STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265524	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHVIEW VILLAGE	2415 NORTH KINGSHIGHWAY SAINT LOUIS, MO 63113

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure systems were in place and staff followed them, to prevent resident to resident sexual abuse and physical abuse from occurring. When Resident #7 was sexually inappropriate with Resident #8, staff did not ensure Resident #7 did not continue to engage in the inappropriate behavior with Resident #8, later that same morning. After learning of the second sexually inappropriate behavior, the facility failed to communicate the first sexually inappropriate behavior to the administrator and Interim Director of Nurses (IDON) in a timely manner. In addition, the facility failed to investigate a physical and/or verbal altercation between (Resident #5) and (Resident #18). Then, approximately two weeks later, Resident #5 attempted to choke Resident #6. After returning from a psychiatric evaluation, the facility failed to ensure staff monitored Resident #5 one on one and failed to communicate the specific incident that occurred between Resident #5 and Resident #6 to staff on the floor where Resident #5 had been moved. The resident sample size was 17. The census was 219. The administrator was notified on 7/9/20 at 4:00 P.M. of an Immediate Jeopardy (IJ) which began on 7/6/20. The IJ was removed on 7/9/20, as confirmed by surveyor onsite verification. Review of the facility abuse, neglect, and mistreatment prohibition policy, updated on 12/4/18, showed: -Definition of abuse: The willful infliction of injury, unreasonable confinement, intimidation, exploitation, mistreatment, or punishment with resulting physical harm, pain or mental anguish. Included is verbal abuse, sexual abuse, physical abuse, and mental abuse. Willful, as used in this definition of abuse, means the individual acted deliberately, not that the individual must have intended to inflict injury or harm; -Neglect: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress; Procedure: In order to ensure no abuse is allowed in the facility, the following steps will be as follows: -Prevention: All residents upon admission are informed of the grievance procedure and the social service employee introduces him/herself as the person to report concerns, All staff receive education on the definition of abuse and what to do if they should suspect or observe any treatment of [REDACTED]. The resident is provided information on how to proceed with filling out a grievance form and who the grievance officer is; -Identification: Patterns of bruising, occurrences or patterns and trends that may constitute abuse shall be investigated to determine if further investigation/concern is warranted. This would include statements from the resident, family members, visitors, employees, and/or roommates or other residents. The investigation at completion should state if further action is taken such as reporting to law enforcement or Department of Health and Senior Services (DHSS); -Training: All employees during their orientation. Also, yearly but may be more frequently; Protection: -During an investigation, an employee alleged to have caused harm is suspended until the investigation is completed. If a resident alleges another resident has caused the harm, the residents are to be separated, preferably to another area of the facility; Reporting/Response: -The facility must ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later that 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to DHSS in accordance with state law; -The facility must report the results of all investigations to the administrator or his/her designated representative and to other officials in accordance with state law; Reports are to include: -Specific description of the incident (persons, date, time and location of the incident); -Relevant information from residents medical record; -A description of the resident's injury and photographs if possible; -Pedigree of any staff member involved and their position as a staff member; -Any written statements; -Documentation of any interviews with other residents who may have been affected; -Documentation of interviews with other residents who might have some knowledge of the incident; -Summary of the investigation including corrective actions/monitoring the facility implemented to prevent the incident from reoccurring; -Police report when available; -Any other relevant information that would be helpful to show what happened for the specific incident and actions taken by the facility not included in the above. Review of an addendum to the above policy, completed on 7/8/20, showed: -Any staff that observes a patient harming or attempting to harm another resident or staff, threatening self harm, inappropriate sexual behaviors, or elopement attempts, must immediately stay with the patient in a one on one setting and document on the facility one on one tool. Staff must inform the charge nurse on the floor, the nursing home administrator, DON and Social Service Worker (SSW) for the floor; -The facility will assure all reportable incidents are reported within 2 hours of the incident. The facility administrator will review the self-report document and follow up with all needed staff to complete the investigation. All additional information collected after the 2 hour frame will be sent over for review; -Staff may not remove any resident from one on one without the approval of the administrator or DON; -Staff will document all one on ones on the facility tool; -Charge Nurse will document in the nurses' notes all resident behaviors and complete a documented nursing assessment each shift for 72 hours in the medical record; -Charge Nurse will notify responsible party, legal guardian/power of attorney (POA), primary physician and document any new orders and follow-up as needed; -Charge Nurse and Social Services will document any interventions in the nurses' notes and report any further behaviors to the physician, responsible party and update staff on any further interventions and place in the 24 hour report sheet; -MDS Nurse will update the care plan; -The Charge Nurse will be responsible for completing an in-house transfer form that includes the reason for the transfer. The Charge Nurse and Social Service Staff will assure there is a note placed in the medical record. The facility tool will be filed by Social Services (room move agreement tool); -The Charge Nurse will assure all information related to the reason for the transfer will be clearly documented in the 24 hour report sheet and communicated to all staff on the floor. Review of the facility's policy on Abuse Prevention, dated 2/2020, used to in-service staff on 3/30/20, showed: -The facility affirms the right of their residents to be free from abuse, neglect, exploitation, misappropriation of property and mistreatment of [REDACTED]. The purpose of this policy is to assure that the facility is doing all that is within it's control to prevent occurrences of abuse, neglect, exploitation, misappropriation property and mistreatment of [REDACTED]. Implementing systems to promptly and aggressively investigate all reports and allegations of abuse, neglect, exploitation, misappropriation of property and mistreatment and making the necessary changes to prevent future occurrences; -Definitions: Physical Abuse: Physical Abuse includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment. Sexual Abuse: includes but not limited to sexual harassment, sexual coercion or sexual assault; -Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of other residents and employees of the facility. In addition, the facility shall take all steps necessary to ensure the

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) safety of residents including, but not limited to the separation of the residents. 1. Review of Resident #8's care plan, updated 3/3/20, showed: -Problem: Resident at risk for Abuse/Neglect related to [DIAGNOSES REDACTED]. Nursing to follow facility protocol per orders. Observe resident closely for change in behavior, tearfulness, anxiousness, [MEDICAL CONDITION], fear and other mood changes. Notify the physician of any noted changes and follow orders as given. Staff to notify any changes to the physician, DON and Social Services. Review of Resident #8's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 4/30/20, showed: -[DIAGNOSES REDACTED]. Review of Resident #7's care plan, updated 3/10/20, showed: -Problem: History of Inappropriate Sexual behavior related to (r/t) touching others/comments toward others; -Approach: Educate resident on inappropriate activities and behaviors with goal setting. Educate resident on risks of sexual activities. Give medication per orders and monitor effectiveness of medication. Make staff aware of the problem. Provide resident with facility protocols on rules/regulations regarding sexual conduct. Reinforce appropriate boundaries for patient/patient staff. Report any inappropriate sexual behavior to Psychiatrist/Primary physician/DON/Administrator. Staff to monitor resident frequently especially at night, making hourly rounds. Review of Resident #7's quarterly MDS, dated [DATE], showed: -[DIAGNOSES REDACTED]. Review of Resident #7's physician's orders [REDACTED]. Review of a facility self report sent to the DHSS, on 7/7/20 at 11:07 A.M., showed: -Date and time of the alleged incident: 7/7/20 at 9:45 A.M.; -Summary of alleged incident: Resident #7 was observed by staff engaging in an inappropriate sexual act with Resident #8; -Handwritten statement dated 7/7/20, no time, completed by Certified Nurse Aide (CNA) I, showed: This A.M. while picking up breakfast trays, he/she witnessed Resident #7 performing an inappropriate sexual act with Resident #8; -Handwritten statement dated 7/7/20 at 10:00 A.M., completed by Certified Medication Technician (CMT) J, showed: He/she was at the nurse's station when Patient Care Assistant (PCA) K and CNA I called him/her to Resident #7 and #8's room. Resident #7 was standing over Resident #8 with his/her pants down standing directly in front of Resident #8; -Handwritten statement, dated 7/7/20 at 10:00 A.M., completed by PCA K, showed: Was picking up trays and saw resident standing in front of another resident. He/she went to get staff; -Handwritten statement, dated 7/7/20 at 10:00 A.M., completed by Nurse L, showed: Staff reported Resident #7 was engaged in an inappropriate sexual act with Resident #8. Review of the facility's Continuous Monitoring Form, dated 7/7/20, showed: -10:00 A.M., Resident #7 sat at the time clock. The time clock is located on the second floor near the nurse's station; -Signed by Nurse L. During an interview on 7/7/20 at 12:20 P.M., the administrator said Resident #7 and #8 had not had any prior incidents, but both had behaviors. The facility was conducting an investigation. The residents have been separated and are no longer roommates. During an interview on 7/7/20 at 1:00 P.M., the Social Service Director said staff notified her at 9:45 A.M. of Resident #7's inappropriate sexual behavior with Resident #8. During an interview on 7/7/20 at 1:30 P.M., CNA I said he/she worked the day shift on the second floor on 7/7/20. At approximately 8:30 A.M., while passing breakfast trays, he/she observed Resident #8 sitting in his/her chair at the bedside. Resident #7 was facing Resident #8 with his/her brief and pants around his/her ankles performing an inappropriate sexual act. CNA I removed Resident #7 from the room and sat him/her at the nurse's station. He/she instructed the resident to sit at the desk. He/she did not stay with the resident nor inform the charge nurse because he/she was not on the floor at the time. He/she continued to pass the trays on the hall. A while later he/she heard PCA K call for staff to come to the resident's room. When he/she arrived at the resident's door, Resident #7's pants and brief were pulled down around his/her ankles. He/she was facing Resident #8 while he/she sat in the chair. He/she immediately removed the resident from the room and brought him/her to the nurse's desk. He/she notified the charge nurse at that time. They were instructed by the charge nurse to began one on one monitoring of Resident #7. The charge nurse notified social services. During an interview on 7/7/20 at 1:03 P.M., CMT J said he/she passed the medications during the day shift on the second floor on 7/7/20. While at the nurse's station, he/she heard PCA K call for staff to come to Resident #7 and #8's room. When he/she and CNA I arrived at the resident's room, Resident #8 sat in his/her chair at the bedside with his/her face turned facing Resident #7. Resident #7 stood facing Resident #8 with his/her pants down. Resident #7 was standing so close to Resident #8's face that it made him/her feel uncomfortable. CNA I pulled up Resident #7's pants, removed him/her from the room and placed him/her at the nurse's station. CNA I notified Nurse L of the incident. Nurse L instructed him/her to stay with the resident while he/she notified social services and the administrator. When asked whether he/she knew of any prior incidents, CMT J said approximately a month and a half ago both residents were found in the bed together on top of the covers. He/she reported it to Nurse L. During an interview on 7/7/20 at 1:20 P.M., PCA K said he/she was working on the second floor on 7/7/20 on the day shift. While picking up trays, he/she walked into Resident #7 and #8's room and saw Resident #7 with his/her pants down next to Resident #8 while he/she sat in the chair. He/she immediately called staff to the room. CNA I came running to the room and removed Resident #7 and placed him/her at the desk. He/she didn't know of any prior incidents. During an interview on 7/7/20 at 2:00 P.M., Nurse L said he/she was the charge nurse on 7/7/20 on the second floor. He/she said Resident #7 has a history of sexually inappropriate behavior. He/she comes out of his/her room with pants down and has a history of touching staff inappropriately. He/she was started on [MEDICATION NAME] due to his/her inappropriate behaviors. This A.M., staff reported Resident #7 was performing an inappropriate sexual act with Resident #8. Staff immediately separated both residents. Resident #8 was placed at the nurse's station. He/she instructed staff to begin one on one monitoring. He/she notified the Social Service Director and administrator. This surveyor asked whether he/she was aware the inappropriate sexual behavior occurred twice instead of once. Nurse L said he/she only knew of the current incident staff reported. After a few minutes, Nurse L said he/she did recall CNA I saying Resident #8 had engaged in inappropriate sexual behavior earlier that morning when he/she reported the current incident. In his/her haste to report the incident, he/she reported the current incident to the Social Service Director. Staff should have reported the first incident immediately. If he/she had known about the first incident he/she would have instructed the staff to separate the residents and place Resident #7 on one on one monitoring. This is what the staff have been instructed to do. He/she doesn't know why CNA I did not report the first incident when it occurred. Review of Resident #7's progress notes, dated 7/7/20, showed: -2:36 P.M. (First note documented for 7/7/20): In house transfer from Two South, sent to Six South due to inappropriate sexual behaviors. Report received from Two South charge nurse. Resident placed on one on one with mental health for behaviors. Resident calm at this time, will continue to monitor; -2:57 P.M.: At 10:00 A.M. staff stated the resident was observed performing an inappropriate sexual act with his/her roommate. The resident was dressed by staff and placed on one on one observation. Social Services was notified. The resident was moved to the sixth floor. During an interview on 7/7/20 at 3:10 P.M., the Social Service Director said Nurse L notified her of Resident #7's inappropriate sexual behavior with Resident #8 at approximately 9:45 A.M. She immediately went to the second floor. Resident #7 was at the nurse's desk with a staff member. She began her investigation at that time. The nurse did not make her aware of prior inappropriate behavior that occurred earlier in the morning. She would have expected staff to report the earlier inappropriate behavior immediately. Resident #8 would have been immediately placed on one on one monitoring. During an interview on 7/8/20 at 9:38 A.M., the interim DON (IDON) said she became the IDON late afternoon on 7/7/20. She was aware of Resident #7's inappropriate sexual behavior with Resident #8. She was not aware a prior incident occurred on 7/7/20. Staff should have removed Resident #7, started one on one monitoring and notified the charge nurse. The resident should not have been left unsupervised. During an interview on 7/8/20 at 10:45 A.M., the administrator and Director of Operations, said they were unaware of a prior incident of inappropriate sexual behavior with Resident #7 and #8 on 7/7/20. Nurse L notified them of one incident on 7/7/20. When they were made aware, Resident #7 was immediately removed from the room and placed on one on one. The administrator said staff should have removed Resident #7 from the room, placed him/her on one on one monitoring and notified the charge nurse. The charge nurse would have notified administration. She doesn't know why this was not done. Staff have been in-serviced on the facility's policy regarding Abuse and Neglect and should know what to do. Review of facility's In-service on Abuse and Neglect, sign in sheet, dated 3/30/20, showed CNA I's signature of attendance. During an second interview on 7/8/20 at 2:15 P.M., CNA I said breakfast trays came to the floor between 8:00 A.M. and 8:30 A.M. It might of been a little later. When he/she brought Resident #7 from the room after the first incident, he/she placed him/her at the nurse's station next to the time clock. CMT J was at the medication cart behind the nurse's station. He/she continued to pass the trays. He/she did not tell CMT J why he/she placed the resident at the nurse's desk. He/she assumed CMT J knew to watch the resident because he/she was at the medication cart when he/she brought the resident out of the room. He/she didn't tell CMT J about Resident's #7 inappropriate sexual behavior with Resident #8. He/she assumed he/she heard him/her tell the resident to stay at the desk. He/she did not see Resident #7 return to the room because he/she was passing trays. During an second interview on 7/8/20 at 2:30 P.M., CMT J said he/she was only aware of one inappropriate sexual behavior involving Residents #7 and #8. PCA K called for staff to come to Resident #7 and #8's room. That was when he/she saw Resident #7 with his/her pants down standing very close to Resident

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F 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) #8's face. CNA I removed Resident #7 from the room and notified Nurse L. Nurse L instructed him/her to stay with Resident #7 for one on one monitoring. During an interview on 7/9/20 at 7:04 P.M., the facility's Medical Director said he expected the staff to follow the facility's policy on Abuse and Neglect. The second incident of inappropriate sexual behavior might not have occurred if staff had followed their policy. 2. Review of Resident #6's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -[DIAGNOSES REDACTED].#6 and Resident #17) received by the DHSS on 4/30/20, showed: -A handwritten statement, dated 4/30/20 at 6:00 P.M. from Mental Health Technician (MHT, a non-nursing staff member trained by the facility to assist nursing staff with residents exhibiting behavioral problems) D, showed Resident #6 rolled down the hall and Resident #17 hit him/her in the face; -A handwritten statement, dated 4/30/20 at 6:00 P.M., from CNA C, showed as he/she passed meal trays, he/she heard Resident #6 crying in his/her room. He/she went to the room and Resident #6 was bleeding from his/her nose; -A typed statement from SSW H, dated 5/1/20, showed Resident #6 was moved to the second floor for protective oversight after being struck in the nose. Review of Resident #6's progress notes, showed: -5/1/20 at 1:28 P.M.: Resident was transferred from the sixth floor to the second floor after a resident to resident altercation. Resident noted to have a bruise to the bridge of his/her nose; -5/4/20 at 4:04 P.M.: Resident remained on observation for resident to resident altercation. Upon assessment, left eye noted to have purple discoloration and red bruise to bridge of nose; -6/10/20 at 2:17 P.M.: Resident sexually inappropriate with female residents and staff. The resident was moved to the third floor. Review of Resident #5's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Adequate hearing and vision; -Clear speech - distinct intelligible words; -Makes self understood: Understood; -Ability to understand others: Understands - clear comprehension; -Brief Interview for Mental Status (BIMS) score of 09 out of a possible 15 (a score of 08-12 indicates moderately impaired cognition); -Physical, verbal and other behavioral problems: Not indicated; -Independent for bed mobility and transfers; -Walking in room/corridor: Did not occur; -Mobility devices: Wheelchair; -[DIAGNOSES REDACTED]. Review of Resident #5's care plan, dated 5/20/20, showed: -Problem: At risk for alteration in thought processes (impaired memory and decision making) related to a history of [MEDICAL CONDITION]. -Problem: At risk for altered moods related to depression, start date 9/16/19. Goal: Display effective coping ability through next review; -Problem: History of drug/[MEDICAL CONDITION], start date 9/16/19. -Problem: Episodes of verbal/physical behaviors towards others, start date 5/28/20. Approach: If resident becomes verbally or physically abusive to another resident, immediately separate them and follow protocol. Review of Resident #6's annual MDS, dated [DATE], showed: -Adequate hearing and vision; -Clear speech - distinct intelligible words; -Makes self understood: Sometimes understands - responds adequately to simple, direct communication only; -Ability to understand others: Sometimes understands - responds adequately to simple, direct communication only; -Short and long term memory: Memory problem; -Inattention and disorganized thinking: Behavior present, fluctuates (comes and goes, changes in severity); -Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually): Behaviors of this type occurred 1 - 3 days; -Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others): Behaviors of this type occurred 1 - 3 days; -Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms, like screaming, disruptive sounds): Behaviors of this type occurred 4 - 6 days, but less than daily; -Independent for bed mobility; -Limited assistance of one person required for transfers; -Walking in room/corridor: Did not occur; -Mobility devices: Wheelchair; -Antipsychotics: Received 7 of the last 7 days. Review of Resident #6's care plan, all problems dated 6/30/20, showed: -Problem: Alteration in thought processes (impaired memory, disorganized thinking) related to [MEDICAL CONDITION]; -Problem: Episodes of verbal/physical behaviors toward others; -Problem: At risk for abuse/neglect related to diagnosis/unable to make needs known/impaired memory. Goal: Will remain free from abuse/neglect through next review date. Review of Resident #5's POS, dated 6/18/20 through 7/17/20, showed a handwritten order by the IDON, dated 6/28/20, for [MEDICATION NAME] (an anti-psychotic) 150 mg every four weeks upon arrival from the pharmacy. The handwritten and the progress notes did not identify why the resident needed the [MEDICATION NAME]. Review of Resident #5's progress note, dated 6/30/20 at 1:52 P.M., showed the IDON documented the physician had been notified due to the resident rolling down the hall cursing and asking other residents if they wanted to fight. New orders received for [MEDICATION NAME] 150 mg every four weeks upon arrival from the pharmacy. Review of a facility self-report received by DHSS on 7/6/20 at 1:58 P.M. (the time stamp showed P.M., but it was received at 1:58 A.M.), and written by Nurse M, showed: -Cover sheet: Date and time of alleged incident: 7/5/20 at 11:25 P.M. Resident #5 attacked and assaulted Resident #6 (roommate). Resident #6 was found on the floor with Resident #5 on top of him/her choking him/her; -Resident to resident altercation form regarding Resident #5, completed by Nurse M, and dated 7/5/20, showed: Resident #5 was found atop of Resident #6 attempting to choke him/her. Every 15 minute checks initiated until Resident #5 is sent out for a psychiatric evaluation. (The last 15 minute check was documented at 12:30 A.M.); -Resident to resident altercation form regarding Resident #6, completed by Nurse M, and dated 7/5/20, showed: Resident #6's roommate assaulted him/her and choked him/her while on the floor. Resident #5 sent to the emergency room for a psychiatric evaluation; -Resident incident report regarding Resident #5, unsigned (same hand writing as Nurse M) dated 7/5/20, showed: Nurse observed Resident #5 assaulting roommate on the floor of his/her room. Resident #5 was attempting to choke Resident #6. Resident #5 did not respond when asked what happened; -Resident incident report regarding Resident #6, unsigned (same handwriting as Nurse M) dated 7/5/20, showed: Resident #6 was found laying on the floor in front of the bathroom with Resident #5 on top of him/her. Resident #5 was yelling and trying to choke Resident #6. Resident #6 could not explain what happened. He/she just stated calm down I'm fine. I want cookies; -Statement sheet, dated 7/5/20 at 11:35 P.M. and signed by CNA N, showed: Commotion heard coming from Resident #5 and Resident #6's room. Upon arrival, Resident #5 was on top of Resident #6 attempting to choke him/her; -Resident #5's progress note, dated 7/5/20 at 11:35 P.M. and signed by Nurse M, showed: Resident #5 was observed on top of Resident #6 assaulting him/her and attempting to choke him/her. Resident #5 was yelling and swinging at Resident #6 and staff. Resident #5 has had violent outbreaks in the past with previous roommates. Resident #5 was not able to be calmed down. Resident #5 was sent to the emergency room for psychiatric evaluation. Resident #5's physician and family notified; -Resident #6's progress note, dated 7/5/20 at 11:35 P.M. and signed by Nurse M, showed: Nurse heard commotion in resident's room. Upon arrival, Resident #6 was observed laying on the floor with Resident #5 on top of him/her assaulting and attempting to choke him/her. Resident #6 did have helmet in place (to protect his/her head in the event of a fall) and has no obvious injuries. He/she denies pain and shows no signs or symptoms of distress. Guardian and physician notified. Resident #5 sent to emergency room . Review of Resident #5's patient transfer form (given to the ambulance crew upon discharge from the facility), dated 7/5/20 at 11:57 P.M., completed and signed by an unknown nurse, showed: Resident #5 was found on top of another resident attempting to strangle him/her. Physician gave orders to send Resident #5 to hospital for psychiatric evaluation. Review of Resident #18's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Clear speech - distinct intelligible words; -Makes self understood: Understood; -Ability to understand others: Understands - clear comprehension; -Short and long term memory: Ok. During a telephone interview on 7/8/20 at 9:00 A.M., Nurse M said he/she worked on the midnight shift the night of 7/5/20. He/she heard a couple of weeks prior to that night another incident occurred between Resident #5 and his/her previous roommate, Resident #18. He/she heard Resident #18 had entered his/her room and Resident #5 began yelling and swinging at Resident #18 and called Resident #18 a stunner, meaning you think your all that or your not all that. Resident #18 apparently said he/she was afraid of Resident #5 and did not want Resident #5 as a roommate. Resident #5 was moved in with Resident #6 as a result. On the night of 7/5/20, he/she heard a commotion, like scuffling and sounds, some words, but not really yelling at that time. He/she and CNA N went to the room to see what was happening. When they entered the room, they found Resident #6 on his/her back with Resident #5 laying on top of him/her. Resident #5 had one of his/her arms wrapped around the back of Resident #6's head, like in a head lock. His/her other hand was on Resident #6's throat. Nurse M tried to remove his/her hand from Resident #6's throat and Resident #5 would put it right back on Resident #6's throat. It took both him/her and CNA N to get Resident #5 off of Resident #6. Resident #5 was saying Resident #6 was a stunner and gave no other reason as to what happened. Resident #6 had no injuries and once they separated the residents, Resident #6 said, calm down, do you have any cookies? Resident #6 is a weak old man/woman that cannot defend him/herself. During a telephone interview on 7/9/20 at 9:15 A.M., CNA N said he/she worked with Nurse M on the night of 7/5/20. A couple of weeks prior to the night of 7/5/20, he/she asked a MHT, in passing how everything was going. The MHT told him/him Resident #5 had been involved in a physical altercation with Resident #18. Resident #18 had said he/she did not want to be Resident' #5's roommate any longer because he/she was afraid of Resident #5. CNA N did not receive a report from nursing involving that incident and had not received any directives from nursing to monitor Resident #5 as a result of that incident. On the night of 7/5/20, he/she and Nurse M

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	265524	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHVIEW VILLAGE	2415 NORTH KINGSHIGHWAY SAINT LOUIS, MO 63113

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 0600 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) heard Resident #6 yelling out a little, not too loud though. They went to the room where they found Resident #6 laying on the floor on his/her back. Resident #5 was laying on top of him/her. One of Resident #5's arms was around the back of Resident #6's neck and the other hand was on Resident #6's throat. Resident #5 was trying to choke Resident #6. Resident #5 had a hold of Resident #6 pret
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 maintain an infection control program during a Coronavirus disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome Coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2). Common symptoms include fever, cough, fatigue, shortness of breath, and loss of smell and taste) pandemic, to provide a safe and sanitary environment for residents, during two of two days of observation. The facility failed to ensure staff properly wore facemasks, disinfected gait belts (Residents #1 and #3), and to ensure staff adhered to transmission-based precautions posted on isolation rooms (Residents #10 and #11). The resident sample size was 17. The census was 219. Review of the facility's Policy on Strategies to Prevent the Spread of COVID-19 in the Facility, dated 3/10/20, showed: -Treatments During COVID-19; -Policy: Treatment Nurse Must Use Separate/Designated Equipment and Cart for COVID Unit; -Procedure: Proper removal of Personal Protective Equipment (PPE) and hand hygiene must be performed prior to exiting the unit; -Treatment nurse must don proper PPE and perform hand hygiene when entering the unit; -Policy: No equipment shall be removed from COVID unit for transfer to another unit; -Procedure: COVID unit must have designated equipment to be used only for COVID residents. This included linen, linen carts, etc; -Eliminate as much as possible the use of shared equipment; -Shared equipment must be sanitized between resident use. Further review of the policy, showed it did not address the correct way to don PPE. Review of CDC.gov, showed: -Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities: -Ensure all health care providers wear a facemask or cloth face covering for source control while in the facility; -How to put on facemasks: -Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin. 1. Observation on the second floor on 6/19/20 at 9:55 A.M., showed four nursing staff wore facemasks covering their mouths and not their noses, in the hallway around several residents. Observation on 6/19/20 at 10:40 A.M., showed Dietary Aide (DA) C washed dishes in the dish washing room, wearing a mask covering his/her mouth, but not his/her nose. During an interview on 6/19/20 at 10:49 A.M., the Dietary Manager said staff should wear a facemask properly, which includes covering the nose and mouth. This will help with infection control. Observation on 7/7/20 at 11:52 A.M., showed Housekeeper O on the bottom floor lobby, surrounded by several staff members, with a cloth mask covering his/her mouth. The mask did not cover his/her nose. Observation on 7/7/20 at 12:23 P.M., showed Nurse G got onto the elevator from the fourth floor. He/she did not have on a mask. Approximately four staff members were present on the unit in close proximity of Nurse G. Observation on 7/7/20 at 1:26 P.M., showed Nurse P at the fourth floor nurse's station with no mask on. Approximately five staff members were in close proximity of Nurse P. During an interview on 7/7/20 at approximately 12:30 P.M., Nurse P said all staff were required to wear a mask at all times in the facility. The mask should cover the nose and the mouth. Observation on 7/7/20 at 1:30 P.M., showed Certified Nurse Aide (CNA) R pushed a cart with residents' meals on the fourth floor hallway leading to resident rooms. Approximately five staff were in close proximity of CNA R. His/her cloth mask covered his/her mouth. The mask did not cover his/her nose. During an observation and interview on 7/7/20 at approximately 1:00 P.M., Patient Care Assistant (PCA) Q was on the second floor of the facility. He/she said staff were to wear masks at all times, including when they were not in residents' rooms. His/her cloth mask covered his/her mouth, but not his/her nose. He/she said the mask was supposed to cover the nose and mouth. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/9/20, showed: -Severe cognitive impairment; -No behaviors; -Extensive assistance with transfers with one person; -[DIAGNOSES REDACTED]. Observation on 6/19/20 at 10:00 A.M., on the second floor non-COVID unit, showed CNA B entered the resident's room with a gait belt around his/her waist. He/she took the gait belt from his/her waist and placed it around his/her neck, touching bare skin, assisted the resident forward on the bed, then took his/her gait belt and placed it around the resident's waist and assisted the resident to transfer from his/her bed into a wheelchair. The CNA then removed the gait belt and placed it back around his/her neck, touching bare skin. During an interview on 6/19/20 at 10:10 A.M., CNA B said he/she should have sanitized the gait belt before placing it on the resident after it touched his/her bare skin neck and then sanitized the belt again before placing it around his/her neck to prevent contamination. CNA B said he/she forgot to sanitize the gait belt. Review of Resident #3's quarterly MDS, dated [DATE], showed: -No cognitive impairment; -No moods or behaviors; -Independent with transfers; -[DIAGNOSES REDACTED]. Observation on 6/19/20 at 10:10 A.M., on the fourth floor, non-COVID unit, showed CNA A wore a surgical mask below his/her nose and over his/her mouth and used a gait belt to assist the resident to transfer from his/her bed into a wheelchair. The CNA put the gait belt around his/her neck after the transfer. During an interview on 6/19/20 at 11:30 A.M., the Director of Operations (DO) said all staff should be wearing a facemask properly, which means their nose and mouth should be covered. They do not have an actual policy on cleaning gait belts, but staff should not let the gait belt touch their bare skin, then the resident, then back to their bare skin. This would be an infection control concern. The DO said the residents in the COVID unit had their own gait belts kept in their rooms, but other residents do not have their own gait belts. 3. Observation of the facility's fifth floor on 7/7/20 at approximately 1:35 P.M., showed a strip of yellow tape on the floor outside the room shared by Residents #10 and #11. One sign posted on the room's door instructed staff to stop and see the nurse before entering the room. A second sign posted on the room's door instructed staff to follow contact and droplet precautions, requiring the use of PPE, including a respirator facemask, gown, and gloves. A rolling cart placed in the hall, next to the resident's doorway, contained gowns and gloves. At 1:39 P.M., Transportation Aide (TA) F approached the resident's room, wearing a surgical mask. He/she did not put on a respirator facemask, gown, or gloves, and entered the resident's room. While in the room, TA F placed both of his/her ungloved hands on the back of a chair where one resident was seated. Approximately two minutes later, TA F exited the resident's room, without sanitizing his/her hands. During an interview on 7/7/20 at approximately 1:43 P.M., TA F said he/she messed up by entering the resident's room without putting on the correct PPE. The fifth floor is designated for residents who have tested positive for COVID-19. The residents on isolation have signs posted on their doors, yellow tape on the floor outside their rooms, and carts of PPE just outside their rooms. All employees are expected to read the posted signs and to put on the appropriate PPE before entering the resident's room. This is to help stop the spread of germs. During an interview on 7/9/20 at 2:30 P.M., the DO said staff should sanitize their hands before entering a resident's room and upon exiting. Isolation rooms have signs posted on the doors to inform staff of precautions to take before entering. Staff are expected to adhere to the posted guidelines, and they must wear respirator facemasks, gowns, and gloves in isolation rooms. Surgical masks are unacceptable in isolation rooms. These precautions should be taken in order to prevent the spread of respiratory illness.
F 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify residents, their representatives, and families of those residing in the facility, following the occurrence of five residents (Residents #12, #13, #14, #15, and #16) confirmed with infections of Coronavirus disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2). Common symptoms include fever, cough, fatigue, shortness of breath, and loss of smell and taste), identified in June 2020. The resident sample was 17. The census was 219. Review of the Director of Social Services' (DSS) communication log, dated 6/23/20, showed the following documentation: -Resident #12's family made aware the resident tested positive for COVID-19; -Resident #13's family made aware the resident tested positive for COVID-19 on 6/22/20; -Resident #14's family made aware the resident tested positive for COVID-19; -Resident #15's family made aware the resident tested positive for COVID-19; -Resident #16's family notified on 6/22/20 the resident tested positive for COVID-19. During an interview on 7/9/20 at 12:28 P.M., the administrator said when a resident tests positive for COVID-19, the DSS is responsible for notifying the affected resident and their representative about the confirmed COVID-19 infection. These notifications are documented in the DSS's communication log. The administrator was not familiar with the regulatory requirement of informing all residents, their representatives, and families of those residing in the facility, of confirmed infections of COVID-19. During an interview on 7/9/20 at 12:38 P.M., the DSS said in June 2020, at least five residents

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F 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	(continued... from page 4) tested positive for COVID-19. She called the families of the affected residents to notify them of the results, as documented in her communication log. She did not provide updates to all other residents and their families of newly confirmed infections of COVID-19. She was unaware of the new facility reporting requirements established in May 2020. During an interview on 7/9/20 at 2:30 P.M., the Director of Operations said she became aware of the requirement for resident and family notification on 7/9/20. Up until that day, the DSS called the families of residents who tested positive for COVID-19, but was not notifying other residents in the facility, or their families.