STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366199	A. BUILDING _____ B. WING _____	08/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRY LANE GARDENS REHAB & NURSING CTR	7820 PLEASANTVILLE ROAD PLEASANTVILLE, OH 43148

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 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 closed medical record review, staff interview, and review of the facility policy related to change in condition and screening residents for signs and symptoms of COVID-19, the facility failed to provide adequate and timely monitoring and treatment for [REDACTED].M. until [DATE] at 5:26 A.M. when the resident was found without vital signs. Actual harm occurred on [DATE] at 6:19 A.M. when the resident was pronouced deceased in the facility. This affected one resident (#75) of twelve sampled residents. Findings include: Review of the closed medical record for Resident #75 revealed the resident was admitted to the facility [DATE] and had [DIAGNOSES REDACTED]. A Minimum Data Set Assessment completed [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired decision making skills. According to the census tab in the electronic medical record, the resident was moved to a room on the A hall on [DATE] (the unit for residents negative for COVID-19 or no symptoms) due to negative COVID-19 test results on [DATE]. The resident also had a negative COVID-19 test result on [DATE]. However, record review revealed the resident was moved to a room on the C hall (the unit with COVID positive residents) on [DATE]. review of the resident's medical record revealed [REDACTED]. Continued review of nurse's notes on [DATE] at 4:47 P.M. revealed the resident was moved from C hall to B hall (the unit for COVID presumptive residents). Record review revealed no documentation related to why this room change occurred. As a result of the room changes, Resident #75 resided for two days on the unit where COVID positive residents were residing when he was not positive for COVID 19. Review of the physician's orders for [DATE] revealed the resident had an order for [REDACTED].M. for diabetes and [MEDICATION NAME]three times a day at 7:01 A.M. , 11:30 A.M., and 4:30 P.M. per sliding scale (amount of insulin given was based on the resident's blood sugar level at that time). The resident would receive four units for a blood sugar of ,[DATE], six units for ,[DATE], eight units for ,[DATE] and ten units for a blood sugar ,[DATE]. The physician was to be notified if the blood sugar was above 400. The resident also had a physician's order to assess for signs and symptoms of COVID-19 every four hours. The order indicated if symptoms were present to document in progress notes. The facility assessment every four hours included temperature and oxygen saturation levels. Review of the medication administration record (MAR) for Resident #75 revealed on [DATE] at 7:01 A.M. Licensed Practical Nurse (LPN) #105 documented the resident refused his blood sugar check. Therefore, there was no evidence any insulin was given. Blood sugars on the previous two days had ranged from ,[DATE]. A nurse's note on [DATE] at 7:38 A.M. by LPN #105 revealed she was alerted Resident #75's oxygen saturation level was 85 percent. The note indicated the nurse had the resident do purse lip breathing to bring his oxygen level up to 95 percent. There was no evidence the physician or Director of Nursing/unit manager were notified. Review of the MAR revealed LPN #105 documented Resident #75 refused his blood sugar checks on [DATE] at 11:30 A.M. and 4:30 P.M. and his regularly scheduled insulin at 5:00 P.M. There was no reason for the refusals documented in the record. Record review revealed the resident had not refused his insulin any other day in [DATE] and had required sliding scale insulin 52 times in [DATE]. The residents oxygen saturation level at 12:00 P.M. and 4:00 P.M. on [DATE] was 91 percent. There was no evidence any treatment was provided and no evidence the physician or director of nursing/unit manager were notified. On [DATE] at 8:00 P.M. the resident had an elevated temperature of 101 degrees and oxygen saturation level of 92 documented on the medication administration record (MAR) by Registered Nurse (RN) #102. The MAR documented Tylenol was given at 10:45 P.M. by RN #102. At 12:00 A.M. on [DATE] the temperature was documented on the MAR as 100.1 degrees and an oxygen saturation level of 91. The resident had not had a temperature above 100 degrees since [DATE] (10 days prior). There was no evidence the physician was notified. There was no evidence the Director of Nursing/Unit Manager were notified. There was no evidence a temperature check or oxygen saturation level were obtained at 4:00 A.M. on [DATE]. There was no documentation in the nurse's notes between 11:45 P.M. (documentation regarding Tylenol given for temperature above 100) and [DATE] at 5:26 A.M. Record review revealed Resident #75 was found on [DATE] at 5:26 A.M. with no pulse or respirations. CPR was initiated and 911 called. However, Resident #75 was pronounced deceased at the facility on [DATE] at 6:19 A.M. Resident #75 had been tested for COVID-19 on [DATE]. The test results received on [DATE] were positive for COVID-19. Interview with State tested Nurse Aide (STNA) #103 on [DATE] at 5:50 A.M. revealed she worked the night shift on Sunday night ([DATE]). She stated she was not working on Resident #75's unit but Resident #75 looked bad. She stated he was breathing funny, was slurring his words, and was very confused. She stated she kept going to the nurse (Licensed Practical Nurse #104) but she kept shrugging her shoulders. Interview with Licensed Practical Nurse (LPN) #104 on [DATE] between 5:10 A.M. and 5:30 A.M. revealed she worked Sunday night ([DATE]). She stated the STNA staff reported Resident #75 was acting funny and was confused. She stated she assessed him and he was rubbing snuff and asked for a pain pill. She stated his vital signs were stable. She stated she saw no need to notify the physician. (There were no nurse's notes completed for Resident #75 by LPN #104 on [DATE]). Interview with STNA #106 on [DATE] at 6:35 A.M. revealed she worked on Resident #75's unit on Sunday night ([DATE]) and Monday night ([DATE]). She stated on Sunday night the resident was a little confused. She stated she told LPN #104, who stated she was already aware. On Monday night ([DATE]) the resident was a little more confused. She stated he thought his phone was a bottle of soap. She stated he was panicky and was having trouble breathing. She stated she got the nurse (RN #102) at the beginning of the shift (6 P.M. to 6 A.M. shift), because the resident stated he wanted to go to the hospital. She stated RN #102 went into his room. She stated she heard the resident ask the nurse if she thought he should go to the hospital. She stated she did not hear the nurses' reply. She stated she knew the resident had a temperature and the nurse had given him Tylenol. She stated she was in his room around midnight and again at 4:00 A.M. She stated at 4:00 A.M. he was snoring. She said then around 5:30 A.M. she heard RN #102 yelling trying to arouse the resident. She stated she then went to get the crash cart for the nurse. She stated another nurse came and the two nurses were doing CPR. Interview with RN #102 on [DATE] at 7:15 A.M. revealed she was the nurse for Resident #75 on Monday night ([DATE]) from 7:00 P.M. to 7:00 A.M. She stated the STNA staff had reported the resident had a fever but did not report any breathing difficulties. She stated the resident had a fever of 101 degrees around ,[DATE]:00 P.M. (documented at 8:00 P.M.) and she gave him Tylenol. She stated she rechecked his temperature but did not remember what time. (Documented at midnight). She stated she was not in his room again until 5:30 A.M. when she found him unresponsive with no pulse or respirations. She confirmed the physician ordered vital signs at 4:00 A.M. were not done prior to him being found unresponsive at 5:30 A.M. She confirmed she did not notify the physician or Director of Nursing of the increased temperature or decreased oxygen saturation level that night. RN #102 revealed the expectation was to notify the physician of a temperature above 99.5 but she did not because the resident had been having elevated temperatures. However, record review revealed no temperatures documented above 100 in the past 10 days. Interview with Assistant Director of Nursing #107 on [DATE] at 3:00 P.M. revealed Resident #75 initially resided on the C hall (the unit for COVID positive residents)after admission so he could be in isolation for 14 days. She confirmed he was moved to A hall (hall with no

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 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) positive or presumptive at the time) on [DATE] after a negative COVID test. She confirmed he was moved to C hall again on [DATE] (unit for positive residents). She stated staff had been told by corporate to move presumptive residents to the COVID positive hall, then they found out they should not cohabitate presumptive residents with positive residents. The resident was then moved to B hall (the new presumptive unit). She stated if a resident had a temperature over 100, the nurse should give Tylenol and recheck the temperature. She stated if the temperature stays above 100, staff should call the physician. She confirmed the vital signs at 4:00 A.M. on [DATE] were not completed and confirmed the physician should have been notified of the resident's elevated temperature. She also confirmed it was documented the resident refused his blood sugar checks and insulin on [DATE] with no explanation why. The Assistant Director of Nursing revealed the physician should have been notified of this also. Review of the facility undated policy titled Screening of Residents for Signs and Symptoms of COVID-19 revealed: In order to provide for the early detection of COVID-19, residents would be screened for signs and symptoms of this infection at least once every shift. Residents should be screened for symptoms of COVID-19 by taking the resident's temperature and pulse oximetry at least once a shift. Contact the Director of Nursing or Unit Manager if any of the following were detected: new onset fever, shortness of breath, cough, sore throat, or a decrease in pulse oximetry from resident baseline or any pulse oximetry reading less than 92. Review of the facility policy dated 2001 and revised ,[DATE] titled, Change in a Resident's Condition or Status revealed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a: a. Significant change in resident's physical/emotional/mental condition. b. Need to alter resident's medical treatment c. Refusal of treatment or medication two or more consecutive times. The policy further stated a significant change of condition was a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff. b. Impacts more than one area of the resident's health. c. Requires interdisciplinary team review and/or revision of the care plan. d. Ultimately is based on the judgement of the clinical staff. The nurse would record in the resident's medical record information relative to change in the resident's medical/mental condition or status. This deficiency substantiates Complaint Number OH 392.
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview and policy review the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to ensure comprehensive and effective infection control policies and practices were developed and implemented to prevent the spread of COVID-19 within the facility. This had the potential to affect all 74 residents residing in the facility. Findings include: As a result of the COVID-19 Focused Infection Control Survey and Complaint Survey, the following was identified: The facility failed to implement effective and recommended infection control practices including proper isolation of residents and the appropriate use of personal protective equipment (PPE) to prevent the spread of COVID-19 throughout the facility. This resulted in Immediate Jeopardy on [DATE] when Resident #12 was moved off the unit for residents with presumptive symptoms (C hall at the time) after only being there for two days. The resident had been placed on the presumptive unit due to experiencing symptoms of COVID and a temperature of 100.4. Resident #12 was moved to a COVID negative unit (A unit), on [DATE]. Resident #12 tested positive for COVID-19 on [DATE] and was moved from the COVID negative hall (A hall) to the COVID positive hall (C hall). This exposed the residents and staff on the COVID negative unit (A hall) to COVID-19. The lack of current effective infection control practices and implementation of effective infection control policies and procedures placed all residents at risk for harm, complications and/or death related to the facilities failure to control the spread of COVID-19 throughout the facility. From [DATE] to [DATE], there were 31 residents identified to test positive for COVID-19, with the most current resident (Resident #13) testing positive on [DATE] and three residents who expired. In addition, seven staff members tested positive for COVID-19. An investigation, including the use of a facility timeline revealed infection control concerns involving Resident #73, #50, #63, #74, #59, #77, #18, #60, #67, #2, #30, #31, #35, #25, #42, #53, #54 and #75. During this time period, the facility failed to implement an effective infection control program to include recommended infection control practices, including proper quarantine/isolation for residents, dedicated staff to provide care for COVID positive and/or COVID symptomatic residents, and proper use of personal protective equipment by staff. Through interviews it was determined the facility failed to coordinate with the local health department to prevent and contain the spread of COVID-19 within the facility. The Director of Nursing (DON #109), who was also the facility's infection control nurse was no longer employed with the facility after [DATE]. Acting Director of Nursing #10 started on [DATE]. At the time of the survey, the facility Administrator was on maternity leave with her last date worked on [DATE]. The Acting Administrator's first day was [DATE]. On [DATE] onsite observations and interviews revealed ongoing infection control concerns including but not limited to the following: Units B and C contained residents who were positive for COVID-19 and Unit A was identified as the presumptive unit. Observations and staff interviews revealed staff were provided with one set of PPE (gown, mask, face shield, and shoe covers) at the beginning of their 12 hour shift. Staff wore the same PPE set for the whole shift. No PPE was observed near each resident's room for use when entering the resident's room. Resident #25, #42, #53, and #54, who were roommates of residents who tested positive, remained upstairs on the secured dementia unit at the time of the onsite survey. Staff interviews also revealed staff were working on the COVID positive units on one day, then later, on another day, worked on the units where non-COVID positive residents resided with no evidence this was due to a staffing shortage. (See findings under F880) a. Review of the Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memo QSO ,[DATE]-ALL dated [DATE] revealed The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). As part of CMS guidance the Focused Infection Control Survey was made available to every provider in the country to make them aware of Infection Control priorities during this time of crisis, and providers and suppliers may perform a voluntary self-assessment of their ability to meet these priorities. The QSO Memo included additional instructions to Nursing Homes. We are disseminating the Infection Control survey developed by CMS and CDC so facilities can educate themselves on the latest practices and expectations. We expect facilities to use this new process, in conjunction with the latest guidance from CDC, to perform a voluntary self-assessment of their ability to prevent the transmission of COVID-19. This document may be requested by surveyors, if an onsite investigation takes place. We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program. Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and whom possible incidents of communicable disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii). On [DATE] at 3:45 P.M. Acting Director of Nursing #100 stated she did not know if the voluntary self-assessment had been completed by the facility. As of [DATE] at 7:00 A.M., no CMS recommended voluntary assessment was provided for review. b. Interview with a staff person from the local County Health Department (HD Staff #108) on [DATE] at 1:42 P.M. revealed she was concerned because of the minimal contact she had had from the facility regarding their COVID cases. HD Staff #108 stated DON #109 had left a message on [DATE] and they then had a lengthier conversation on [DATE]. HD Staff #108 stated her last conversation with the facility was with DON #109 on [DATE] and had not received an update since then. HD Staff #108 stated she had faxed forms to the facility on [DATE] to be filled out for each resident who was positive but had not received any response. She stated she had recommended the facility utilize the Tele-ICAR resource available to them, however they declined. Tele-ICAR is a Tele-Infection Control Assessment and Response (Tele-ICAR) tool. Through this tool, the facility would work with the local health department to complete a detailed infection control assessment of elements of infection control practices and specifically related to COVID-19. The findings of the assessment could then be used to target specific infection prevention and control practices. https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/assessment-tool-nursing-homes.pdf Interview with Acting Director of Nursing #100 on [DATE] at 3:45 P.M. revealed the facility had called the local health department that day and were now interested in the Tele-ICAR resource. However, she stated they told the health department they would not be available for this resource this week as they were too busy. Review of the facility undated policy titled COVID policy revealed the facility was to maintain close communication and collaboration with the local health authorities. c. Interview with the

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F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Medical Director on [DATE] at 12:40 P.M. revealed he routinely visits the facility once per week and was last at the facility on [DATE]. He was aware of the current number of resident cases of COVID-19. He was not aware of the current number of staff cases of COVID-19. He stated he was aware of three staff being positive for COVID-19 when there were actually seven. He stated the facility had not routinely kept him up to date with what was going on at the facility related to COVID-19. He stated the former DON was not very forthcoming with information. He stated early on the facility had asked for guidance on setting up a COVID positive unit but had not asked for any further guidance. He stated he was not involved in the revision of the facility COVID policy dated [DATE]. He stated he was not aware of a PPE shortage at the facility and was not aware staff were now wearing a set of PPE for the entire shift. He also confirmed it would not be appropriate to move a resident who was COVID negative to the COVID positive unit. This deficiency substantiates Complaint Number OH 392.