STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366294	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SPRENGER HEALTH CARE OF MASSILLON SNF	205 ROHR AVENUE NW MASSILLON, OH 44646

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**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 record review, interview and review of facility Self Reported Incidents the facility failed to prevent Residents #14 and #5 from physical abuse by another resident. This resulted in actual harm when an altercation between two cognitively impaired residents (Residents #14 and #33) resulted in comminuted fractures of a facial bone, and bruising and swelling of the left cheek and eye area for Resident #14. An altercation between Residents #5 and #12 resulted in the residents hitting and kicking each other but neither was injured. This affected two (Residents #14 and #5) of four residents investigated for a physical abuse allegations and had the potential to affect 23 additional residents currently residing in the facility. The facility census was 25. Findings include: 1. During the initial tour of the facility on [DATE] from 7:50 A.M. to 10:10 A.M. interviews with staff Registered Nurse (RN) #41, and State tested Nursing Assistant (STNA) #42, and STNA #43 indicated they were instructed by the Director of Nursing (DON) to not report allegations of abuse in the facility. The staff indicated the DON informed them the residents had behaviors and not to document resident to resident incidents in the resident's record. The staff indicated the facility was not staffed adequately to supervise the residents closely to prevent resident to resident altercations. The staff indicated almost all of the residents in the facility had behaviors and were impulsive. The staff indicated the residents had extensive care needs and they were unable to meet their needs and supervise the residents to protect them adequately from resident to resident altercations. At 11:00 A.M. the facility was informed the staff had indicated the DON instructed them to not report resident to resident altercations and allegations of abuse. At 11:30 A.M. the facility indicated the DON was sent home pending an investigation of instructing the staff to not report abuse allegations. Resident #14 was admitted on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. A review of Resident #14's nursing progress note dated [DATE] indicated he was found with a hematoma to the left cheek and the physician assessed Resident #14 and ice was applied to his left cheek. Resident #14 was sent to the emergency room . There was no additional documentation of the altercation with Resident #33. A review of Resident #14's hospital record dated [DATE] indicated a computerized tomography (CT) diagnostic test was performed to evaluate the his facial bones for a fracture. The results indicated an acute comminuted fracture (The bone is broken into more than two pieces) of the anterior wall of the left maxillary sinus (one of the four paranasal sinuses, which are sinuses located near the nose) with mild depression of fracture fragments. There was a hemorrhage (bleeding) of the aerated secretions within the left maxillary sinus. The left cheek was swollen with [MEDICAL CONDITION] (presence and passage of air in tissue-space) and mild swelling of the left periorbital soft tissue with no [MEDICAL CONDITION]. Resident #14 was discharged from the emergency room and returned to the skilled nursing facility. Resident #33 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review Resident #33's of the nursing progress note dated [DATE] indicated Resident #33 had a physical altercation with another resident. The progress note indicated the behavior put Resident #33 at significant risk for physical illness or injury. The impact on other residents put them at significant risk for physical illness or injury, significantly disrupted the living environment and care. Interventions implemented included one on one attention which was ineffective. Resident #33's clinical record indicated he was under the care of hospice and died in the facility on [DATE]. A review of Resident #33's nursing progress notes dated [DATE] indicated Resident #33 had a physical behavior directed towards another resident. The description of the incident indicated an altercation with another resident with no details of the incident documented. The progress note indicated Resident #33 was not exhibiting hallucinations or or delusions. The behavior put significant risk for physical illness or injury to another resident, significantly interfered with another resident's participation in activities of social interaction. The behavior put others at significant risk for physical injury, significantly intruded on privacy/activity of others, disrupted the care/living environment. The progress note indicated the effectiveness of the interventions implemented worsened the behavior, A review of Resident #33's hospital record dated [DATE] indicated Resident #33 suffered a contusion of the left hand and admitted to striking another resident in the skilled nursing facility where he resided. Resident #33 reported he had punched Resident #33 to defend her honor due to Resident #14 took another female resident's (unnamed) cane that belonged to her father. Resident #33 did not meet the criteria for admission to the hospital and was in stable condition. Resident #33 was sent back to the skilled nursing facility upon discharge from the emergency room . A review of of the facility Self Reported Incident (SRI) dated [DATE] indicated Resident #14 had an altercation with Resident #33. The report indicated Resident #33 was seen exiting Resident #14's room looking distressed. Resident #33 proceeded to walk in the common area of the facility. A nurse entered Resident #14's room to check on him and found him seated on the bed with a hematoma under the left eye along with several scratches and the eye was discolored. Resident #14 and Resident #33 were unable to recount the events leading up to the altercation. Resident #33 was sent to the hospital for a psychiatric evaluation and informed the hospital staff he had punched Resident #14 to defend his girlfriend's honor. An investigation was conducted and the staff were interviewed. The investigation indicated at 6:15 P.M. on [DATE] the Hospice Nurse (RN #40) saw Resident #33 exit Resident #14's room. RN #40 asked Resident #33 if everything was all right. Resident #33 didn't answer and proceeded to walk to the common area of the facility. RN #40 went in Resident #14's room to check on him and found him seated on the bed with a bloody eye. The DON and Physician were notified and first aide was provided to Resident #14's left eye and Resident #33's swollen fingers on the left hand and then both residents were sent to the hospital. The police were called and Resident #14's family was notified. Resident #14's family did not want to press charges. Both residents returned to the facility between 1:45 A.M. and 2:30 A.M. on [DATE]. A review of the incident report dated [DATE] completed by the Hospice Nurse (RN #40) indicated the same details of the altercation as indicated on the facility investigation of the incident. RN #40 notified the DON and physician and the physician assessed Resident #14's left eye. RN #40 assessed Resident #33's left hand and found the second and third knuckles were swollen on his left hand. An interview with Resident #14 on [DATE] at 9:00 A.M. indicated another resident had punched him in the face. Resident #14 was unable to remember the details of the incident. Resident #14 stated he was not concerned about the incident and indicated Resident #33 was no longer in the facility. 2. Resident #5 was admitted to the Skilled Nursing Facility (SNF) on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. At the time of the incident on [DATE], Resident #5 resided in the Assisted Living (AL) connected by a hallway to the SNF. Resident #5's nursing progress note dated [DATE] indicated he was in a wheelchair, in the common area shared by the Al and SNF residents, when another resident stopped and cursed at him, then swung, striking him on the back and top of his head. The resident had a hoodie on and it did protect him when he was hit and he denied pain /injury. The nurse walked between the two residents preventing further altercation. Resident #5 was taken to his room and evaluated. He denied any pain or discomfort. There were no marks or areas present from the occurrence. Resident #5's Minimum Data Assessment ((MDS) dated [DATE] indicated Resident #5 had verbal behaviors directed towards others and not directed towards other which occurred daily, rejection of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) care and wandering in the facility. A plan of care was initiated upon readmission to the facility with interventions implemented. Resident #12 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #12's MDS assessment dated [DATE] indicated he exhibited wandering behaviors daily with a significant intrusion on the privacy and activities of others. A plan of care was initiated upon admission with interventions initiated to address the behaviors. A review of Resident #12's nursing progress notes indicated no documentation of the incident with Resident #5 on [DATE]. A review of the facility's SRI investigation of a resident to resident altercation dated [DATE] indicated Resident #5 and Resident #12 argued with each other resulting in physically punching and kicking each other. The facility investigation indicated Resident #5 was in a wheelchair propelling himself to the dining room shared by the SNF and AL residents. Resident #12 was walking behind Resident #5 and used profanity to ask him to move faster. Resident #5 turned around in his wheelchair and used profanity to respond to Resident #12. Resident #12 responded by cursing at Resident #5 and started punching him in the head three times. Resident #5 reacted by kicking Resident #12. Two staff members intervened and separated both residents. Both residents were assessed and found no injury resulting from the physical altercation. Interviews with Resident #5 and Resident #12 on [DATE] at 8:45 A.M. and 8:50 A.M. indicated no memory of the incident as described on [DATE] on the incident report. An interview with the Regional interim DON on [DATE] at 11:30 A.M. verified the above findings and indicated the DON would be dealt with pending the outcome of their investigation. The facility policy and procedure titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated ,[DATE] indicated abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. The types of abuse included, verbal abuse, sexual abuse, physical abuse and mental abuse. The response to abuse allegations indicated staff should report all incidents/allegations immediately to the Administrator or designee. The physician and responsible party should be notified of the incident/allegation of abuse. Documentation in the nursing progress notes should include the results of the resident's assessment, notification of the physician and responsible party and treatment provided. The allegation of abuse should be investigated with in five working days from the incident and reported the State of Ohio Department of Health within 24 hours of the alleged abuse incident. The investigation should include the resident, the accused, and all witnesses. After completion of the investigation, an examination of all the evidence, the Administrator would make a determination if the abuse allegation was substantiated. For resident to resident abuse appropriate interventions would be initiated/implemented to prevent further incidents of abuse. This deficiency substantiates Complaint Number OH 569.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the staffing in the facility was adequate to provide supervision to prevent resident to resident abuse in the facility. This affected two residents (Resident #14 and Resident #5) out of four residents investigated for resident to resident abuse. This had the potential to affect all 25 residents currently residing in the facility. Findings include: 1. During the initial tour of the facility on [DATE] from 7:50 A.M. to 10:10 A.M. interviews with staff Registered Nurse (RN) #41, State tested Nursing Assistant (STNA) #42, and STNA #43 indicated they were instructed by the Director of Nursing (DON) to not report allegations of abuse in the facility. The staff indicated the DON informed them the residents had behaviors and not to document resident to resident incidents in the resident's record. The staff indicated the facility was not staffed adequately to supervise the residents closely to prevent resident to resident altercations. The staff indicated almost all of the residents in the facility had behaviors and were impulsive. The staff indicated the residents had extensive care needs and they were unable to meet their needs and adequately supervise the residents to prevent resident to resident altercations. The staff indicated they provided care for all the residents in the Skilled Nursing Facility (SNF) as well as the attached Assisted Living (AL) portion of the facility. The staff indicated they had complained to the administrative staff and DON and were informed there was not enough money in the budget to hire additional staff. There were four STNAs and one RN performing their assigned duties. A review of of the facility Self Reported Incident (SRI) dated [DATE] indicated Resident #14 had an altercation with Resident #33. The report indicated Resident #33 was seen exiting Resident #14's room looking distressed. Resident #33 proceeded to walk in the common area of the facility. A nurse entered Resident #14's room to check on him and found him seated on the bed with a hematoma under the left eye along with several scratches and the eye was discolored. Resident #14 and Resident #33 were unable to recount the events leading up to the altercation. Resident #33 was sent to the hospital for a psychiatric evaluation and informed the hospital staff he had punched Resident #14 to defend his girlfriend's honor. An investigation was conducted and the staff were interviewed. The investigation indicated at 6:15 P.M. on [DATE] the Hospice Nurse (RN #40) saw Resident #33 exit Resident #14's room. RN #40 asked Resident #33 if everything was all right. Resident #33 didn't answer and proceeded to walk to the common area of the facility. RN #40 went in Resident #14's room to check on him and found him seated on the bed with a bloody eye. The DON and Physician were notified and first aide was provided to Resident #14's left eye and Resident #33's swollen fingers on the left hand and then both residents were sent to the hospital. The police were called and Resident #14's family was notified and indicated they did not want to press charges. Both residents returned to the facility between 1:45 A.M. and 2:30 A.M. on [DATE]. A review of the incident report dated [DATE] completed by RN #40 (the Hospice Nurse) indicated the same details of the altercation as indicated on the facility investigation of the incident. RN #40 notified the DON and physician and the physician assessed Resident #14's left eye. RN #40 assessed Resident #33's left hand and found the second and third knuckles were swollen on his left hand. Medical record review revealed Resident #14 was admitted on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. A review of Resident #14's nursing progress note dated [DATE] indicated he was found with a hematoma to the left cheek and the physician assessed Resident #14 and ice was applied to his left cheek. Resident #14 was sent to the emergency room . There was no additional documentation of the the altercation with Resident #33. A review of Resident #14's hospital record dated [DATE] indicated a computerized tomography (CT) diagnostic test was performed to evaluate the his facial bones for a fracture. The results indicated an acute comminuted fracture (The bone is broken into more than two pieces) of the anterior wall of the left maxillary sinus (one of the four paranasal sinuses, which are sinuses located near the nose) with mild depression of fracture fragments. There was a hemorrhage (bleeding) of the aerated secretions within the left maxillary sinus. The left cheek was swollen with [MEDICAL CONDITION] (presence and passage of air in tissue-space) and mild swelling of the left periorbital soft tissue with no [MEDICAL CONDITION]. Resident #14 was discharged from the emergency room and returned to the skilled nursing facility. Medical record review revealed Resident #33 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review Resident #33's of the nursing progress note dated [DATE] indicated Resident #33 had a physical altercation with another resident. The progress note indicated the behavior put Resident #33 at significant risk for physical illness or injury. The impact on other residents put them at significant risk for physical illness or injury, significantly disrupted the living environment and care. Interventions implemented included one on one attention which was ineffective. Resident #33's clinical record indicated he was under the care of hospice and died in the facility on [DATE]. A review of Resident #33's nursing progress notes dated [DATE] indicated Resident #33 had a physical behavior directed towards another resident. The description of the incident indicated an altercation with another resident with no details of the incident documented. The progress note indicated Resident #33 was not exhibiting hallucinations or or delusions. The behavior put significant risk for physical illness or injury to another resident, significantly interfered with another resident's participation in activities of social interaction. The behavior put others at significant risk for physical injury, significantly intruded on privacy/activity of others, disrupted the care/living environment. The progress note indicated the effectiveness of the interventions implemented worsened the behavior, A review of Resident #33's hospital record dated [DATE] indicated Resident #33 suffered a contusion of the left hand and admitted to striking another resident in the skilled nursing facility where he resided. Resident #33 reported he had punched Resident #33 to defend her honor due to Resident #14 took another female resident's (unnamed) cane that belonged to her father. Resident #33 did not meet the criteria for admission to the hospital and was in stable condition. Resident #33 was sent back to the skilled nursing facility upon discharge from the emergency room . An interview with Resident #14 on [DATE] at 9:00 A.M. indicated another resident had punched him in the face. Resident #14 was unable to remember the details of the incident. Resident #14 stated he was not concerned about the incident and indicated Resident #33 was no longer in the facility.

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Resident #33's and Resident #14's plan of care had interventions initiated to address their specific behaviors. 2. A review of the facility's investigation of a resident to resident altercation dated [DATE] indicated Resident #5 and Resident #12 argued with each other resulting in physically punching and kicking each other. The facility investigation indicated Resident #5 was in a wheelchair propelling himself to the dining room shared by the Skilled Nursing Facility (SNF) and Assisted Living (AL) residents. Resident #12 was walking behind Resident #5 and used profanity to ask him to move faster. Resident #5 turned around in his wheelchair and used profanity to respond to Resident #12. Resident #12 responded by cursing at Resident #5 and started punching him in the head three times. Resident #5 reacted by kicking Resident #12. Two staff members intervened and separated both residents. Both residents were assessed and found no injury resulting from the physical altercation. Resident #5 was admitted on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #5's nursing progress notes indicated no documentation of a resident to resident altercation on [DATE]. Resident #5's Minimum Data Assessment ((MDS) dated [DATE] indicated Resident #5 had verbal behaviors directed towards others and not directed towards other which occurred daily, rejection of care and wandering in the facility. A plan of care was initiated upon readmission to the facility with interventions implemented. Resident #12 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #12's MDS assessment dated [DATE] indicated he exhibited wandering behaviors daily with a significant intrusion on the privacy and activities of others. A plan of care was initiated upon admission with interventions initiated to address the behaviors. A review of Resident #12's nursing progress notes indicated no documentation of the incident with Resident #5 on [DATE]. Interviews with Resident #5 and Resident #12 on [DATE] at 8:45 A.M. and 8:50 A.M. indicated no memory of the incident as described on [DATE] on the incident report. Both residents indicated they felt safe in the facility and had no concern in regard to the allegation. An interview with Resident #18 on [DATE] at 8:50 A.M. indicated there were many resident to resident altercations in the facility which the facility failed to handle adequately. Resident #18 indicated he tried to follow the rules and stay away from the other residents as much as possible. Resident #18 was unable to remember the specific days or residents involved in the incidents but indicated he would just stay in his room and try not to socialize with the other residents. An interview with the Regional interim DON on [DATE] at 11:30 A.M. verified the above findings and indicated the DON would be dealt with pending the outcome of their investigation. The facility identified there were 22 residents who needed assistance of one to two staff members for bathing, 18 residents for dressing, 17 residents for transferring, 19 for toilet use and 14 residents for eating. There were 16 residents who needed assistance with ambulation, 13 residents who were occasionally or frequently incontinent of urine and six resident who were occasionally or frequently incontinent of bowel. There were 12 residents with behavioral healthcare needs and 15 residents with dementia. There were four residents receiving intravenous therapy, intravenous nutrition and/or blood [MEDICAL CONDITION]. The facility census was 25. A review of the staffing schedule dated [DATE] to [DATE] indicated the staff listed on schedule matched the hours worked on their payroll time cards. The staffing tool was completed from [DATE] to [DATE] and the facility failed to meet the 2.5 minimum staffing requirement on [DATE] and [DATE]. The facility policy and procedure titled Abuse, Neglect, Exploitation, and Misappropriation of Resident Property dated ,[DATE] indicated abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. The types of abuse included, verbal abuse, sexual abuse, physical abuse and mental abuse. The response to abuse allegations indicated staff should report all incidents/allegations immediately to the Administrator or designee. The physician and responsible party should be notified of the incident/allegation of abuse. Documentation in the nursing progress notes should include the results of the resident's assessment, notification of the physician and responsible party and treatment provided. The allegation of abuse should be investigated with in five working days from the incident and reported the State of Ohio Department of Health within 24 hours of the alleged abuse incident. The investigation should include the resident, the accused, and all witnesses. After completion of the investigation, an examination of all the evidence, the Administrator would make a determination if the abuse allegation was substantiated. For resident to resident abuse appropriate interventions would be initiated/implemented to prevent further incidents of abuse. This deficiency substantiates Complaint Number OH 569.
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, record review, interview and the Centers for Disease Guidelines for control of the spread of scabies the facility failed to implement appropriate infection control measures to prevent the spread of a scabies type rash among residents in the facility. This affected seven (Residents #3, #7, #11, #13, #14, #18 and #20) of eight residents reviewed for skin rash and had the potential to affect all 25 residents currently residing in the skilled nursing home facility. Findings include: 1. Resident #3 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #3's clinical record indicated a physician order [REDACTED]. Resident #3's plan of care revised on 06/08/20 indicated a potential for skin impairment due to a rash noted on 05/25/20. 2. Resident #7 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #7's clinical record indicated physician orders [REDACTED]. A nursing assessment dated [DATE] indicated a mild rash under the breast. Resident #7's plan of care initiated on 06/08/20 indicated a possible scabies infection. Interventions were initiated to administer medications as ordered and monitor for adverse side effects. 3. Resident #11 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #11's clinical record indicated a physician order [REDACTED]. 4. Resident #13 was admitted on [DATE] with [DIAGNOSES REDACTED]. On 06/08/20 a plan of care was initiated for possible scabies infection. Interventions were initiated to address the infection. Physician orders [REDACTED]. 5. Resident #14 was admitted on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. A review of Resident #14's clinical record indicated no assessment in the electronic record of a rash or other skin condition. Resident #14's plan of care initiated on 06/08/20 indicated on 05/26/20 a rash was noted, and he had a possible scabies infection. Interventions were initiated to address the possible scabies infection. The physician orders [REDACTED]. On 06/24/20 the physician order [REDACTED]. 6. Resident #18 was readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #18's clinical record indicated a dermatologist note dated 09/02/20 indicated the assessment/plan for suspected scabies infection and included a plan for the application of [MEDICATION NAME] cream to affected areas. The dermatologist note indicated there was considerable [DIAGNOSES REDACTED] of the web spaces and some involvement of the wrist with excoriated papules with involvement of the buttock and waist. There were many scattered pink papules involving the trunk, back, all extremities and hands. 7. Resident #20 was admitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident #20's physician orders [REDACTED]. On 06/08/20 the weekly skin assessment indicated resident had a rash and treatment in place. During the initial tour of the facility on 09/08/20 from 7:50 A.M. to 10:10 A.M. interviews with staff Registered Nurse (RN) #41, State tested Nursing Assistant (STNA) #42, and STNA #43 indicated the facility had a problem with a contagious rash possibly a scabies infection in the facility. The staff indicated many residents and staff had a rash and the facility had not protected the residents from spread of the rash. The staff indicated the residents were not on isolation precautions and the staff did not wear a gown while providing direct care to the residents. The staff indicated they had direct skin to skin contact with all the residents every day. The staff indicated they had all contracted the rash in the facility and they thought the rash was consistent with the signs and symptoms of a scabies infection. The facility had two hallways in the shape of a T. The longer hallway had Assisted Living (AL) residents and connected to the Skilled Nursing Facility (SNF) portion of the building. The residents and staff were observed walking back and forth from both the AL and SNF portions of the facility. There was no door separating the two portions and the staff provided care to residents of both the AL and SNF portions of the facility. An interview with Resident #13 on 09/08/20 at 8:15 A.M. indicated earlier in the summer he had a rash. The facility applied cream to the rash and it was much better now. An interview with the Administrator and Regional Director of Nursing (DON) on 09/08/20 at 12:45 P.M. indicated all staff had been treated for [REDACTED]. The Administrator indicated he had recently started his administrative duties at the facility and was unaware the rash the residents and staff were contracting was contagious and could be due to scabies infection. The Administrator and Regional DON were unable to identify the number of residents and staff members who had a rash since May 2020. An interview with Resident #18 on 09/09/20 at 8:50 A.M. indicated he had a rash over his entire body for many weeks. Resident #18 indicated the facility had recently applied cream to his skin which seemed to help. Resident #18 indicated he had been seen by a dermatologist and informed him he had a scabies infection. Resident #18 indicated during a cigarette break at 12:00 P.M. approximately a week ago the DON came outside and announced to all the residents smoking that they did not have scabies. Resident #18 indicated a few days later everyone had to be treated for [REDACTED].#18 indicated he had lost trust with the ability of the facility to timely handle infections in the facility. During the interview and observation of Resident #18's skin exposed on his

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) arms revealed a scabbed rash covering both arms and hands. Resident #18 pulled up both of his pant legs and revealed a red pimple type rash on both lower legs which was dark red with scabbed areas. An interview with Resident #14 on 09/09/20 at 9:00 A.M. indicated he had a rash on his arms and chest approximately one month ago. The staff applied cream to the rash and the rash was much better now. Resident #14 indicated he had heard the DON inform all the residents that the rash they suffered from was not from a scabies infection. An interview with STNA #44, STNA #43, and STNA #42 on 09/09/20 at 9:10 A.M. indicated many of the residents started complaining of a rash and severe itching in the spring (April) of 2019. The facility had all the staff and residents treated with [MEDICATION NAME] cream (drug of choice for the treatment of [REDACTED]. The staff indicated the rash had started again this past spring (May) 2020 in both the SNF and AL portions of the facility. The three staff indicated they all had contracted the rash and were unhappy with the timeliness of the facility's response to the rash. Many of the residents in the SNF portion had also contracted the rash. The staff indicated all the staff and residents were treated with [MEDICATION NAME] cream but not until 09/03/20. The staff indicated they didn't understand why all staff and residents were not treated in the facility when the rash was identified in May of 2020. The staff indicated the facility had not isolated the residents who had a rash or implemented the appropriate isolation measures to prevent the spread of the rash to the staff and other residents. A review of facility infection control log dated 01/2020 to 09/2020 indicated on 05/25/20 Resident #18 and five additional residents (Residents #3, #7, #11, #13 and #20) had a rash and were treated with [MEDICATION NAME] cream. The infection control log dated 06/01/20 to 06/30/20 had no indication Resident #14 had a rash or other skin condition on his feet and hands. The infection control log indicated on 06/04/20 the resident had an abscess which was treated with a 10-day course of antibiotics. An interview with the Regional DON on 09/09/20 verified the findings. The Regional DON indicated the rash that had spread to the residents and staff had not been definitely diagnosed as scabies but did agree the rash was contagious. Review of The Centers for Disease Control (CDC) guidelines for the control of spread of scabies dated 11/02/2010 indicated control measures for multiple cases of non-crusted scabies should consist of heightened surveillance for early detection of new cases, proper use of infection control measures when handling patients (e.g. avoidance of direct skin-to-skin contact, hand washing, etc.), confirmation of the [DIAGNOSES REDACTED]. Skin-to-skin contact with scabies patients should be avoided for at least 8 hours after treatment. In addition, an institution-wide information program should be implemented to instruct all management, medical, nursing, and support staff about scabies, the scabies mite, and how scabies is and is not spread. Epidemiological and clinical data should be reviewed to determine the extent of the outbreak and risk factors for spread. Control measures for an outbreak involving one or more cases of crusted scabies should involve rapid and aggressive detection, diagnosis, infection control, and treatment measures because this form of scabies is so highly transmissible. Unrecognized crusted scabies often is the source of institutional outbreaks of scabies. Infection control personnel and dermatologists should be involved as soon as scabies is suspected in an institution. An institution-wide information program should be implemented to instruct all management, medical, nursing, and support staff about scabies, the scabies mite, and how scabies is and is not spread. Until successfully treated, patients with crusted scabies should be isolated from other patients who do not have crusted scabies. Assigning a cohort of caretakers to care only for patients with crusted scabies can reduce the potential for further transmission. Direct skin-to-skin contact between a patient with crusted scabies and his/her caretakers and visitors should be eliminated by following strict contact precautions, including the use of protective garments such as gowns, gloves, and shoe covers. The patient's room should be cleaned thoroughly. Bedding and clothing used by a person with scabies should be machine-laundered using the hot water and hot dryer cycles. All staff, volunteers, and visitors who may have been exposed to a patient with crusted scabies, or to clothing, bedding, or furniture used by such a patient, should be identified and treated. Treatment should be strongly considered even in equivocal circumstances because of the complexity of controlling an institutional outbreak and the low risk associated with treatment. All suspected and confirmed cases, as well as all potentially exposed patients, staff, visitors, and family members should be treated at the same time to prevent re-exposure. Remember that symptoms of scabies can take weeks to appear the first time a person is infested; however, the person still can spread scabies during this asymptomatic period. Persons with crusted scabies generally require treatment at least twice, a week apart. Topical treatment with [MEDICATION NAME] or oral treatment with ivermectin has been used successfully, although ivermectin currently is not FDA-approved for treatment of [REDACTED]. All new patients and staff should be screened and treated for [REDACTED]. The local health department and neighboring institutions should be notified of the outbreak and of any patients who may have been transferred to or of staff who may have worked in other institutions. This deficiency substantiates Complaint Number OH 569.