STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105508	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EAST RIDGE RETIREMENT VILLAGE INC	**19225 SW 87TH AVE CUTLER BAY, FL 33157**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a safe, clean and comfortable environment for one resident (Resident #111) out of twenty seven residents sampled during survey as evidenced by: 1) ants were observed on the Resident #111,s bed and 2) Resident # 111 bed linen and over bed table were visibly. There were 67 residents residing in the facility at the time of the survey. The findings included: Review of the face sheet for Resident #111 revealed an admission date of [DATE]. Clinical [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for Resident #111 dated 09/16/2020, Section C - Cognitive Patterns revealed Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating cognitive intact. For Section G- Functional status, Resident #111 required extensive assistance for bed mobility, transfer, toilet use and personal hygiene. On 09/29/20 at 10:15 AM, during observation and interview, ants were observed in Resident #111's bed, close to his feet. The bed linens were visibly soiled. the over bed table was visibly soiled with food residue. (Photographic evidence). Resident #111 stated that he had not noticed the ants in his bed. Staff C, Licensed Practical Nurse (LPN) was called and notified about ants in Resident # 111's bed. Staff C acknowledged the ants and revealed observation of two more ants in the residents bed, one ant was closer to Resident #111's head and another closer to his hand. Staff C stated that maintenance would be called to take care of the ants. On 09/29/20 at 11:16 AM, approximately one hour after the first observation Residents #111 still had ants in his bed and soiled bed linens. On 09/29/20 at 12:00 PM, Staff D, CNA was observed leaving Resident #111's room. The bed linens were changed and no ants were observed. The CNA stated, He is done for you. On 09/30/20 at 02:08 PM, Staff B, CNA revealed that, the facility fumigated Resident #111's room with a spray in the morning. Staff B revealed the ants were noticed in Resident #111's bed in the morning. On 09/30/20 at 02:23 PM,Staff J, a Registered Nurse (RN) revealed during an interview that, the CNAs are responsible for keeping the residents clean and rounds are done to check. Staff J stated that the overnight nurse reported to him that Resident #111 had ants in his bed. The nighttime nurse had cleaned the bed, changed the sheet and placed an order for [REDACTED].#111's bed and explained that the nurse only told her to provide care to Resident #111.
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 observation, interview and record review the facility failed to provide activities of daily living (ADL) care for one of two residents (Resident #55) sampled for ADL's care of 67 residents residing in the facility. The findings included: Review of Resident #55 medical record documented a re-admission to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the resident Activities of Daily Living (ADL) care plan initiated on 08/25/20 documented the resident require extensive assistance to include grooming and hygiene. Review of the resident's Minimum data set (MDS) quarterly assessment dated [DATE] documented the resident has cognitive impairment and requires extensive assistance. On 09/29/20 at 10:55 AM, observation revealed Resident #55's receiving oxygen via nasal cannula. Further observation revealed the resident's right hand with black/brownish debris underneath his fingernails and a loose adult brief. Consequently, an interview was conducted with Resident #55 and stated that someone told him that there were going to trim his fingernails and did not come back. Resident was not able to state a date. On 10/01/20 at 11:30 AM, observation of Resident #55' s right hand continues to reveal dark debris underneath the fingernails. On 10/01/20 at 2:00 PM, entered Resident #55's room with Staff G, a Licensed Practical Nurse. Observation revealed the resident finishing eating his lunch picadillo meat with his bare hand and verbalized the food was good. Further observation revealed Staff G removed the resident's tray and did not offer or perform residents hand hygiene. On 10/02/20 at 1:02 PM, a side by side observation of Resident #55's right hand fingernails was conducted with Staff K, a Certified Nursing Assistant and Staff G. An interview was conducted with Staff K, the CNA (Staff K) stated that she saw Resident #55 fingernails with debris during morning care and added that the resident's fingernails should not have been that way, that it should have been taken care of. On 10/02/20 at 2:48 PM, the Assistant Director of Nursing (ADON) stated that the resident's fingernails are to be cleaned by the Certified Nursing Assistants. The ADON was apprised of Residents #55 fingernails with dark debris.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide restorative service to maintain ambulation status for one (Resident #57) of two residents sampled for rehabilitation, as evidenced by: Staff failed to provide planned restorative services for Resident # 57 to maintain walking ability in the restorative program. This deficient practice has the potential to affect any of the five residents that ambulate with assistance or assistive device. There were 67 residents residing in the facility at the time of the survey. The findings include: Review of the Restorative Nursing Services Policy and Procedures, not dated, revealed Residents will receive restorative nursing care as needed to help promote optimal safety and independence and maintain functional ability. Review of the Mobility and Range of Motion Policy and Procedures, not dated, revealed that residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. Review of face sheet for resident #57 revealed an admission date of [DATE]. Clinical [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) for resident #57, dated 06/24/2020, Section C - Cognitive Patterns revealed Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating cognitive intact. For Section G- Functional status, Resident #57 required extensive assistance for bed mobility, transfer, toilet use, personal hygiene and walk in room. For walking in the corridor, the activity occurred once or twice. Review of the MDS for Resident #57, dated 09/01/20, Section G- Functional Status, revealed that the functional status of walking in room dropped from extensive assistance to activity occurred only once or twice, and the functional status of walking in the corridor, dropped from Activity occurred once or twice to Activity did not occur, for period ranging dates of 06/24/20 to 09/01/20. For Section O- Special Treatment, on 09/01/20, the Restorative Nursing Program was not coded for walking, bed mobility, transfer, dressing and eating. Review of the Therapist Progress & Discharge Summary, dated 6/17/2020, revealed that Resident #57 met the goal and was capable to ambulate 150 feet safely with 2-wheeled walker and maximum assistance (75%) times two on even surfaces. Review of the Restorative Care Program for

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Resident #57, dated 6/17/2020, revealed the goals were Maintain Lower Extremity, Range of Motion and Endurance. Maintain functional ability such as bed mobility and transfer. Maintain ability to ambulate. The approach included Ambulate with patient providing assistance as needed and as tolerated with front wheeled walker and moderate assistance with two recommended for ambulation. Review of Referral/Screen to Rehabilitation Services dated 10/01/2020 for Resident #57 noted that the patient was observed ambulating in hallway in front of patient's room with Restorative Nurse, Certified Nursing Assistant (CNA) and Nurse Supervisor with maximum Assistant of two . safety provided. Prescribed restorative program still appropriate. On 09/29/20 at 08:57 AM, during an interview, Resident #57 revealed that she came to the facility for therapy and was not receiving therapy anymore. Resident # 57 stated that they used to come to take her to walk with a walker in the hallway, but they have stopped since last month. On 09/30/20 at 01:41 PM, the Therapy Program Director, revealed that Resident #57 was admitted to the facility in February, 2020. Resident #57 was evaluated and treated in therapy as a short term patient to do rehabilitation seven times per week and to return home. On 04/24/2020 the insurance discharged Resident #57 from skilled rehabilitation and she was at maximum potential. The family members decided that home was not ready for her and decided that she would return home after COVID-19. The doctor ordered outpatient therapy for three times per week and Resident # 57 was seen three times per week until 06/16/20. Resident #57 reached her plateau and after 06/16/2020 she was placed on the restorative program. The Therapy Program Director stated that the nurse should do restorative. The Therapy Program Director stated that Resident #57 needed maximum assistance to walk and Resident #57 also needed two people to walk with her. On 10/01/20 08:28 AM, the Restorative Certified Nursing Assistant (CNA) Staff E, stated that Resident #57 was on the restorative program. The only thing that Resident #57 was doing was bed mobility, upper and lower extremity an nobody was walking Resident #57 and that Resident #57 was walking yesterday with therapy staff. Staff E reported that restorative staff were not walking with Resident #57 because she was afraid of falling and it takes two people to do that. Resident #57 did not refuse to try, but she was afraid to fall. On 10/01/20 at 09:22 AM, Staff F, Restorative Nurse revealed that resident #57 was still on the restorative program. Staff F stated that Resident # 57 was doing range motion and bed mobility; this was about all Resident #57 was capable to do. Staff F reported that Resident #57 required extensive assistance from two people for transfer. The range motion was more for maintaining bed mobility. Resident # 57 was not capable of walking with a walker; she did not ambulate and when she was discharged from therapy she used the walker with extensive assistance from two people, and Resident #57 needs extensive assistance and the nurse was not capable to ambulate her. On 10/01/20 at 01:15 PM, the Therapy Program Director reported that Resident #57 was discharged to restorative. The restorative nurse decided the frequency of the restorative therapy for maintenance and at that point, she did not think the resident would make any more progress and restorative was for maintenance. Resident #57 goals were to maintain strength flexibility, endurance and coordination, and upper body extremity, activities of daily living (ADL) functions and transfers. Resident #57 had not been walking with a nurse or staff in the corridor. The Restorative Nurse explained that Resident #57's initial goal was to maintain ambulation (she was discharged from Physical therapy walking 150 feet with maximum assistance of two staff), The Restorative nurse stated that no staff was walking with Resident #57. On 10/02/20 at 09:02 AM, Staff G, Licensed Practical Nurse (LPN) revealed that Resident #57 gets nervous when she went to walk. The CNAs were not be able to get her to walk and they did not have CNAs walking Resident #57 because she was on at risk for falls. Staff G stated that the Restorative Nurse should walk the resident and that is usually done with two people. Staff G, LPN stated that the CNAs could not do that but the restorative staff, with help, could do that.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to treat the development of complications related to skin irritation for one of one (Resident #23) resident sampled for catheter care as evidenced by failure to obtain a physician order [REDACTED].#23 medical record documented a re-admission to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #23's care plan initiated on 07/08/20 included interventions to provide catheter care every shift and a care plan initiated on 07/21/20 titled I have the potential for skin breakdown related to impaired toilet use and bowel incontinence with interventions to include provide peri care as needed .monitor skin during care . Review of Resident #23's Minimum data set (MDS) admission assessment dated [DATE] documented the resident needs extensive assistance with his daily care and is has severe cognition impairment. On 10/01/20 at 1:28 PM, observation during catheter care performed by Staff-K, a Certified Nursing Assistant for Resident #23 was conducted. During the catheter care provided by Staff K, it was noted that Resident #23 scrotum was beefy red in color. Observation revealed Staff K applied triple antibiotic to the redness in the resident's scrotum, inguinal area and to the bottom. Consequently, an interview was conducted with Staff K and she stated that she has been applying triple antibiotic to redness on Resident # 23's scrotum Resident #23, and his bottom since last week. Review of Resident #23 medical record documented a physician order [REDACTED]. On 10/02/20 at 1:01 PM, a joint interview was conducted with Staff K and Staff G, a Licensed Practical Nurse. Staff K stated that she applied triple antibiotic to Resident #23 during catheter care observation on 10/01/20 because there was no barrier cream in the storage room. Staff K was asked if she asked the nurse for the triple antibiotic and stated that she did not because she has been given a green light to use it before. Staff K stated that she got the triple antibiotic package from the storage room. Staff K stated that she used the triple antibiotic when there is no barrier cream in the storage room and added that she has been substituting it since last week for Resident #23 scrotum and bottom. Staff G stated that she was not aware that Staff K used triple antibiotic for Residents #23's redness to the scrotum. Staff G stated that she was aware of the resident's scrotum redness and that she did not have a physician order [REDACTED]. The review of Resident #23's treatment administration record (TAR) for September and October 2020 lacked evidence of documentation regarding the resident's treatment for [REDACTED]. On 10/02/20 at 2:53 PM, during an interview the facility's Assistant Director of Nursing (ADON/IP)/Infection Preventionist, stated that they need to have a physician order [REDACTED]. The ADON/IP confirmed there was no evidence of a physician order [REDACTED].
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review the facility failed to practice proper hand hygiene during dining in one of four areas observed for dining as evidenced by, staff picked up soiled sheet of paper towel sheet from the floor, adjusted her pants on her body and then touched the resident's food without performing hand hygiene. This deficient practice have the potential to affect all 65 residents, eating by mouth out of the 67 residents residing in the facility at the time of the survey. The findings include: Review of the Hand washing/ Hand hygiene Policy and Procedure, no date, revealed that the facility considers hand hygiene the primary means to prevent the spread of infections. It further showed that all personnel shall follow the hand washing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The staff should use an alcohol-based hand rub containing at least 70% alcohol; or, alternatively, soap (anti microbial or non-anti microbial) and water before and after assisting residents with meals. On 09/29/2020 at 08:09 AM, during dining observation, Staff A, Licensed Practical Nursing (LPN) took the food tray from the food cart to deliver to be delivered to a resident. Staff A, LPN left the food tray on the resident's food table. Staff A, LPN picked up a paper towel that was dropped on the floor and placed it in the garbage. Staff A, LPN adjusted her pants .Staff A, LPN did not perform hand hygiene Staff A, LPN then proceeded to open a container of milk for the resident. On 09/29/2020 at 8:39 AM, Staff A, LPN stated during an interview that she was distributing the food trays to the residents and she should have used hand sanitizer on her hands after serving food and between patients. Staff A, LPN revealed that she was supposed to also sanitize her hands after she picked up the paper towel that was dropped on the floor and placed it in the garbage and touched her clothes, but she forgot to do it. On 10/02/2020 at 12:09 PM, during an interview the Director of Nursing ,(DON) revealed that staff should sanitize their hands before taking the food tray to be delivered the rooms and sanitize their hands again before getting another tray. The DON after staff picked something up from the floor and adjusted pants, Staff should have performed hands hygiene before touching the resident's food on the tray.

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2)
F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on observations, record reviews and interviews the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to implement and demonstrate an effective and appropriate plan of action to correct identified repeated deficiencies related to food handling, as evidenced by repeated deficient practice identified for F 812 (for Food Procurement,store prepare/serve food in sanitary manner),during consecutive annual surveys. The repeated deficient practice have the potential to affect all residents residing in the facility. There were 67 residents residing in the facility at the time of this survey. A review of the facility's survey history revealed, during the annual Recertification survey January 02,2018 to January 06,2018 the facility failed to distribute food under sanitary conditions and was cited F 812(for Food Procurement,store prepare/serve food in sanitary manner), as evidenced by staff failure to practice hand hygiene during dining in one of four dining rooms where meal distribution was observed. On the annual Recertification survey conducted on January 22,2019 to January 25,2019, deficient practices was again identified at F 812 because the facility failed to distribute food under sanitary conditions, as evidenced by staff failure to practice hand hygiene during dining, in one of four dining rooms where meal distribution was observed. The facility had the same deficient practice identified for F 812 during the annual recertification survey conducted on September 29,2020 through October 02,2020. During dining the facility's staff failed to practice hand hygiene in one of four dining areas. On 10/02/20 at 12:36 PM, the Administrator/ Risk Manager reported that the QAPI committee meets monthly. The team is members include the Administrator/ Risk Manager, the Medical Director, Director of Nursing, (DON), Assistant Director of Nursing (ADON), Minimum Data Set (MDS) Coordinator, Social Services Director, Activities, Restorative nurse staff, Medical records, Human Resources, Dietary and Dietitian, Nursing Supervisors and Pharmacy Consultant. For dining the committee has been focusing on hand hygiene, education, monitoring. They are doing audits for compliance in hand hygiene during meals services and food storage and preparation. After COVID-19 , they change the process of serving meals and they are still doing infection control. They had in-service and audits regarding hand hygiene. They installed additional hand sanitizer in the dining rooms to make more available. They had supervisors monitoring and filling audit form to be reviewed by QAPI committee to see if additional training needed.The DON stated that they are still doing observations on hand hygiene related to dining.
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 ensure infection control procedures were followed as evidenced by 1.) failure to ensure proper disposal of Personal Protective Equipment (PPE) for one (R#311)out of four residents reviewed on isolation contact precautions, 2.) failure to follow transmission based precautions for resident diagnosed with [REDACTED].#261) out of 4 residents reviewed for isolation contact precautions,3.) failure to disinfect the glucometer with an approved product during medication administration observation with a potential to affect nine residents (R#49,R#18, R#19, R#29, R#50, R#35, R# 55, R#231, R#230) with a physician order for [REDACTED].#34, #35, #39, #41, #43, #44 and #48). There were 67 Residents residing in the facility at the time of the survey. The findings included: 1). Record review of the Physician's Order Sheet (POS) for resident #261 revealed that on 09/28/2020 the resident was prescribed 1 gram (g) of [MEDICATION NAME], an [MEDICAL CONDITION] medication, to be given twice daily for shingles. Further Review of the POS [REDACTED]. Observation and interview on 09/29/2020 at 12:19 PM revealed that resident #261's room was on contact precautions; signage was posted and PPE was located outside of the resident's room. Further observation revealed the resident in her room in her reclining chair, covered with a blanket. The resident was not interviewable. Inside the resident's room there was one receptacle box labeled linen, with a yellow bag in it. There was no red biohazard bin in the resident's room for disposable of PPE. Interview with the Registered Nurse (Staff H) who was present stated that there was no red biohazard bin in the room because she was told that with the new changes in the regulations there did not have to be one; staff were instructed to dispose of PPE in the resident's trash bin in the bathroom. Observation on 09/30/2020 at 7:59 AM revealed resident #261 in bed watching television; the bed was in low position. Further observation of the resident's room revealed that there was now a cardboard box receptacle with a red biohazard bag inside of it. Interview with the Nurse Supervisor (Staff I) on 09/30/2020 at 2:55 PM revealed that resident #261 was on contact precautions for shingles; she was admitted to the facility with it. Nursing staff were supposed to wear PPE equipment when entering the resident's room, and there were two boxes in the resident's room. The box with red biohazard bag was for any for PPE that was soiled with blood, and any other PPE that needed to be disposed of. The other box was for both linen and clothes. There was always two boxes in the room; one with a yellow bag, and other one with a red bag in it. The Nurse Supervisor was not aware of any new changes that involved not placing red biohazard receptacles in a room for a resident that was on contact or isolation precautions. Interview with Director of Nursing (DON/Infection Preventionist) on 09/30/2020 at 3:08 PM revealed that for residents on contact precautions nursing staff have to wear gown and gloves, which was provided to them outside of the resident's room. They are to don the gown and gloves, enter the resident's room, and once care was provided they were to remove the PPE before leaving the room; all per physician's orders. In the resident's room there was a red biohazard bag for staff to dispose of PPE, and for the linens there was a yellow bag that would be removed and incinerated. The DON stated that Staff H was confused about the instructions that were given to her. A nursing consultant completed a walk-through of the facility and reported that since there was an observation unit for residents who may have COVID-19 they did not need to include red biohazard bins in their rooms. However, this was not the case for the residents who were on contact precautions; there should have been a red biohazard bag in the resident's room for any items that may be soiled with bodily fluids. 2.) Review of the Communicable/Contagious Diseases Policy and Procedure (Revised Date-3/14/2020) documented: Policy Statement-Our facility will attempt to protect the health and safety of our employees, residents and visitors by attempting to prevent the spread of communicable/contagious diseases. Policy Interpretation and Implementation-12) Appropriate Transmission-Based Precautions will be implemented, as per physician's orders: a) For a resident on Contact Precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment. Observation on 9/29/20 at 8:25 AM, revealed on the doorframe to R #311 room was a stop sign to see the nurse for instructions and a white container with drawers outside the room that contained gowns, masks and gloves. The gowns, masks and gloves are also referred to as personal protective equipment (PPE). Observation on 9/29/20 at 8:32 AM revealed a dietary worker instructed by Staff C, LPN to take a breakfast tray (disposable) into resident Resident #311's room and leave it on the bedside table. Staff C, LPN instructed the dietary worker not to put on PPE which were located outside the door. The dietary worker entered the resident's room without using PPE and gave the resident her breakfast tray. On 9/29/20 at 8:33 AM, during an interview Staff C, LPN stated, The resident is on contract precaution for [MEDICAL CONDITION]. We just took a culture this morning for [MEDICAL CONDITION] on the resident. We are not sure she has [MEDICAL CONDITION]. We think it is not active. That is why I told the dietary worker not to put on PPE. Observation on 9/29/20 at 8:36 AM revealed Staff C, LPN entered Resident #311's room without putting on PPE. Observation on 9/29/20 at 9:02 AM revealed Resident #311 sitting up in bed, wearing glasses, bilateral 1/4 side rails, eating breakfast and watching television. Resident was on contact precaution. Stop sign on the door and PPE remain outside the door. Observation on 9/29/20 at 9:51 AM revealed the Physical Therapist entered Resident #311's room without putting on PPE. Record review of the September 2020 Physician's Order Sheets for Resident #311 documented contact precautions every shift for [MEDICAL CONDITION]. The order was written on 9/27/20 at 7:00 PM. Record review of the September 2020 EMAR (Electronic Medication Administration Record) for Resident #311 documented contact precautions every shift for [MEDICAL CONDITION]. The Director of Nursing on 9/30/20 at 9:51 AM stated, if a resident is on contact precaution, before staff go into the room, they have to don the gown and gloves. They already have the mask on and eye protection. 3.) Review of the facility's policy titled Disinfection of Glucometers revised on 02/14/20 documents clean and disinfect glucometer's between each resident use .unfold super Sani-cloth and thoroughly wet surface. treated surface must remain visibly wet for two minutes, and then let air dry .do not use alcohol to clean meter . On 09/29/20 at 11:43 AM, observation was conducted during a finger stick for blood sugar check for Resident #41 performed by Staff A, a Licensed Practical

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) Nurse. Observation revealed Staff A gathered all supplies including a glucometer (machine to check blood sugar) in a foam tray and placed the tray on top of the resident's dresser and performed the procedure. Continued observation revealed Staff A, took the foam tray and the glucometer with her, returned to the medication cart and placed it on top of the cart and without performing disinfection, Staff A placed the glucometer back in the medication cart drawer. Staff A stated the resident needs insulin and retrieved an insulin pen, placed it on the foam tray and returned to the resident's room. Further observation revealed Staff A did not perform disinfect the top of the medication cart. On 09/30/20 at 1:00 PM, Staff A stated that she cleans the glucometer before and after she uses it. Staff A was apprised that she did not clean it after use on 09/29/20 after Resident #41 blood sugar check. Staff A stated that she was not sure if she had to clean the meter after and added that she looked at the meter and did not see anything. On 09/30/20 at 2:38 PM, Staff J, a Registered Nurse, stated during an interview that he cleans the glucometer with an alcohol wipe before use and with a germicidal wipe after use. On 10/01/20 at 11:36 AM, observation revealed Staff G, a Licensed Practical Nurse, cleaning the glucometer with disinfecting wipes. Staff G stated that the glucometer was cleaned but that she wiped again with the disinfecting wipes. Observation revealed Staff G gathered the glucometer and finger stick supplies and proceeded with the procedure. Further observation revealed Staff G returned to the medication cart, wiped the glucometer with the disinfecting wipes wrapped the meter with the disinfecting wipe. Staff G was asked what organism the disinfecting wipes would kill and the contact time and stated she leave it wrapped for 5 to 10 minutes. A side by side review of the disinfecting wipes container manufacturer label information was conducted with Staff G. The label documented kills 99.9% of bacteria .for disinfection, wipe hands thoroughly for one minute and let dry for two minutes . The container label did not list what type of organism it was approved for and did not list the ingredients. On 10/02/20 at 2:53 PM, an interview was conducted with the facility's Assistant Director of Nursing (ADON/IP)/Infection Preventionist. The ADON/IP stated the nurses are to clean the glucometer before and after use with a disinfecting wipe. A side by side of the disinfecting wipes container was conducted. The ADON/IP, stated that the container does not list organism to kill. During the interview, the ADON/IP was asked to submit the disinfecting wipes manufacturer information related to ingredients and organism to kill. She was apprised regarding nurses not cleaning the glucometer as she stated. On 10/02/20 03:54 PM, a side by side review of the disinfecting wipes container manufacturer label information was conducted with the facility's Director of Nursing (DON). The label documented kills 99.9% of bacteria .for disinfection, wipe hands thoroughly for one minute and let dry for two minutes . The container label did not list what type of organism was approved for and did not list the ingredients. The DON was asked to submit the disinfecting wipes manufacturer information related to ingredients and organism to kill requested previously. On 10/02/20 at 4:20 PM, the DON provided the disinfecting wipes information. The item description was provided and documented alcohol wet wipes .antiseptic cleaning .wipes for body . The DON stated that the disinfecting wipes are not an approved wipe to clean a glucometer. The DON stated that the nurses are to clean the glucometer with a Sani Cloth or an alternative. 4) On 09/29/20 at 10:43 AM, tour to the facility's third floor Television (TV)/Activity room, revealed seven (7) residents playing indoor hockey without wearing a face mask. The activity was conducted by the facility's Activities Supervisor. Observation revealed two of those seven residents were three to five feet apart, not six feet apart as required. On 09/29/20 at 11:10 AM, observation revealed six of seven residents continued playing indoor hockey in the third floor Television/Activity room, directed by the activities supervisor, and without wearing a face mask. Further observation revealed Resident #48, without a face mask, was moved out of the activity area, to the adjacent room by the activity Supervisor. Observation revealed the facility's third floor nursing supervisor talking with Resident #48 and did not offer a face mask to the resident. On 09/29/20 at 11:40 AM, observation revealed six residents continued to be in the TV/activity room participating in the sing-along activity. Observation revealed Resident #41 singing at sing along and was able to be heard across the room and not wearing a face mask. On 10/01/20 at 11:30 AM, observations revealed Staff G, a Licensed Practical Nurse, wheeling Resident #41 down the hall with her face mask not covering her nose. Observation revealed no attempt/intervention from Staff G to reposition or adjust the resident's face mask. On 10/01/20 at 11:36 AM, Staff G stated during an interview that the residents are to wear a mask when they are out of their rooms. On 10/02/20 at 9:29 AM, an interview was conducted with the facility's Activities Supervisor. The Activities Supervisor stated that since 09/07/20 (Labor Day) from 10:00 AM to lunch time, they socially distance small group activities in the activities room. She stated that they limited the amount of people in the activity area, usually about six people. She added that in the afternoon they do one to one visit. The activities supervisor stated that each resident have been assessed for the ability to wear a mask and that she receives an updated list daily from the nursing staff that listed every resident and indicates who can wear a face mask. On 10/02/20 at 9:30 AM, a side by side review of the list for the resident that have been assessed for the ability to wear a mask was conducted with the activities supervisor. The supervisor confirmed those seven residents as Resident #34, #35, #39, #43, #44, #48 and added that #41 came in later. The activities supervisor stated that on the morning of 09/29/20, she was directing Indoor hockey and that six residents (Resident #34, #35, #39, #43, #44 and #48), were assessed for the use of a face mask and that were able to wear a mask .The activities supervisor was asked why those six residents that were able to wear a mask, were not wearing one during the activity that was conducted out of their room and lack of social distancing that was observed with some of the residents being less than six feet apart. The activities supervisor stated, I was thrown off and added that she took the residents out of the room as they were and did not check them for a face mask. She stated, I might overlook. The activities supervisor stated that regarding social distance, she goes by the length of the table to check for six feet apart. Observation revealed that no tables were in the activities room at the time of the Indoor Hockey. She stated that the Indoor Hockey activity lasted an hour long and that Resident #41 (the seventh resident) joined the sing-along activity after the Indoor hockey activity. On 10/02/20 at 10:32 AM, observation on the facility's third floor TV/activity area revealed Resident #22 without a face mask. On 10/02/20 at 10:33 AM, observation revealed Staff M, activities aide, stated oh, no mask stop the activity to review the list of resident's mask assessment, then retrieved a face mask and asked the resident if she would wear a mask and the resident nodded her head up and down, Staff M proceeded to place a face mask. On 10/02/20 at 10:35 AM, an interview was conducted with Staff M and stated that she brought Resident #22 to the activity area without a mask and stated that the resident is not to wear a mask. She stated if a resident cannot wear a mask, they cannot come to the activity area and they keep them in their room. On 10/02/20 at 11:20 AM, Staff L, a Licensed Practical Nurse on the third floor stated that every resident is to wear a mask when they are out of their room to go to activities. She added that those residents that can't keep a face mask on, stayed in their room and the activities staff go to their room. On 10/02/20 at 11:23 AM, Staff G, a LPN stated that the residents are to wear a mask once they come out of the room to the activity area, they must wear a mask. On 9/30/20 at 1:42 PM, during an interview the Director of Nursing (DON) revealed, we have a face covering assessment done for all new admissions and also for all of the long term care and current residents. Based on results, we determine if a resident is safe to use a face mask. The assessment is based on cognitive and respiratory status. If they are determined to be safe, we provide them with a surgical mask. Residents assessed to be safe to wear the mask are supposed to wear the mask whenever they leave the room. Review of the facility policy titled Resident Mask Wearing revised July 31, 2020 revealed: Policy: This facility will provide residents with face coverings, as appropriate, for use when they leave their rooms. Facility will offer face coverings to those individuals which upon assessment were deemed appropriate to wear face covering. If a resident refuses to wear a face covering, staff will remind resident to maintain social distancing and monitor compliance. Procedure: The following procedure will be used: a. Resident are assessed upon admission for determination of whether resident can safely wear face covering. b. If a resident is able to wear a face mask, as per assessment, residents will be encouraged to wear face covering when leaving room. The facility will provide resident with face covering. c. If a resident refuses to wear a face covering, staff will remind residents to maintain social distancing and monitor compliance. Review of the the Center for Disease Control (CDC) website https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html indicates for source control: Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Review of the county positivity rate at the time of this suvey for COVID-19 was 4.5%.