resident appeared to have stopped breathing. Writer saw resident at approx. (approximately) 10am and resident presented with labored breathing but was still breathing. Writer contacted POA at 10:35 am. Writer contacted general medicine at approx 10:40 am and also writer contacted Madison county coroner at 10:45A.M. Writer currently awaiting coroner arrival. There was no prior documentation of R17's labored breathing or if the facility contacted the doctor of this. On 8/19/2020 at 11:00 AM V8, Licensed Practical Nurse (LPN), stated with regards to where the nursing staff would have charted/documented R17's assessments and vital signs We document in the progress notes in the computer. There are nurses that don't have computer access. They have to document on paper. If it is not in the nurses notes in the computer or on paper, then it wasn't done. On 9/2/2020 at 12:30 PM V13, Infection Control Nurse, stated When a resident has a change in condition, I would expect the resident to be monitored every shift. The nurses would perform full assessment on the resident. The physician would be notified of any changes in the resident's condition. On 9/3/2020 at 9:22 AM V28, Advanced Practice Registered Nurse, stated I was not notified of (R17's) elevated heart rate. With her being positive for COVID and having changes in condition, I would expect the staff to monitor and assess her at least every shift. I would expect the staff to notify me with changes in R17 condition. It is possible that she would have been sent to the hospital. I will send residents to the hospital unless the family requests them to stay in the facility. The Facility's Notification of a Change in a Resident's Status Policy, dated 1/2015, documents The attending physician/responsible party will be notified of a change in a resident's condition, per standards of practice and Federal and/or State Regulations. 1. Guideline for notification of physician/responsible party (not all inclusive): a. Significant change in/ or unstable vital signs (Temperature, B/P, Pulse, Respiration). e. Symptoms of an infectious disease. 2.

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Document in the notes: a. resident's change in condition. b. Physician notification. c. Notification of responsible party. 2. R41's physician's orders [REDACTED]. On 08/04/20 at 2:29 PM, R41's Nurse's Note written by V29, Registered Nurse (RN) documented R41 was afebrile (without fever) with an oxygen saturation of 84% (normal reading is typically between 95-100 %). It documented R41 was not feeling well and not eating. There was no documentation that the physician was notified at that time. On 08/05/20 at 2:27 AM, V8, LPN, documented a late entry for 08/04/20 with no entry time. R41's Nurse's Notes documented R41 was alert and oriented x (times) 1 (normal A & O x 2-3), oxygen saturation 80%, heart rate 99, respirations 26 and temperature 101.5 (degrees Fahrenheit/F). It documented R41 was lethargic with malaise (general feeling of illness/discomfort), diarrhea and skin turgor poor. It documented V8 called V28, Advanced Practice Registered Nurse/APRN, and then sent R41 to the hospital. There was no documentation of R41 being closely monitored or additional assessments being done after 2:29 PM on 8/4/20. On 08/25/20 at 2:00 PM, V29 stated R41 was not feeling well the day she went out to the hospital and had several episodes of diarrhea through the night and that morning, not eating and just not wanting to get out of bed much. V29 stated R41's oxygen saturation levels were low, but after repositioning her it came up. V29 stated that the charting entry comes at the end of the shift and events may have happened earlier in the day. V29 stated she could not remember the exact time of day when the above entry happened with R41 but stated she had been told by staff R41 had not eaten breakfast or lunch. V29 denied calling the doctor or family at that time, stating she did not know if these symptoms were from COVID related infection or not. V29 stated she thought R41 was COVID-19 positive at the time. On 08/25/20 at 2:15 PM, V8 stated R41 was having trouble breathing with episodes of diarrhea throughout the day and was not her usual self. She stated later in the evening (could not remember exact time of day), R41 had a fever, was confused and oxygen saturation levels were low in the 80's. V8 stated she called V28 and was told to send R41 to the hospital. V8 denied knowing how long R41 had these symptoms. V8 stated she was not aware if R41 was COVID-19 positive. V8 stated she could not recall if she had notified the family of R41's change in condition or transfer to the hospital. On 09/02/20 at 12:20 PM, V13, LPN/Infection Preventionist, stated during the months of June and July 2020, the facility did not have testing supplies for COVID-19. She stated none of the residents were tested for COVID-19 until 8/7/20. V13 stated she would not have known for sure if R41 was positive or not because she was not in the facility on 08/07/20 when all were tested . On 09/03/20 at 8:35 AM, V28, APRN, stated he recalled being informed that R41 was having difficulty breathing, but no other details. V28 stated he could not remember what time of day he was contacted but did recall telling staff to send R41 to the hospital. V28 stated he thought R41 was positive for COVID-19. V28 stated he would have expected the facility staff to notify him of an oxygen saturation level in the 80's. He stated he would have expected the facility staff to monitor R41 more frequently, document any changes and notify him of a change in condition. V28 stated he would order to have any resident that was having difficulty breathing to the hospital for evaluation. V28 stated he was not sure if a delay in sending R41 to the hospital contributed to her death because he did not assess her at that time. On 09/03/20 at 11:52 AM, V48, R41's daughter, stated the family was not notified of R41's change in condition or that she had been transferred to the hospital on [DATE]. She stated the hospital notified them on 08/05/20 at 2:00 PM that R41 was admitted on [DATE] with a [DIAGNOSES REDACTED]. V48 stated R41 required assistance with all ADL's due to her left leg being contracted. R48 stated she felt like there were so many changes in staffing that there was no continuity of care for R41 and that not being notified of changes was part of the staff not knowing when R41 had a change from her usual condition. The State of Illinois Certificate of Death Worksheet, dated 08/13/20, documented R41's causes of death as Hypoxemic [MEDICAL CONDITION] and Novel [MEDICAL CONDITION] Infection. The CDC website page, Responding to Coronavirus (COVID-19) in Nursing Homes, updated 4/30/2020, documented the facility should implement the following for residents who have tested positive for COVID-19 or who are experiencing symptoms of COVID-19: Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections; and Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
F 0692 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor, assess and implement intervention to prevent weight loss for 1 of 3 residents (R7) reviewed for nutritional status in a sample of 45. This failure resulted in R7 experiencing a 16-pound weight loss in one month and hospitalization for dehydration. Findings include: R7's Dietary Notes, dated 7/28/2020 documents R7's weight on 7/3/2020 was 153 pounds with no significant weight loss. R7's Minimum Data Set (MDS), dated [DATE], documents that R7 is independent with eating; requiring no encouragement or cues. The MDS documented she is cognitively impaired. R7's current Care Plan, documented I am at risk for weight loss due to my [DIAGNOSES REDACTED]. R7's care plan lists the goal as, I will have no complications in my nutritional status and maintain a stable weight thru my next review: 10/30/20. The approaches include, Offer me a substitute if you notice I am not eating what is served. and Weigh me monthly and PRN (As needed). R7's physician's orders [REDACTED]. R7's Nurse's Notes, dated 8/11/20, documented that R7 was complaining of an upset stomach which she associated with a stomach ulcer. R7's Nursing Notes document that on 8/18/2020, at 7:12 PM, R7 was repeatedly complaining of stomach pain and refused dinner. There was nothing documented as to what interventions were attempted such as offering a substitute or providing encouragement. On 8/19/2020, at 12:00 PM, R4, R7's roommate, stated She (R7) has not been eating. R7's Nurse's Notes, dated 8/21/20 at 12:46 PM documented R7 continued to complain of upset stomach. On 8/25/2020, at approximately 12:00 PM, R7 had her lunch tray in front of her, untouched. At this time, R7 stated, I can't eat. I think my ulcer is back. I haven't eaten in 3 or 4 days. V49, Licensed Practical Nurse/ LPN provided R7 a supplement drink. R7 took one sip out of it. There was no documentation in R7's medical record regarding if the facility assessed R7's continued refusal of food and stomach pain. R7's Care Plan was not updated to address R7's refusal of food and stomach pain. On 8/25/2020, at 2:00 PM, V5, Licensed Practical Nurse (LPN) stated that the medical director had written an order to discontinue weights due to the scale being located off the isolation hall. On 8/27/2020, at 2:17 PM, V36, Medical Director, stated that he did not write the order to discontinue the weights, nor was he aware they had been. R7's Nursing Notes document that on 8/28/2020, R7 experience nausea, vomiting and stomach pain. R7's POA (Power of Attorney) was contacted and requested R7 be sent to the emergency room for evaluation. On 9/1/2020, at 2:15 PM, V34, R7's family member, stated R7 had been admitted to the hospital and was severely dehydrated. R7's Dietary Notes, dated 8/28/2020 documents R7's current weight was 137 and that R7 had experienced a significant weight loss of 10.46%. The Dietary Note documented recommendations to add to weekly weight and begin health shake three times daily with meals. On 9/3/2020, at 1:20 PM, V36, stated, A 10% weight loss from not eating is harmful to the patient and could have potentially been the cause of her (R7's) hospitalization . Some residents require a lot more cueing in order to eat. As of 9/3/2020 at 3:51 PM, after multiple request, the facility had still not provided an appetite log for R7.
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to administer medications as ordered. There were 26 opportunities with 2 errors resulting in a 7.69 % medication error rate. The errors involved (R6, R39) in the sample of 45 out of 12 residents observed during medication administration. Findings include: 1. On 8/25/2020 at 12:45 PM, V3, Licensed Practical Nurse (LPN), was administering medications to R39. V3 stated, (R39) takes his meds crushed. V3 crushed all of R39's medications including Potassium Chloride ER (Extended Release) 10 MEQ (milliequivalents) and gave them to him in yogurt. R39's physician's orders [REDACTED]. It also documents that Potassium Chloride ER are not to be crushed. On 8/27/2020 at 2:00 PM, V37, Nurse Practitioner, stated, Technically not supposed to give Potassium crushed. It can be dissolved in water. They need to let us know so we can give an alternative form if the patient cannot swallow pills. On 8/27/2020, at 2:17 PM, V36, Medical Director, stated, They are not supposed to crush extended release pills. An Article from Medical News Today documents, Many pills have special coatings on them to regulate their rate of release when they enter the body. Crushing them can change the rate of release and lead to temporary overdose. 2. R6's POS, dated August 2020, documents, [MEDICATION NAME] 0.25 mg (Milligrams) TID. The POS does not specify the times to administer. R6's POS, dated July 2020, documents, [MEDICATION NAME] 0.25 mg TID at 8 AM, 12 PM, and 8 PM. R6's Medication Administration Record [REDACTED]. On 8/25/2020, at 3:06 PM, V8, LPN, administered 4 PM meds, including [MEDICATION NAME] 0.25 mg to R6. On 8/27/2020 at 2:00 PM, V37 stated, Every 8 hours would be my preference for scheduling [MEDICATION NAME]. (They) should be verifying the MAR indicated [REDACTED]. On 9/3/2020 at 2:03 PM, V2, Director of Nursing (DON), stated, if the times of the

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F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) order had been changed per patients request, there would have been a telephone order written. The facility's Medication Administration- General Guidelines policy and procedure, undated, documents, Procedure: 2. Medications are administered in accordance with written orders of attending physicians, taking into consideration manufacturer's specifications, and professional standards of practice. It continues, 20. If safe to do so, medication tablets may be crushed or capsules emptied out when resident has difficulty swallowing. A. Sustained release or [MEDICATION NAME] coated dosage forms should generally not be crushed and require a specific physicians order to do so.
F 0880 **Level of harm -** Immediate jeopardy **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 develop and implement infection control procedures to prevent the spread of COVID-19 infection by: failing to implement transmission based precautions, implementing procedures for COVID -19 positive staff and/or symptomatic staff; encouraging residents to wear masks and socially distance from others, utilizing personal protective equipment and perform hand-hygiene and ensuring the environment is clean and sanitary. This failure has the potential to affect all 81 residents living in the facility. This failure resulted in an Immediate Jeopardy (IJ) which began on 8/9/20 when 11 residents, R13, R15, R17, R18, R20, R21, R23, R24, R25, R26 and R28 who resided on the Memory Care unit, tested positive for COVID-19 and the facility failed to implement transmission-based precautions and isolate these resident from residents without COVID-19. Subsequently on the Memory Care Unit, three additional residents, R9, R16 and R27 tested positive for COVID-19. Due to these residents' comorbidities and vulnerabilities, this failure increases their risk for severe illness from COVID-19 and possible death. The Immediate Jeopardy was identified on 8/26/20. On 8/26/20 at 2:13 PM, V1, Administrator, V2, Director of Nurse, V35, Director of Clinical Operations and V12, Clinical Operations Consultant were notified of the Immediate Jeopardy. The surveyors confirmed by observations, record review and interview that the Immediate Jeopardy was removed on 8/27/20 but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of in-service training. Findings include: 1.On 8/17/2020 at 11:10 AM, V1, Administrator, stated The COVID-19 positive residents are located on the COVID-19 Unit (100-hall). But we do have a couple of residents that came back positive over the weekend that are on the Memory Unit. The facility provided a list on 8/17/20 of residents on the Memory Unit who currently tested positive for COVID-19. The following 15 residents were on this list: R9, R12, R13, R15, R16, R17, R18, R20, R21, R23, R24, R25, R26, R27, and R28. On 8/26/20, the facility provided the Line List for COVID-19 Outbreaks in Long Term Care Facilities. The Line List documented that 2 residents, R42 and R6 tested positive for COVID-19 on 7/27/20. The last documented resident on the line list, R44, was noted to be positive on 8/15/20. At that time, the line list documented 60 residents had tested positive for COVID-19. On 9/2/20, at 11:45 AM, V39, Local County Health Department (LCHD) Staff Nurse, stated that the facility was required to notify the Local County Health Department the total number of residents and staff who tested positive for COVID-19 and the total number of deaths which were related to COVID-19. V39 stated that on 8/31/20, the facility had reported to the LCHD 76 residents and 35 staff persons had tested positive for COVID-19. V39 stated the facility reported 19 deaths related to COVID-19. 2. The following observations were conducted on the Memory Unit on 8/17/20 and 8/19/20: On 8/17/2020 at 11:15 AM when entering the Memory Care unit, there were residents in the dining room, without masks and without maintaining social distancing. There were no signs on the residents' rooms' doors indicating any of the residents were on transmission-based precautions. All the residents' room doors were opened to the hallway. V14 and V15, Certified Nurse's Assistants were working on the Memory Unit. On 8/17/20, from 11:20 AM through 11:38 AM, V14 and V15 identified the residents in each of the rooms and if they had tested positive or negative for COVID-19. V14 and V15 stated that many of the residents who had tested positive with COVID-19 were still residing with roommates who had tested negative for COVID-19. V14 and V15 stated the following residents had tested positive for COVID-19: R9, R12, R13, R15, R16, R17, R18, R20, R21, R23, R24, R26 and R28. V14 and V15 stated those positive residents are roommates with the following residents who had tested negative for COVID-19: R10, R11, R14, R19, R22, R27 and R29. On 8/17/20 at 11:37 AM, R21, who was identified as testing positive for COVID-19, was ambulating in the hallway. At that time, R21 was not wearing a mask and was walking by other residents and staff without socially distancing. None of the staff attempted to redirect R21 at that time. On 8/17/2020 from 11:40 AM through 1:16 PM, during the mealtime, residents were gathered in the dining room/activity area for lunch. None of these residents were wearing masks. Residents were sitting at square tables that sat four residents each. The tables were approximately three feet apart. While residents were seated at these tables, these residents could not socially distance 6 feet apart. R25, R16, R27, R26, R13, R18, R28 were all identified as residents who tested positive for COVID-19. These residents were seated at tables with R14, R30, R22, R19, R29 and R31 who had all tested COVID-19 negative. On 8/17/2020 at 11:43 AM and throughout the mealtime, R27, who has been identified as COVID negative, was ambulating in the dining room and up and down the hall without wearing a mask. R27 was not socially distancing from other residents and staff did not intervene or provide redirection. At 1:16 PM R27 was walking in the dining room and the hallway, coughing. R27 was not wearing a mask. V14, V15, and V16 did not intervene or redirect. The staff did not encourage R27 to perform hand hygiene. On 8/17/2020 at 11:50 AM R12, who has been identified as testing positive for COVID-19, was ambulating in the dining room and in the hallway without a mask. At no time did staff, including V14 and V15, provide redirection or attempt to cue R12 to wear a mask. On 8/17/2020 at 12:00 PM, in the dining area, R22, who has been identified as COVID negative, was sitting at a table with R26, and R13, who have been identified as testing positive for COVID-19. R22 coughed and sneezed in her hand. R22 did not cover her mouth or nose when she sneezed. R22 was not wearing a mask. V14, V15, and V16, Licensed Practical Nurse did not attempt to cue or assist R22 with hand hygiene after she coughed. On 8/17/2020 at 12:06 PM R23, who has been identified as COVID-19 positive, was sitting at table in the dining room, coughing without a face mask. R23 did not cover his mouth when coughing. V14, V15, and V16 did not encourage or cue R23 when he was coughing to cover his mouth. On 8/19/20, at 5:50 AM, on the Memory Care Unit, none of the residents' rooms' doors had signage that any of the residents were on transmission-based contact-droplet precautions. At that time, V14 and V30, Licensed Practical Nurse/LPN were working on the Unit. V14 stated that those residents who tested positive for COVID-19 were located from rooms 309 to 316. At that time, R43 and R13 were standing in the hall outside their rooms with no masks on. V14 provided no redirection to go back to their rooms. V14 stated R43 did not have COVID-19 but R13 was positive for COVID-19. V14 and V30 stated the residents were all moved on 08/17/20 and again on 08/18/20 due to some of the residents sharing rooms with positive residents. V14 and V30 stated they were not sure why the negative residents were still sharing the same hall, especially since they have many that wander the halls all day. V14 and V30 stated they did not know if they were supposed to use new PPE when going in and out of positive resident rooms and stated they wear the same gowns unless they leave the unit. On 08/19/20 at 6:30 AM, V26, CNA came onto the Memory Care unit to work. V14 stated to her Why are you on this unit, because you're positive (tested positive for COVID-19) and we still have negative residents? V26 told her she was told to come to this hall to work. V26 went into every room on the hall with the same gown, gloves, mask and face shield to check on residents. V26 took R13 by the arm and walk her back into her room from the hallway. V26 then went into R17's room and reposition R17 in bed. Both residents in this room, have COVID-19 infection. V26 continued up and down the hall in and out of resident rooms. At 7:25 AM, V26 was informed by V15, CNA she needed to be on the North hall to work. V26 exited the Memory Care hall through the 200-hall then went directly to the North hall double doors. V26 did not doff her PPE when leaving the Memory Care unit. The facility's undated Line List for COVID-19 Outbreaks in LTC Facilities, undated, was provided on 8/26/20. The Line list documented V26 had an onset of COVID-19 on 8/14/20. On 08/19/20 at 7:45 AM, on the Memory Unit, V25, Maintenance and V32, Housekeeping, began hanging a plastic sheet-like barrier with a zipper in the middle. The plastic sheet was hanging from the ceiling to the floor starting at resident rooms [ROOM NUMBERS]. The plastic was attached from the ceiling to the floor around two small poles attached to either wall. There was an approximate 1-1.5-inch gap between the wall and the poles on either side. The plastic was not secured to the ceiling, floor or walls for an airtight seal. V32 stated he was told to come assist V25 and assumed it was to separate the positive (tested positive for COVID-19) residents from the negative ones. While V25 and V37 were putting up the plastic, R27 was wandering the hall between the positive and negative side. On 8/19/2020 at 8:10 AM R12, who has been identified as testing positive for COVID-19 with symptoms of fever, was walking up and down the hallway coughing and made no attempt to cover her mouth. R12 was not wearing a mask. R12 did not maintain social distancing as she walked pass R33, who has been identified as COVID negative. On 8/19/2020 at 8:15 AM R27, who was identified as newly COVID positive, was walking in the hallway coughing, and was not wearing a mask. R27 walked through the zipper area of the plastic and opened the fire doors into the common area. R27 did not maintain social distancing as she walked past R33, who has been identified as COVID negative, sitting in the hallway. V15 redirected R27 and walked with R27 through the hall, again walking pass R33, to her room. At

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F 0880

Level of harm - Immediate jeopardy

Residents Affected - Many

(continued... from page 4)

8:17 AM, V15 stated (R27) is confused and will not remember or understand the redirection. At 9:00 AM, again, R27 came through the plastic sheeting from the positive side to the negative. V14 was in another resident's room passing breakfast tray and was informed by V31 that R27 had come through the plastic barrier. V14 then retrieved R27 and returned her to her room. On 8/19/2020 at 8:35 AM R7 was walking in the hall coughing in her hand with a runny nose. R7 did not have a mask on. R7 did not maintain social distancing when walking pass R21, who has been identified as positive, who was standing in the hallway. On 08/19/20 from 5:50 AM to 11:20 AM, R43 was wandering in the hall of the Memory Care unit. Staff were observed to redirect R43 multiple times back into her room, but she would stay for a short time and would come back out into the hall. R43 did not wear a mask and was not asked by any staff to wear one. At 6:15 AM, V14 stated they do not have masks for the residents. On 8/17/2020 at 11:40 AM V14, CNA was working on the Memory Unit. V14 stated We do have multiple residents that are positive for COVID. The positive and negative residents are in the same room. The positive residents do wander in rooms of negative residents or vice versa. In and out of each other's room. We try to redirect but with only 2 CNAs it can be difficult. They (residents) don't understand and will do it again. The residents eat in dining room. I don't know what precautions were put in place for the COVID positive residents. No one is on droplet isolation. On 8/17/2020 at 11:50 AM V15, CNA working on the Memory Unit, stated The residents wander in and out of each other's room. You will find them laying in each other's beds. If the 2 CNAs are in the rooms no one is here to watch the others. We do have positive residents on the hall. The residents are not separated. They (positive) are in the rooms with the negative residents. Not sure of any precautions put in place. No isolation. If there was isolation there would be a sign on the door. The residents with the infection would be moved and separated from the other residents. We have not done that. All the residents do wander in and out of the rooms and up and down the hall. On 8/17/2020 at 11:57 AM V27, Housekeeper, was working the Memory Unit.V27 stated I don't know of any residents on isolation. I know there are residents that are positive but don't know who they are. On 8/17/2020 at 1:30 PM V16, Licensed Practical Nurse (LPN), was questioned regarding how she knows who is positive for COVID-19. V16 stated I go and ask. They (Administration) get the results and then will tell us. But I don't wait. I go to them and ask. I need to know. Currently do not have any residents on droplet isolation or precautions. If they were there would be a sign on the door to report to the nurse. Biohazard containers would be in the room and supplies outside the door. Residents that are positive are in the rooms with negatives. No separation has been done. And we have residents with symptoms. On 8/17/2020 at 2:45 PM V17, Agency CNA, was working on the evening shift on the Memory unit. V17 stated I don't know of any residents on any isolation. I assume the nurse would tell us, but the nurse is not back here. If there were residents on isolation there would be barrels in the hallway and signs would be outside the door. But none are down here. On 8/17/2020 at 2:48 PM V18, CNA, was working the evening shift on the Memory unit. V18 stated It's my first day down here. I have not received report of residents on precautions. I'm not aware of any droplet precautions. On 8/17/2020 at 2:49 PM V19 CNA, was working the evening shift on the Memory unit. V19 stated If any residents were on precautions, we would be told that by the nurse. I have not received that information. There would be supplies and signs outside doors. On 8/17/2020 at 2:50 PM V20, Laundry Aide, was entering and exiting rooms, delivering residents' laundry on the unit and stated I don't know anyone on any isolation or precautions. I don't know anyone with COVID 19. I come in, do my job and go home. On 8/17/2020 at 3:00 PM V5, Minimum Data Set/Care Plan Coordinator, stated The process for residents that are positive for COVID is those residents are placed on precautions standard and droplet precautions and in isolation. We do have residents with positive results on the unit. The COVID positive residents and the negative residents should not be in the same room. The rooms don't allow for 6 feet, social distancing and if both residents were not positive then 1 resident would have to be moved. The residents should have been moved immediately. None of the residents should be eating in the dining room. Each resident should have a mask on. The COVID 19 results came back Saturday (8/15) and we are starting to make some room changes. There were residents with results on 8/10 and symptoms that should have had room changes and placed on droplet isolation before today. On 8/19/2020 at 9:36 AM V28, Nurse Practitioner, FNP, stated When resident test positive for COVID I would expect the resident to be placed on droplet isolation immediately. I would expect the residents that are negative and the residents that are positive to be separated. On 8/19/2020 at 11:40 AM V1, Administrator stated If a resident's COVID 19 results were positive. Droplet precautions are to be put into place immediately upon receiving results. Not a week later. The residents should wear face mask and the staff should encourage them. On 8/24/2020 at 4:34 PM, when asked if a resident tested positive for COVID 19 what would be your expectation of the facility, V36, Medical Director, stated I would expect the positive residents to be separated from the negative residents and placed on Contact and Droplet isolation immediately. The residents on the memory unit have memory issues with other comorbidities. Having the negative and the positives together puts the negative residents at risk for getting [MEDICAL CONDITION]. Each resident responds differently. Due to the residents' vulnerability this could be life threatening. The following residents are located on the Memory Care Unit and have tested positive for COVID-19: R13's August 2020 POS documented she has [DIAGNOSES REDACTED]. R13's Laboratory Result, dated 8/09/2020, documented she had tested positive for COVID-19. R15's August 2020 POS documented she has [DIAGNOSES REDACTED]. R17's August 2020 physician's orders [REDACTED]. R17's Laboratory Result, dated 8/09/2020, documented she had tested positive for COVID-19. R18's August 2020 POS documented she has a [DIAGNOSES REDACTED]. R18's Laboratory Result, dated 8/09/2020, documented she had tested positive for COVID-19. R20's August 2020 POS documented he has [DIAGNOSES REDACTED]. His Laboratory Result, dated 8/09/2020, documented he had tested positive for COVID-19. R21's August 2020 POS documented she has a [DIAGNOSES REDACTED]. R21's Laboratory Result, dated 8/09/2020, documented she had tested positive for COVID-19. R23's August 2020 POS documented he has a [DIAGNOSES REDACTED]. R24's August 2020 POS documented he has [DIAGNOSES REDACTED]. R24's Laboratory Result, dated 8/09/2020, documented he had tested positive for COVID-19. R25's August 2020 POS documented she has a [DIAGNOSES REDACTED]. R25's Laboratory Result, dated 8/09/2020, documented she had tested positive for COVID-19. R26's August 2020 POS documented she has [DIAGNOSES REDACTED]. R26's Laboratory Result, dated 8/09/2020, documented she had tested positive for COVID-19. R28's Face Sheet, not dated, documented she has [DIAGNOSES REDACTED]. R28's Laboratory Result, dated 8/09/2020, documented she had tested Positive for COVID-19. R9's August 2020 physician's orders [REDACTED]. R9's Laboratory Result, dated 8/15/2020, documented she had tested positive for COVID-19. R16's August physician's orders [REDACTED]. R16's Laboratory Result, dated 8/15/2020, documented she had tested Positive for COVID-19. R27's August 2020 POS documented she has [DIAGNOSES REDACTED]. R27's Laboratory Result, dated 8/17/2020, documented she had tested positive for COVID-19. R27's current Care Plan did not have documentation that R27 was positive for COVID-19 infection or interventions in place. R12's August 2020 POS documented she has [DIAGNOSES REDACTED]. R12's Care Plan, dated 8/8/20 documented she had tested positive for COVID-19 and should be placed on Isolation Droplet precautions. After multiple request, the facility was unable to provide a laboratory test result confirming R12 had COVID-19. The Facility's Coronavirus (COVID-19) Policy, revised 7/7/20, documented Any resident suspected of having Coronavirus will be placed on Standard, Contact and Droplet Precautions as per CDC guidelines. The Policy documents The infected resident will remain in his/her room on precautions with the door closed, if possible. The asymptomatic roommate will be moved to a private room, if available or to the Designated Unit, for observation pending consultation with the local health department. The Centers for Disease Control (CDC) website page, Responding to Coronavirus (COVID-19) in Nursing Homes, updated 4/30/2020, documented the facility should implement the following for residents who have tested positive for COVID-19: Ensure the resident is isolated and cared for using all recommended COVID-19 PPE; Place the resident in a single room if possible pending results of [DIAGNOSES REDACTED]-CoV-2 testing; Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit); If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission; If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit; Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for [DIAGNOSES REDACTED]-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). The CDC website page, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated on July 15, 2020, documents Source control refers to use of cloth face coverings or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. The website page documents Patients and visitors should, ideally, wear their own cloth face covering (if tolerated) upon arrival to and throughout their stay in the

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 5) facility. If they do not have a face covering, they should be offered a facemask or cloth face covering, as supplies allow. Patients may remove their cloth face covering when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room. 3. R5's POS, dated August 2020, documented R5 was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The Facility's Line List for COVID-19 Outbreaks in Long Term Care Facilities, undated, documented R5 had the onset of COVID-19 on 8/7/20. The Line list documented she had tested positive for COVID-19 but did not document when the positive laboratory results were received. On 08/17/20, R5 was in a room located on the positive COVID-19 unit on the 100-hall. R5's Nurse's Notes and Daily Care Guide, both dated 8/20/20, documented she resided on the 100-hall, the COVID-19 positive unit. On 08 25/20, at 11:30 AM, R5 was observed in a room on the Memory unit (300 hall). There was no signage on her room door indicating she was on any type of transmission-based precautions. On 08/25/20, 12:30 PM V16, LPN stated R5 was just moved to the Memory unit on 08/24/20. V16 stated she was not sure if R5 had COVID-19 or not. On 08/19/20 at 12:45 PM, V1, Administrator, was asked for vital signs, nurse's notes for August 2020 and any information on when R5 was tested for COVID-19 and the results. As of 08/28/20 at 3:00 PM, there was no additional documentation given by the facility. 4. On 8/17/2020, at 11:45 AM, V7, LPN, I found out yesterday (8/16/2020) I was positive. I was sick all last week and I worked. V7 stated (V1) knew I was sick with cough, no taste/smell, low grade temp, and a headache too. She (V1) told me to come to work even when I had symptoms. On 8/17/2020, throughout the day shift on the COVID-19 positive unit, V7 was coughing often and her eyes were blood shot. V7 appeared very fatigued and winded. V7's lab report documents the specimen was collected on 8/14/2020. The laboratory results dated [DATE] documents V7 is positive for COVID-19. On 8/26/2020, at 8:30 AM, a telephone interview was conducted with V7. V7 stated she was at home quarantining with symptoms of a cough, shortness of breath, loss of taste/smell as well as extreme fatigue. V7 could be heard coughing during the conversation. V7 also stated, The last day I worked was 8/18/2020. I worked a double on the memory care unit. As a nurse manager, I am not on the staffing pattern but I fill in when staffing is low. I help answer call lights and pass trays every day I work. 5. On 8/19/20 at 7:25 AM, V29, Registered Nurse (RN) was passing medication on the COVID-19 positive hallway (North Hall). V29 stated she had just come back today after being off due to having positive COVID-19. V29 stated she had been symptomatic during her time off. V29 stated she had not been feeling well for a few days prior to being tested but continued to come to work. V29 stated her symptoms started on 08/06/20 and she was not tested until 08/08/20. V29 stated she was at work on 08/10/20 when she was informed, she had tested positive for COVID-19. She stated she was told to finish her shift and go home. She stated she then was off from 08/11/20 to 08/18/20 and returned 08/19/20. She stated she will be retested [DATE] by facility staff. The facility's Line List for COVID-19 Outbreaks in Long-term Care Facilities documented V29 had onset of COVID-19 symptoms on 8/7/20 and had tested positive for COVID-19. The CDC website page, Preparing for COVID-19 in Nursing Homes updated on 6/25/20, documents As part of routine practice, ask HCP (including consultant personnel and ancillary staff such as environmental and dietary services) to regularly monitor themselves for fever and symptoms consistent with COVID-19; Remind HCP to stay home when they are ill; if HCP develop fever (T100.0F) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace. Have a plan for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers). The website page document Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19; Actively take their temperature and document absence of symptoms consistent with COVID-19; and if they are ill, have them keep their cloth face covering or facemask on and leave the workplace. The CDC website page, Criteria for Return to Work for Healthcare Personnel with [DIAGNOSES REDACTED]-CoV-2 -Infection (interim Guidance), updated on 8/10/20, documents Healthcare Personnel (HCP) with mild to moderate illness who are not severely immunocompromised can return to work when at least 10 days have passed since symptoms first appeared, at least 24 hours have passed since last fever without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved. The website page documents Note: HCP who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive [MEDICAL CONDITION] diagnostic test. The facility's policy, titled, Coronavirus dated 5/29/2020, documents, Staff members who have signs and symptoms of respiratory infection while on the job should: immediately stop work and self-isolate at home. 6. On 8/17/2020, at 10:45, V1 stated, All residents who have tested positive for COVID-19 reside on the North Hall in the facility. We are wearing the yellow reusable gowns until they enter the (COVID isolation) unit. When staff enter the unit, they are to use the blue disposable gowns. V1 stated that all residents on the COVID-19 unit are on droplet contact precautions. V1 stated that all staff are expected to wear blue disposable gowns, gloves, goggles/and or face shields. On 8/19/2020, V25, Maintenance, entered the double doors to the North COVID isolation hall in a reusable cloth yellow gown and proceeded past the shower curtain that was being used as a plastic barrier to the rest of the hall. At that time, V35, Director of Clinical Operations, stated, You need to put on a blue gown before entering this area. V25 stated, Oh, that's new today. On 8/19/2020, at 12:25 PM, V25, was in the hallway of North hall and stated he was just checking the rooms, and it was his first time wearing the blue isolation gowns. V25 continued to state, I had just been wearing the yellow (gown). On 8/17/2020, at 11:11 AM, V5, MDS Coordinator, exited the North COVID isolation hall through the double doors wearing a blue disposable gown over a yellow reusable gown. V1 instructed V5 that she was to doff the blue gown before exiting the isolation hall. At this time, V1 stated, She should have removed the blue gown before exiting the unit. The facility's policy, titled, Coronavirus dated 5/29/2020, documents, Preventing Illness: 1. The best way to prevent the illness is to avoid being exposed to [MEDICAL CONDITION] and properly using/wearing PPE when needed. 7. On 8/17/2020, at approximately 11:45 AM, V7, LPN/Unit Manager, stated, We have no housekeeping staff back here (on the COVID-19 unit). It doesn't help prevent the spread of infection. On 8/17/2020, at 11:55 AM, the floors were visibly soiled and sticky throughout the North COVID isolation hall. At this time, V5, LPN stated, We haven't had housekeeping back here in over a week. On 8/17/2020, at 12:30 PM, R1, who resides on the COVID-19 unit, stated, They do not clean my room. On 8/17/2020, at 1:00 PM, V1 stated, Honestly, I don't know when the last time it (the COVID Isolation hall) was cleaned. Housekeeping called off today. We will call in evening shift to do housekeeping. We should be cleaning high touch surfaces 4 times a day. On 8/19/2020, at 8:45 AM, R1 stated, They still have not cleaned my room since we talked about it the other day (8/17/2020) and the bathroom stinks. The facility's policy, titled, Coronavirus dated revised 7/7/20, documents, Environmental Cleaning with an approved disinfectant should be completed daily, or when visibly soiled and for terminal cleaning after infection has resolved. Clean all high touch point areas. The Policy documents An approved disinfectant will be used for cleaning the rooms of residents with Coronavirus. Attention should be given ro bedside tables, handrails, call buttons, windowsills, and toilets. 8. On 08/19/20 at 5:45 AM, upon arrival to the front door to the facility, V30, Licensed Practical Nurse (LPN) was standing and smoking in front of the entrance. V30 gave this surveyor the code to get into the building and stated no one was available to do any screening at this hour. There was no one at the front desk or in the lobby area. V30 did not attempt to screen the surveyor. The CDC website page, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated on July 15, 2020, documents to Screen everyone (patients, HCP (Healthcare Personnel, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 infection and ensure they are [MEDICATION NAME] source control. The website documents Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature 100.0F or subjective fever; and ask them if they have been advised to self-quarantine because of exposure to someone with [DIAGNOSES REDACTED]-CoV-2 infection. 9. On 8/19/20, at 5:50 AM, V30 walked through the double doors of the COVID-19 unit with a mask on only and without hand sanitizing or donning a gown, gloves or face shield/goggles. Multiple signs on the double doors documented full PPE required past this point including gown, mask, face shield or goggl