STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 00 B. WING	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00362208, IN00363081, IN00363498, and IN00364184. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00362208 - Substantiated. Federal/state deficiencies related to the allegations are cited at F755 and F761. Complaint IN00363081 - Substantiated. Federal/state deficiencies related to the allegations are cited at F921. Complaint IN00363498 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580 and F609. Complaint IN00364184 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F755, F761, and F880. Survey dates: October 4, 5, 6, and 7, 2021 Facility number: 000032 Provider number: 155077 AIM number: 100273330 Census Bed Type: SNF/NF: 89 Total: 89 Census Payor Type: Medicare: 7 Medicaid:82 Total: 89	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 15, 2021.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate			

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	assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and record review, the facility failed to immediately notify the physician and resident's family, and/or legal representative of an injury of unknown origin resulting in significant bruising to the left hand (Resident F), and a resident change in condition resulting in the resident calling 911 and subsequent hospitalization (Resident JJ) for 2 of 3 residents reviewed for physician and family notification. Findings include: 1. On 10/5/21 at 10:58 a.m., Resident F was observed with Qualified Medication Aide (QMA) 33 lying in bed with her eyes closed, wearing a hospital gown, disheveled appearance, hair not combed, and bedding rumpled. The resident's left hand was observed to have extensive dark blackish bruising on the entire back of the hand,	F 0580	Tag: F 580 Notify of Changes (Injury/Decline/Room, etc.) SS = **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The involved residents have both been assessed head to toe with no new findings noted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	11/05/2021

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	midway down and wrapped around the middle finger, and down the ring finger. There was a blood soaked 2 inch by 2 inch bandage above the left wrist and loosened white gauze around the mid left forearm. QMA 33 indicated she was not aware and could not explain how Resident F obtained the injury to her left hand. Licensed Practical Nurse (LPN) 9 and LPN 10 indicated, they routinely worked the B hallway, but were not aware of how the resident obtained the injury to her hand. On 10/6/21 at 3:07 p.m., Resident F was observed lying in bed with her eyes closed. The left hand was open to air, and the entire back of hand discolored with dark blackish bruising from her wrist, down the ring finger approximately 1 inch, and down to the middle knuckle on the middle finger. There was a moon shaped scab on the back of the hand measuring approximately 1 inch in length and ¼ inch in width at the widest in the middle. The scab was dry with no drainage. On 10/7/21 at 12:30 p.m., observation of Resident F lying in bed with her eyes closed. The left hand was observed open to air, the entire back of the hand dark blackish bruising from wrist and down middle finger. Bruising had started to extend down left ring finger and up above outer left wrist bone. Resident F's record was reviewed on 10/6/21 at 2:43 p.m. Diagnoses on Resident F's profiled included, but were not limited to, dementia with behavioral disturbance, psychosis, history of displaced fracture of right ring finger, osteoarthritis, disorder of bone density and structure, and displaced intertrochanteric fracture of left femur.		All residents have the potential to be affected. The Director of Nursing/designee will conduct a facility wide skin sweep, Director of Nursing/designee will audit the clinical notes on all residents to ensure any change of conditions were reported to all appropriate parties. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be educated on proper notification when a change in condition is noted. Prior to, or during, the clinical meeting (Monday thru Friday), the Director of Nursing/designee will audit the clinical notes from the previous day to ensure that any resident change in condition is reported to all appropriate parties in a timely manner. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Nursing/designee will audit clinical notes daily (Monday thru Friday) for four (4) weeks; three times	

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	Physician's Orders for Resident F, dated October 2021, indicated there was no documentation to indicate treatment orders had been obtained for a hand injury. A Nursing Note for Resident F, dated 10/3/21 at 4:45 p.m., indicated the resident had a skin tear to the right index finger area cleaned and covered with non-adherent dressing, hospice made aware. Resident F's resident record lacked documentation to indicate the resident had received an injury to the left hand, and the physician and family had been notified. Resident R's record lacked documentation to indicate an Initial Assessment of Non-Pressure related Skin Condition assessment had been completed of the left hand to include a date, description of the injury, or measurements of the bruising. Resident F's resident record lacked documentation to indicate a care plan had been initiated related to an injury of unknown origin to the left hand. On 10/6/21 at 2:50 p.m., LPN 9 indicated Resident F had received a skin tear on the back of her left hand on Saturday 10/2/21, and then it bruised. She thought there had been documentation of the incident in the resident's medical record, but upon review of the notes did not see documentation. LPN 9 indicated when a physician or family members were contacted, even for general information of new orders, she would document the communication in the Nurse's Notes. On 10/6/21 at 2:56 p.m., LPN 10 indicated she		(3x) a week for the following four (4) weeks; two times (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	

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had not been assigned to care for Resident F and was not sure what happened to her left hand. When a resident had a skin injury the information was to be passed along to the Director of Nursing Services (DNS) for tracking purposes. The physician and family were also to be notified, and the contact and response documented in the Nurse's Notes.

On 10/6/21 at 3:46 p.m., the Director of Nursing Services Specialist (DNSS) indicated Resident F's Nurse's Notes had documentation to indicate the resident had a skin tear on the right forefinger.

An annual Minimum Data Set (MDS) assessment, completed on 8/24/21, assessed Resident F as having a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment. There were no physical or verbal signs or symptoms of behaviors, and no rejection of care. The resident required limited assistance of 1 person physical assist for bed mobility, transfers, eating, and toilet use. She did not walk in the room or corridor. She was total dependence of 1 person physical assistance for locomotion on and off the unit, and personal hygiene. She was an extensive assistance of 1 person physical assist for dressing. No falls since the prior assessment. No pressure ulcers or skin conditions requiring treatment.

On 10/6/21 at 4:25 p.m., the DNSS indicated there was no documentation in Resident F's medical record found regarding the injury to the left hand. Nursing staff should have initiated skin sheets at the time of the incident to assess and monitor for injury, got an x-ray to rule out injury to include fracture, notified the physician and family, and notified administration. Certified

Nursing Assistants (CNA's) were supposed to report to the nurse any new skin areas, and the nurse was responsible for reporting to management and following up with an assessment, and notification to the physician and family.

On 10/7/21 at 12:25 p.m., LPN 10 indicated, Resident F's record indicated orders for an x-ray to the left hand had been written, but there was no documentation to indicate the x-ray had been completed. LPN 10 indicated the x-ray probably had not been done yet as the order was not sent as STAT (as soon as possible), and the mobile x-ray company was slow in coming for routine orders.

2. On 10/5/21 at 12:37 p.m., Resident JJ indicated the prior week he had a fever of 105.7 F (Fahrenheit) and had to call 911 by himself and was then admitted to the hospital.

Resident JJ's record was reviewed on 10/6/21 at 4:13 p.m. Diagnoses on Resident JJ's profile included, but were not limited to quadriplegia, urinary tract infection, generalized muscle weakness, history of respiratory failure with hypoxia, and neuromuscular dysfunction of the bladder.

A care plan for Resident JJ, last dated 7/13/21, indicated the resident has a history of UTI's. The goal was for the resident to be free from signs or symptoms of UTI's. Interventions included, but were not limited to, monitor vital signs as indicated.

A Nurse's Note for Resident JJ, dated 9/23/21 at 11:59 p.m., indicated the resident was sent out to a local hospital emergency room at 11:05 p.m.

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	The Director of Nursing Services (DNS) and on call were made aware. There was no documentation to indicate symptoms or reason for the emergency room visit. A History and Physical from a local hospital, dated 9/23/21, indicated resident presented via EMS with abdominal pain and nausea. He also had a fever of 103.0 F for EMS. He had his foley catheter flushed x 2 days ago and reports a bunch of sediment from it since then, which is when the onset of his symptoms started. He reports he feels the abdominal pain laterally along his sides. Discharge Instructions from a local hospital, visit date 9/23/21, indicated diagnosis from today's visit UTI and quadriplegia. Call 911 if any of these occur: trouble breathing, or fast heart rate. When to get medical advice, call your healthcare provider right away if any of these occur: fever of 100.4 F or higher. A Nurse's Note for Resident JJ, dated 9/24/21 at 4:00 a.m., indicated the nurse had received a report from the ER. The resident had been diagnosed with a Urinary Tract Infection (UTI), his foley catheter had been changed, and he was given orders for 2 new antibiotics. Nurse's Notes for Resident JJ, dated 9/24/21 at 6:30 a.m., indicated the resident had returned from the hospital with a diagnosis of UTI. A Nurse's Note for Resident JJ, dated 9/24/21 at 7:00 a.m., indicated resident had a temperature of 103.6 (normal 97.0 F - 99.0 F) per night shift QMA. A Nurse's Note for Resident JJ, dated 7:30 a.m., indicated the resident had a temperature of 107.0			

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	F., the resident was covered in multiple blankets, and the extra blankets were removed. A cold cloth was placed on the resident's forehead and ice packs in his arm pits times 2. Tylenol (antipyretic) given at this time. A Nurse's Note for Resident JJ, dated 9/24/21 at 8:30 a.m., indicated the resident's temperature was rechecked and read 105.7 F. The cold cloth was rewet, and ice packs adjusted. The resident proceeded to call 911 per self to go back to the ER. Physician's Orders for Resident JJ, dated 9/24/21, indicated there was no documentation to indicate physician's orders had been obtained to transfer the resident to the emergency room (ER) for evaluation and treatment related to a high fever. A Nurse's Note for Resident JJ, dated 9/24/21 at 8:50 a.m., indicated the resident left the facility via Emergency Medical Services (EMS) and returned to a local hospital. Resident JJ's record lacks documentation to indicate the physician or responsible party were notified of the resident having an abnormally high temperatures or being sent to the hospital on 9/24/21. A hospital Final Report, dated 9/24/21, indicated Resident JJ had been in the ER the prior day with nausea, abdominal pain, and fever, evaluated and given an antibiotic for probable UTI based on a urinary analysis, then sent back to the facility last night. This am Resident JJ was brought back to ER for fever, tachypnea (abnormally rapid breathing) and tachycardia (abnormally fast heart rate).			

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A Nurse's Note for Resident JJ, dated 9/28/21 at 5:40 p.m., indicated the resident returned from the hospital at this time. The resident had orders for an antibiotic following UTI, sepsis and viral pneumonia.

On 10/6/21 at 12:00 p.m., the Nurse Practitioner indicated Resident JJ had recently called 911 and went to the hospital for about a day, then returned with a diagnosis of UTI and orders for antibiotics. The resident had a chronic catheter due to paraplegia was paranoid about UTI's, would continually think he has symptoms even when he did not, and insisted on seeing a male physician. The NP indicated she had not received a recent call so was assuming Resident JJ had no further issues. He was not on her list to see that day.

On 10/7/21 at 9:28 a.m., the DNSS indicated when the resident was identified as having a temperature on 9/24/21 of 103.6 F then 107.0 F, staff should have gotten another thermometer to retake his temperature to assure accurate as that would be "brain fry" range. The physician should have been notified at that point for instructions, the resident was his own responsible party so there was no family to notify. The resident called 911 himself to be sent back the hospital, staff did not. The resident record lacked a vital sign tracking sheet, and documentation of vital signs were being monitored other than the Nurse's Notes. Resident JJ's Nurse's Notes lacked documentation to indicate the resident's condition was being assessed following his return from the hospital on 9/28/21. The facility had no policy on vital signs and followed the regulation for notification of physician and family.

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	This Federal tag relates to Complaints IN00363498 and IN00364184. 3.1-5(a)(1) 3.1-5(a)(2)			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 0609	F609 Reporting of Alleged Abuse	11/05/2021

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	Based on observation, interview, and record review, the facility failed to report an injury of unknown origin resulting in significant left hand bruising for 1 of 1 residents reviewed for reporting allegations of abuse (Resident F). Findings include: On 10/5/21 at 10:58 a.m., Resident F was observed with Qualified Medication Aide (QMA) 33 lying in bed with her eyes closed, wearing a hospital gown, disheveled appearance, hair not combed, and bedding rumpled. The resident's left hand was observed to have extensive dark blackish bruising on the entire back of the hand, midway down and wrapped around the middle finger, and down the ring finger. There was a blood soaked 2 inch by 2 inch bandage above the left wrist and loosened white gauze around the mid left forearm. QMA 33 indicated she was not aware and could not explain how Resident F obtained the injury to her left hand. Licensed Practical Nurse (LPN) 9 and LPN 10 indicated, they routinely worked the B hallway, but were not aware of how the resident obtained the injury to her hand. On 10/6/21 at 3:07 p.m., Resident F was observed lying in bed with her eyes closed. The left hand was open to air, and the entire back of hand discolored with dark blackish bruising from her wrist, down the ring finger approximately 1 inch, and down to the middle knuckle on the middle finger. There was a moon shaped scab on the back of the hand measuring approximately 1 inch in length and ¼ inch in width at the widest in the middle. The scab was dry with no drainage. On 10/7/21 at 12:30 p.m., observation of Resident F lying in bed with her eyes closed. The		SS=D **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The resident was assessed head to toe, and all findings were documented and reported to the appropriate parties, including MD, family and ISDH. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. A facility wide investigation will be conducted. Executive director/designee will conduct interviews with alert and oriented residents and Director of Nursing/designee will conduct a facility wide skin sweep on residents that are not able to be interviewed. If issues/areas are noted all appropriate parties will be notified. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	

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	left hand was observed open to air, the entire back of the hand dark blackish bruising from wrist and down middle finger. Bruising had started to extend down left ring finger and up above outer left wrist bone. Resident F's record was reviewed on 10/6/21 at 2:43 p.m. Diagnoses on Resident F's profiled included, but were not limited to, dementia with behavioral disturbance, psychosis, history of displaced fracture of right ring finger, osteoarthritis, disorder of bone density and structure, and displaced intertrochanteric fracture of left femur. Physician's Orders for Resident F, dated October 2021, indicated there was no documentation to indicate treatment orders had been obtained for a hand injury. A Nursing Note for Resident F, dated 10/3/21 at 4:45 p.m., indicated the resident had a skin tear to the right index finger area cleaned and covered with non-adherent dressing, hospice made aware. Resident F's resident record lacked documentation to indicate the resident had received an injury to the left hand. Resident R's record lacked documentation to indicate an Initial Assessment of Non-Pressure related Skin Condition assessment had been completed of the left hand to include a date, description of the injury, or measurements of the bruising. On 10/6/21 at 2:50 p.m., LPN 9 indicated Resident F had received a skin tear on the back of her left hand on Saturday 10/2/21, and then it bruised. She thought there had been		The interdisciplinary team along with all line staff will in serviced on Abuse and Reporting appropriately. During morning meeting (Mon – Fri) the Executive Director will discuss with department heads whether there have been any reports of abuse of any kind since last meeting. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director/designee will complete at least 5 random audits in form of interviews with residents/staff daily (Mon- Fri) for four (4) weeks; then three times (3x) a week for the following four (4) weeks; two-time (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved **By what date the systemic**	

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	155077	A. BUILDING 00 B. WING	10/07/2021

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	documentation of the incident in the resident's medical record, but upon review of the notes did not see documentation. On 10/6/21 at 2:56 p.m., LPN 10 indicated she had not been assigned to care for Resident F and was not sure what happened to her left hand. When a resident had a skin injury the information was to be passed along to the Director of Nursing Services (DNS) for tracking purposes. On 10/6/21 at 3:46 p.m., the Director of Nursing Services Specialist (DNSS) indicated Resident F's Nurse's Notes had documentation to indicate the resident had a skin tear on the right forefinger. On 10/6/21 at 4:25 p.m., the DNSS indicated there was no documentation in Resident F's medical record found regarding the injury to the left hand. Nursing staff should have initiated skin sheets at the time of the incident to assess and monitor for injury, got an x-ray to rule out injury to include fracture, notified the physician and family, and notified administration. Administration then could have reported an injury of unknown injury to the Indiana Department of Health (IDOH), launched an investigation, and reviewed or updated the resident's care plan. Certified Nursing Assistants (CNA's) were supposed to report to the nurse any new skin areas, and the nurse was responsible for reporting to management and following up with an assessment, and notification to the physician and family. On 10/6/21 at 5:15 p.m., the DNSS provided an Accident and Incident Reporting policy, dated 10/2014, and indicated the policy was the one currently being used by the facility. The policy		**changes by completed:** November 5, 2021	

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	indicated, " ...An Accident/Incident form is to be completed for all incidents involving residents, employees, and visitors. A written description of circumstances surrounding the incident is to be completed and submitted to the nursing supervisor as soon as possible during the tour of duty in which the incident occurred. The report form should be initiated as soon as possible following the incident, after appropriate assessment and necessary emergency intervention is completed...Procedure: 1. Resident: Complete assessment and provide necessary emergency care. Notify physician, family, and nursing supervisor...." An Indiana State Department of Health Incident Reporting Policy, dated 7/15/15, indicated, " ...To provide guidance on the type of incidents to be reported, the timeline for reporting, and the information to be included in the report ...4. Injuries of Unknown Source- An injury should be classified as an injury of unknown source when both of the following conditions are met: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of the injury or the location of the injury ...." This Federal tag relates to Complaint IN00363498. 3.1-28(c)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its			

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	residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on observation, interview, and record review, the facility failed to ensure medications were available for administration for 1 of 6 residents observed for medication availability (Resident JJ). Findings include:	F 0755	Tag: F755 SS = D **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	11/05/2021

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	On 10/5/21 at 12:37 p.m., Resident JJ was observed sitting in an electric wheelchair at bedside and indicated his fleet enema (used for constipation) and relistor injection (used to treat opioid induced constipation) were not available, and he had not received them the past few days as ordered. On 10/5/21 at 12:40 p.m., observation of Resident JJ's medications with LPN 10, and she indicated the fleet enema and relistor injection were not in the cart. LPN 10 indicated the medications were administered every other day on opposite days, which meant he should have received at least one of the medications daily. It was the evening and night shift nurses' responsibility for orders and administering those medications. A Medication Administration Record (MAR) for Resident JJ, dated October 2021, indicated the fleet enema was not documented as having been administered on 10/3 or 10/5, and the Relistor injection was not documented as having been administered on 10/4/21. A Night Shift Memo to nurses and Qualified Medication Aides (QMA's), undated, indicated tasks to be completed to include, but were not limited to, temperature checks on the refrigerators, prepare all medications to be returned to the pharmacy, go through the medication carts for loose pills and dispose properly, check open dates on medications (exclude medication cards), reorder any medications, replenish all supplies needed, and clean refrigerators as needed. "It is the expectation that these tasks be completed each night."		The residents' orders have been reviewed and any missing medication were ordered, and all appropriate parties notified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. The Director of Nursing/designee will conduct a facility wide audit to ensure that all residents have the correct medication readily available for administration per MD orders. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All licensed nurses and QMA's will be educated on Medication administration and general guidelines. Prior to, or during, the clinical meeting (Monday thru Friday), The Director of Nursing/designee will audit the MAR/TAR from the previous day to ensure that proper procedure was followed for any resident that didn't receive a medication. **How will the corrective action(s) will be monitored to**	

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	On 10/5/21 at 2:33 p.m., the Director of Nursing Services Specialist (DNSS) indicated, the facility had no specific policy for who was to reorder medications, but the nurse who observed the resident to be low or out of a medication should have pulled the sticker and reordered the medications. On 10/5/21 at 2:34 p.m., the DNSS provided a Medication Administration and General Guidelines policy, dated 2020, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so ...Procedure: 1. Medications are prepared, administered, and recorded only by licensed nursing ...2. Medications are administered in accordance with written orders of the attending physician ...3. The person administrating medications adheres to Universal Precautions, using proper hand hygiene, gloves when appropriate, before beginning medication pass, prior to handling any medications, and after coming into direct contact with a resident. Gloves will be worn before administration of any ophthalmic, otic, intranasal inhaled, topical, vaginal or rectal medication ....5. Medications are administered at the time they are prepared. Medications are not pre-poured ...12. If a dose of regular scheduled medication is withheld, refused, or given at other than the scheduled time [e.g., resident not in facility at scheduled dose time, initial dose of antibiotic], the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. The physician must be notified when a dose of		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Nursing/designee will MAR/TAR daily (Monday thru Friday) for four (4) weeks; three times (3x) a week for the following four (4) weeks; two times (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	

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	medication has not been given ...." This Federal tag relates to Complaints IN00362208 and IN00364184. 3.1-25(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to ensure medications were labeled properly, destroyed properly, and stored properly in 3 of 3 medication carts, 1 of 2	F 0761	Tag: F761 SS = E **What corrective action(s) will**	11/05/2021

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	treatment carts, and 1 of 2 resident refrigerators observed for medication storage. Findings include: On 10/4/21 at 10:56 a.m., an observation of the B hallway medication cart for rooms 1 - 17 with Licensed Practical Nurse (LPN) 9, the following was observed: a. Resident P's opened vial of Breaziel Insulin Aspart with no opened dated. b. Resident Q's opened vial of Humalog insulin with no opened date, and an opened vial of Lantus insulin with no opened date. c. Resident R's 2 opened bottle of Latanoprost 0.05% eye drops (used to treat glaucoma) with no opened date. d. Resident S's opened Admelog insulin pen with no opened date. e. Resident H's Novolog insulin flexpen with no opened date. f. Resident T's opened Basaglar insulin pen with no opened date. g. Resident U's opened bottle of Travoprost 0.004% eye drops (used to treat glaucoma) , opened bottle of Brimonidine Sol 0.2% eye drops (used to treat glaucoma), opened bottle of Rhopressa Sol 0.02% eye drops (used to treat glaucoma), and opened bottle of Pilocarpine 4% eye drops (used to treat glaucoma), all without opened dates. The front B hallway treatment cart was observed with a tube of Remedy Antifungal Cream without a pharmacy label or resident name, LPN 9 indicated it was house cream to be used for any resident. A tube of Diclofenac Sod Topical Gel (antifungal) opened, and the resident label peeled off, a tube of Mupirocin 2% ointment (antibiotic) with the resident label blacked out		**be accomplished for those residents found to have been affected by the deficient practice:** The effected residents' medications have been replaced with new unopened medications with appropriate labels/stickers/dates on each item. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. The Director of Nursing/designee will conduct a facility wide audit to ensure that all medications in carts/ cabinets/refrigerators have the correct labels/stickers/dates per regulation. Any medication that is found will be destroyed and reordered at no cost to the resident. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** All licensed nurses and QMA's will be educated on Medication storage in the facility. The Director of Nursing/designee will audit the Medication	

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	with marker, and a tube of Santyl (used to treat necrotic wounds and burns) with no pharmacy label or resident name. LPN 9 indicated she did not know who the medications belonged to or the reason they were in the cart without proper labeling. On 10/4/21 at 11:22 a.m., the B hallway medication cart for rooms 18 - 25, and A hallway with LPN 10, the following was observed: a. Resident V's opened Incruse Ellipta inhaler (an anticholinergic medication used to treat chronic obstructive pulmonary disease [COPD]) with no opened date. b. Resident W's opened bottle of Latanoprost Sol 0.005% eye drops with no opened date. c. Resident X's bottle of Lumigan Sol 0.01% eye drops (used to treat glaucoma) with no opened date. d. An unlabeled mediation cup of unidentified orange crushed medications in the top drawer of the medication cart. LPN 10 was observed to toss the medication cup into the open trash can on the side of the medication cart. e. An opened tube of Iodosorb gel (used to clean wounds) with no resident label was observed in a drawer on the medication cart. LPN 10 indicated it was probably used for wound care. No explanation of why a wound gel was being stored among resident oral medications. On 10/5/21 at 10:31 a.m., observation of the D hallway treatment cart with the Director of Nursing Services (DNS). There were opened tubes of Iodosorb gel, Diflucan Ointment 1%, and a barrier cream in the cart without a pharmacy label or resident name. On 10/5/21 at 10:34 a.m., observation of the D hallway medication cart with Registered Nurse		carts/cabinets/refrigerators to ensure that proper labels/stickers/dates are on each container per regulations. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Nursing/designee will MAR/TAR daily (Monday thru Friday) for four (4) weeks; three times (3x) a week for the following four (4) weeks; two times (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	

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	(RN) 18, the following was observed: a. Resident SS's opened Budesonide inhaler (used to treat asthma and COPD symptoms), unboxed, with no label or opened date. An opened bottle of Fluticasone propionate nasal spray (a steroidal bronchodilator) with no opened date. c. Resident TT's opened bottle of Ketorolac 0/5% ophthalmic solution (used to treat pain) with an opened date of 4/19/21. On 10/5/21 at 10:42 a.m., Wellness Director 4 indicated the nurse who opened a medication bottle or vial should have put an opened date on the vial or container. All treatment tubes should have had a pharmacy label with the resident name and instructions for use. There was no such thing as a "general use" medication. On 10/5/21 at 10:50 a.m., RN 18 indicate, as the nurse she felt it was her responsibility to make sure the medication cart was tidy, medications were available for administration, and any medication vial or bottle she had opened were dated at that time. On 10/5/21 at 2:34 p.m., the DNSS provided a Medication Storage in the Facility policy, dated 2020, and indicated the policy was the one currently being used by the facility. The policy indicated, "Medications and Biologicals are stored safely, securely, and properly following manufacture's recommendations or those of the supplier ...Procedure ... [the pharmacy] dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable ...5. Eye medications are kept separate from ear medications ...7. Medications labeled for individual residents are stored separately from			

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	floor stock medications ..." On 10/5/21 at 2:34 p.m., the DNSS provided a Drug Destruction policy, dated 2020, and indicated the policy was the one currently being used by the facility. The policy indicated, "In the event that the facility must destroy medications [controlled or non-controlled] the facility will adhere to the rules and regulations of their specific State Health Department as well as any other regulatory body including but not limited to the Drug Enforcement Agency [DEA], State Board of Pharmacy, and OSHA ..." This Federal tag relates to Complaints IN00362208 and IN00364184. 3.1-25(b)(7) 3.1-25(j) 3.1-25(k) 3.1-25(l) 3.1-25(o) 3.1-25(s)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident			

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	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	A. Based on observation, interview, and record review, the facility failed to follow facility protocol for cleaning a shared glucometer (an instrument for measuring the concentration of sugar in the blood) to prevent contamination of blood borne pathogens for 2 of 2 residents observed for blood sugar monitoring (Residents FF and GG). B. Based on observation, interview, and record review, the facility failed properly prevent possible exposure to COVID-19 when the facility failed to ensure residents on transmission-based precautions (TBP, isolation to help prevent the spread of disease) for suspected COVID-19 were monitored for COVID-19 symptoms, failed to ensure staff wore appropriate PPE (personal protective equipment) throughout the facility to include common areas and isolation resident rooms, failed to ensure staff performed proper PPE donning/doffing, and failed to ensure staff completed hand hygiene at appropriate times for 3 of 4 days of observation for infection control.	F 0880	Tag: F880 SS = E **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The residents that had the chance of cross contamination received explanation and education about possible risk. The MD was notified, and no negative outcomes were noted. Those residents exposed due to inappropriate PPE remain on daily checks to monitor for signs and symptoms of any type of illness and have shown no signs or symptoms at this time. **How other residents having the potential to be affected by the**	11/05/2021

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	Findings include: A. On 10/5/21 at 12:21 p.m., Registered Nurse (RN) 18 was observed as she checked the blood sugar of Resident Ff with a glucometer. RN 18 placed a testing strip into the glucometer, drew blood from Resident Ff's finger, and placed a drop of blood onto the testing strip. She removed the testing strip from the glucometer and threw it away in a trash can in the resident's room. On 10/5/21 at 12:35 p.m., RN 18 was observed as she checked the blood sugar of Resident Gg with the same glucometer as was used with Resident Ff. RN 18 placed a testing strip into the glucometer, drew blood from Resident Gg's finger, and placed a drop of blood onto the testing strip. RN 18 did not clean the glucometer between when she checked Resident Ff's blood sugar and when she checked Resident Gg's blood sugar. During an interview on 10/5/21 at 12:38 p.m., RN 18 indicated she used same the glucometer for Resident Ff and Resident Gg it was the common glucometer. The residents had their own individual glucometers, but sometimes they did not work properly, and it was faster to use the common glucometer to check all the residents' blood sugars. RN 18, indicated she had bleach wipes to clean the glucometer between residents. She should have cleaned the glucometer between Resident Ff and Gg, but she just forgot. On 10/5/21 at 3:33 p.m., the Chief Operating Officer (COO) provided an undated policy titled, "Shared Glucometer Cleaning Protocol". He indicated this was the current policy in use by the facility at that time. The policy indicated,		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. All staff members identified will receive education along with disciplinary action related to failure to following infection control guidelines and policies. **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Executive Director/designee will educate all staff on appropriate PPE in all areas which will include green, yellow and red. The Director of nursing/designee will educate licensed nurses and QMA's on proper Glucometer usage and cleaning. The Executive Director/designee will educate all staff on Handwashing **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Director of Nursing/designee will compete random audits on appropriate	

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	"Glucometers shared by multiple patients will be thoroughly wiped with [approved low level disinfectant] and allowed to air dry after every use and between every patient." CDC Guidance, "Infection Prevention during Blood Glucose Monitoring and Insulin Administration" indicated, "Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents." B1. During a continuous, uninterrupted observation that began on 10/5/21 at 8:04 a.m., Licensed Practical Nurse (LPN) 10 was observed as she prepared and administered medications for Residents E, Z, Bb, and X. LPN 10 was observed as she used a computer at the nurses' station. She stood up from the nurses' station, handed papers off to other nursing staff, and walked to a medication administration cart that was parked in the hallway to prepare resident medications. She removed pills from pill packs and placed them into a small plastic cup with pudding for Resident E. She did not perform hand hygiene or put on gloves before she prepared the resident's medications. LPN 10 indicated Resident E was scheduled for pills and eye drops that day. LPN 10 entered Resident E's room. She did not perform hand hygiene before she entered the room. LPN 10 removed a pair of gloves from her shirt pocket, put them on, and proceeded to attempt to administer eye drops into Resident E's eyes. She did not perform hand hygiene before she put on the gloves. On 10/5/21 at 8:10 a.m., LPN 10 walked back to		usage and cleaning of glucometers, handwashing, and appropriate PPE usage daily (Monday thru Friday) for four (4) weeks; three times (3x) a week for the following four (4) weeks; two times (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	

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	the medication administration cart to prepare medications for Resident Z. She spilled a powdered thickening agent on top of the medication cart and used her bare hands to brush the powder from the top of the cart onto the floor. She then picked a piece of paper up from the floor and placed it into the trash can attached to the medication cart. She continued to prepare mediations for Resident Z. LPN 10 did not perform hand hygiene during the observation. On 10/5/21 at 8:19 a.m., LPN 10 entered Resident Z's room. She did not perform hand hygiene before she entered the room. LPN 10 assisted the resident with sitting up in bed and moved his bed side table closer to him. The bedside table was observed with an unidentified spilled liquid that covered one-third of the table surfaced, several cups, tissues, pieces of paper, and dried stained substances on the bedside table surface and table base. LPN 10 removed several items from the bedside table and placed them into a trash can in the resident's room. LPN 10 pulled gloves out of her shirt pocket, put on gloves, and checked the resident's blood pressure by placing an automatic blood pressure cuff around the resident's wrist. She did not perform hand hygiene after moving and clearing the resident's bedside table and before she withdrew the gloves from her pocket and put them on to assess the resident. On 10/5/21 at 8:29 a.m., LPN 10 entered Resident Bb's room to administer his medications. She did not perform hand hygiene before she entered the room. She put on gloves and checked the resident's blood pressure. She did not perform hand hygiene before she put on gloves to assess the resident.			

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	On 10/5/21 at 8:34 a.m., LPN 10 returned to the medication cart in the hallway and prepared medications for Resident X. She placed a pair of gloves into a box that contained a bottle of eye drops for Resident X. At 8:42 a.m., LPN 10 entered the resident's room. She did not perform hand hygiene before she entered the resident's room. LPN 10 placed an automatic blood pressure cuff around the resident's wrist. After she checked his blood pressure, LPN 10 removed the box of eye drops from her shirt pocket and removed the gloves from the box. She put on the gloves and administered eyes drops into Resident X's eyes. She did not perform hand hygiene before she assessed the resident, put on gloves, and administered the eye drops. On 10/5/21 at 10:27 a.m., the resident isolation hall was observed. Signs were hung on the walls at the entry to the hallway that indicated the residents on that hallway were in transmission-based precautions (TBP). Certified Nursing Assistant (CNA) 26 was observed as she exited the isolation room of Residents K and Pp. She wore a N95 face mask and a face shield. The CNA was observed as she removed her used face shield and cleaned it with a disposable bleach wipe. During an interview at that time, CNA 26 indicated all the rooms in the hallway were in TBP. She knew the residents were in isolation, and what PPE to put on because of the signs in the hall. On 10/5/21 at 10:30 a.m., CNA 26 was observed as she went back into the isolation room of Residents K and Pp. She threw away the used bleach wipe into the trash can inside the residents' room and exited back out into the hallway. She did not perform hand hygiene or put on a gown or gloves before she entered the			

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	isolation room. On 10/5/21 at 10:36 a.m., during a continuous, uninterrupted observation, the Activities Director was observed as she delivered drinks and snacks into multiple residents' rooms. The Activities Director went into and exited from the rooms of Residents Mm, W, F, and Nn without performing hand hygiene. She used hand sanitizer for the first time when she exited Resident Nn's room. On 10/5/21 at 10:44 a.m., an unidentified CNA was observed going into a resident's room. She grabbed several gloves from a box of gloves that was placed on the hallway handrail. The CNA did not use perform hand hygiene before she entered the resident's room. A hand sanitizer dispenser was hung on the wall, on the same side as the handrail with the box of gloves, less than 2 feet from the resident's room entrance. On 10/5/21 at 11:40 a.m., CNA 26 was observed inside an isolation room from the hallway, through the residents' open room door as she assisted Residents V and Qq with their bedside tables, and repositioning. She wore an N95 mask and a face shield. CNA 26 did not have on gloves or a gown. During an interview on 10/5/21 at 11:42 a.m., CNA 26 indicated she was an agency CNA, and she was not sure what she was supposed to do in the rooms (related to PPE). She knew all the residents on A wing were on isolation, but she was not sure what that meant. She did not know if she should have on PPE just for close care or what. She acknowledged the TBP and PPE signs in the hallway that she had discussed earlier that same day, but indicated she still was not sure			

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what to do.

During an interview on 10/5/21 at 11:55 a.m., the Director of Nursing Services (DNS) indicated the signs are hung on the isolation unit and told the staff what PPE was needed in the isolation area. CNA 26 had worked the isolation unit before and should have known to wear PPE in the isolation rooms.

On 10/5/21 at 12:18 p.m., an unidentified dietary aide was observed on the secured unit as he delivered a meal cart to the residents. The dietary aide wore a faced shield which had been tilted up, and a surgical mask that had been pulled down to below his chin. The dietary aide was observed as he walked through the halls, with his mouth and nose exposed, and past greater than 6 residents who were walking around the unit.

On 10/5/21 at 12:21 p.m., RN 18 was observed as she entered Resident Ff's room to check his blood sugar and administer insulin. RN 18 put on gloves, and used a lancet (a small, sharp objects that are used to prick the skin) to draw blood from the resident's finger. She did not perform hand hygiene as she entered the resident's room or before she put on gloves to draw the resident's blood. After she tested the resident's blood sugar, she removed the testing strip with blood on it, with her gloves still on. She then removed the gloves and turned them inside out so that the bloody testing strip was encased inside the rolled-up gloves. She used her bare hands to pick the lancet up off the resident's bedside table, and carried it out into the hallway, where she disposed of it into a sharps container (a hard plastic container that is used to safely dispose of hypodermic needles and other sharp medical instruments).

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On 10/5/21 at 12:35 p.m., RN 18 entered Resident Gg's room. RN 18 put on gloves and used a lancet to draw blood from the resident's finger. She did not perform hand hygiene as she entered the resident's room or before she put on gloves to draw the resident's blood.

During an interview on 10/5/21 at 12:52 p.m., the Director of Nursing Services Specialist (DNSS) indicated, the facility followed state health department and CDC guidelines for infection control and COVID-19.

On 10/5/21 at 2:49 p.m., unidentified therapy staff was observed in the therapy gym, working with a resident. The therapy staff member was seated, less than two feet from the resident. The staff member's mask was pulled to below her chin. The resident was observed drinking liquid from cup, with her face mask pulled down to below her chin.

On 10/6/21 at 11:08 a.m., Dietary Aides 29 and 31 were observed in the facility kitchen as they prepared beverages in large drink pitchers and walked through the kitchen while food for the residents was being prepared. Both Dietary Aides 29 and 31 had face masks pulled to below their chins while they worked in the kitchen. During an interview at that time, the Kitchen and Housekeeping Manager indicated, kitchen staff should have on masks, worn above their mouth and nose, while they were in the facility. At that time, the manager instructed Dietary Aides 29 and 31 to place their face masks over their mouths and noses.

During an interview on 10/6/21 at 1:08 p.m., Wellness Director 4 indicated all staff in the

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	facility should wear a face mask over their mouth and nose the entire time they were in the facility. At that time, because of the elevated county COVID-19 positivity rate, all staff should also wear a face shield while they were in the facility. For isolation rooms, all staff should put on PPE before entering the isolation room. Staff should put PPE on even if they were just walking into the resident's room for a moment. On 10/6/21 at 1:13 p.m., Dietary Aide 31 was observed as she walked through the facility lobby, past 2 residents and 3 staff. She wore a face shield that had been tilted up and did not cover her face. Her face mask was pulled to below her chin. During an interview on 10/6/21 at 3:54 p.m., Wellness Director 32 indicated residents in isolation on TBP had vital signs, to include assessment of temperature, heart rate (the number of heart beats in one minute), respirations (the number of breaths in and out in one minute), and blood pressure; as well as COVID-19 signs and symptoms, checked once per shift. She did not have documentation of the vital signs or COVID-19 symptom assessments for the residents in isolation (Residents K, V, Pp, and Qq). The nurses kept their documentation on paper logs. The nurses did not keep the documentation in a centralized location so that it could be viewed by other nursing staff. The oncoming nurse would know the previous shift's assessment findings if it was discussed in shift change report. Wellness Director 32 indicated she would check with the nurses who took care of the residents in isolation on TBP and obtain copies of their documentation. During an interview on 10/7/21 at 9:12 a.m., the			

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	DNSS indicated the residents on isolation should have their vital signs checked and be assessed for COVID-19 symptoms once a shift. The DNSS indicated she and Wellness Director 32 were not able to locate the vital signs and COVID-19 symptom monitoring since admission for Residents K, V, Pp, and Qq who were in isolation on TBP. The DNSS indicated resident assessment documentation should be in a centralized location, and readily available for nursing staff to reference to care for the residents. On 10/5/21 at 3:33 p.m., the Chief Operating Officer (COO) provided an undated policy titled, "Shared Glucometer Cleaning Protocol." He indicated this was the current policy in use by the facility at that time. The policy indicated, "Throughout the procedure, perform appropriate hand hygiene. 1. Wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or bodily fluids. 2. Perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for other persons." On 10/6/21 at 10:34 a.m., the Chief Operating Officer (COO) provided a policy titled, "Pandemic COVID-19 Emergency Preparedness Plan", dated 2/23/21. He indicated this was the current policy in use by the facility at that time. The policy indicated, "This facility shall screen ...each resident (at least daily) ...for signs of COVID-19 ...All LTC [long term care] facilities should require those in direct patient care to wear a mask during their entire shift ...The facility has a process to identify/ screen and manage residents with symptoms of respiratory infection (e.g. cough, fever, sore throat) upon			

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	admission and daily during their stay in the facility, which includes implementation of appropriate Transmission-Based Precautions, when indicated." On 10/6/21 at 10:34 a.m., the COO provided a policy titled, "Handwashing/ Hand Hygiene", dated 10/2014. He indicated this was the current policy in use by the facility at that time. The policy indicated, " ...Hand hygiene is the single most important measure for preventing the spread of infection ...Situations that require hand hygiene include, but are not limited to: Before and after direct resident contact, before and after performing any invasive procedure (e.g., fingerstick blood sampling), before and after assisting a resident with meals, upon coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident), after removing gloves or aprons ...." On 10/6/21 at 10:34 a.m., the COO provided an undated policy titled, "Probari Assessment-Based Log". He indicated this was the current policy in use by the facility at that time. The policy indicated, "Upon the start of each shift, all residents must be screened by nursing for the following symptoms using the Probari assessment-based log: Cough, shortness of breath, malaise, fatigue, sore throat, nausea, vomiting, diarrhea, and muscle aches or pains. In addition, all residents must have temperature, respiratory rate, and oxygen saturation documented on the log." On 10/6/21 at 1:06 p.m., Wellness Director 4 provided undated signs for Yellow Zone, Contact Precautions, and Droplet Precautions. She indicated these were the protocols in use by the facility at that time. The "Yellow Zone" sign			

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	indicated, "Transmission based precautions- Contact Droplet- PPE Required: N95 Mask/ Approved KN95; Universal Eyewear: Face shield or goggles; Single gown- with each encounter gowns must be single use per resident ...Gloves (hand hygiene donning/ doffing)". The "Contact Precautions" sign indicated, "Contact Precautions everyone must: Clean their hands, including before entering and when leaving the room; Providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit." The "Droplet Precautions" sign indicated, "Droplet Precautions everyone must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose, and mouth are fully covered before room entry." CDC guidance, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes", dated 9/10/21, indicated, "...Evaluate Residents at least Daily: Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection. Actively monitor all residents upon admission and at least daily for fever (temperature 100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry ... Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further			

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	evaluation for SARS-CoV-2 infection ... Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection: HCP caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator) ... Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection...."B2. On 10/4/21 at 10:10 a.m., the Housekeeping Supervisor was observed coming from the C hallway, walking past the reception desk, then continuing down the A hallway (yellow zone). The Business Office Manager (BOM) confirmed the Housekeeping Supervisor was wearing a black cloth mask with rhinestones on the resident hallways versus an approved surgical or N95 mask. A yellow stop sign posted at the entrance of the A hallway indicated, "Yellow Zone. Transmission Based Precautions. Contact Droplet. PPE required: N95 mask, approved KN95. Universal eyewear, face shield or goggles..." On 10/4/21 at 10:12 a.m., observation of Therapist 8 in Resident QQ's room on the A hallway, standing leaning over the foot of the bed towards the resident who was lying propped in bed, the therapist was not wearing a face shield. An isolation tote was observed outside the resident's doorway containing PPE. A sign on the resident's doorway indicated, "Stop droplet precautions. Everyone must: clean their hands, including before entering and when leaving room. Make sure eyes, nose and mouth are fully			

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	covered before room entry. Remove face protection before room exit." The DNS confirmed the employee was a therapist and the resident was in a transmission based precaution room. On 10/4/21 at 10:15 a.m. the management team was observed to have left the conference room on the yellow zone when morning meeting dispersed and return to the conference room for an entrance conference. All management observed on the yellow zone wearing surgical masks, and no face shields or goggles. On 10/4/21 at 10:32 a.m., observation of Resident K being pushed back to his room on the A hallway from the front of the facility by the Activity Assistant who was wearing a surgical mask and no eye protection. On 10/4/21 at 10:53 a.m., Resident UU was observed wheeling himself in a wheelchair back to his room from outside smoking. As the resident passed the nurse's station and staff, the resident's surgical mask was under his chin, he was not observed being prompted by staff to put his surgical mask back over his nose and mouth. On 10/4/21 at 12:12 p.m., Resident L was observed lying in bed with an oxygen mask under his chin. Hospice Nurse 34 indicated the resident had dementia and did not like to keep oxygen on per nasal cannula. Hospice Nurse 34 was observed to stand over Resident L as she performed a respiratory assessment to include listening to his lungs with a stethoscope, her face within inches of his. Hospice Nurse 34 was observed to be wearing a surgical mask and no eye protection. An isolation tote with PPE was observed outside the doorway.			

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On 10/4/21 at 12:42 p.m., Speech Therapist 12 was observed with a surgical mask and no eye covering, delivering a lunch tray to Resident S. She was observed to lean within inches of the resident as she assisted him with repositioning in bed and rearranging his bedding. Speech Therapist 12 then entered Resident VV's room, patted the resident on the shoulder, and sat down within 2 feet of the resident. She was observed to lean within inches of the resident's face as she spoke, and remained as she conversed with the resident until 12:54 p.m.

On 10/4/21 at 2:51 p.m., the Activity Assistant was observed wearing a surgical mask and no eye protection as he pushed Resident K in a wheelchair back to his room on the yellow zone. The Activity Assistant indicated, he had come and got the resident and then brought him back from a cigarette break. Resident K was the only resident residing on the yellow zone at this time that smoked, so he was taken out back where the staff smoked to be away from other residents.

On 10/4/21 at 2:58 p.m., the Housekeeping Supervisor was observed taking a trash bag out of Resident H's room, she was wearing a black cloth mask, and her mask was over her mouth but not covering her nose.

On 10/4/21 at 3:05 p.m., the Housekeeping Supervisor was observed going in and out of Resident H's room 3 times speaking with the resident as she kept calling her back into the room. The Housekeeping Supervisor's cloth mask remained over her mouth but not her nose.

On 10/4/21 at 3:08 p.m., the Housekeeping Supervisor was observed running the sweeper in

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	Resident H's room, her cloth face mask was over her mouth, but under her nose. The Housekeeping Supervisor acknowledged he was wearing a cloth mask. On 10/4/21 at 3:38 p.m., Resident Y was observed sitting on the side of his bed receiving an aerosol nebulizer treatment. The door to the room was open, there was no nurse or staff observed in the area, and there was no sign on the door to indicated respiratory precautions. Residents were observed to be wheeling by Resident Y's door to access the outside door near his room. On 10/4/21 at 3:53 p.m., Resident B requested to be repositioned in bed. CNA 14 was observed to enter the room with his face shield pushed back onto his forehead providing partial coverage of his face and wearing a surgical mask over his mouth but under his nose. On 10/5/21 at 10:23 a.m., observation of the main therapy gym with the ED. Therapist 17 was observed providing therapy services to Residents CC and DD who were wearing surgical masks under their chins. Therapist 17 was observed wearing a face shield and surgical mask under her chin as she worked back and forth within 1 foot of the residents' faces. On 10/6/21 at 10:45 a.m., Resident Y was observed sitting on side of his bed, oxygen per nasal cannula from a concentrator on the floor. RN 18 indicated she had given the resident his breathing treatment earlier that morning. RN 18 indicated, there was no signage to put on the door to indicate respiratory or aerosol precautions, and the curtain was not pulled or door to the hallway closed during treatments due to the			

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	resident would get anxious. If the roommate did not want to leave the room during breathing treatments, the curtain would be pulled. On 10/6/21 at 10:59 a.m., QMA 23 indicated only nurses were allowed to administer resident nebulizer treatments, but she knew signs regarding aerosol precautions were to be posted during the treatments. On 10/6/21 at 12:09 p.m., a resident food tray was observed sitting outside room A21 (yellow zone) on top of an isolation tote. At 12:16 p.m., CNA 26 was observed to retrieve the food tray with styrofoam containers and remainder of food, carry it down A hallway then B hallway (a green zone hallway), and place on the meal tray delivery cart among other resident trays. On 1 0/5/21 at 10:44 a.m., the Wellness Director indicated, the D hallway was a green zone. But staff wore PPE to always include a surgical mask and face shield as they were close with residents in their rooms and in the hallways where residents were known to wander frequently. The A hallway was the yellow zone at this time, and staff were required to wear a N95 mask, face shield, gowns, and gloves for resident care. CDC Guidance, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", dated 9/10/21, indicated, " ...the safest practice is for everyone in a healthcare setting to wear source control ... Source control options for HCP [health care personnel] include: A NIOSH-approved N95 or equivalent or higher-level respirator OR A respirator approved under standards used in other			

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	countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR A well-fitting facemask ... Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel) ... Cloth mask: Textile (cloth) covers that are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by healthcare personnel." CDC Guidance, "Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages" dated 12/29/20, indicated, "In healthcare settings, facemasks are used by HCP as 1) PPE to protect their nose and mouth from exposure to splashes, sprays, splatter, and respiratory secretions (e.g., for			

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patients on Droplet Precautions) and 2) source control to cover their mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing."

CDC Guidance, "Hand Hygiene in Healthcare Settings", dated 1/8/21, indicated, "When and How to Perform Hand Hygiene: Use an Alcohol-Based Hand Sanitizer: Immediately before touching a patient, After touching a patient or the patient's immediate environment, After contact with blood, body fluids or contaminated surfaces, Immediately after glove removal. Wash with Soap and Water: When hands are visibly soiled, After caring for a person with known or suspected infectious diarrhea. When and How to Wear Gloves: Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs."

This Federal tag relates to Complaint IN00364184.

3.1-18(a)

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F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			
	Based on observation and interview, the facility failed to maintain safe and sanitary resident rooms on 4 of 4 hallways observed for cleanliness. Findings include: On 10/4/21 at 10:00 a.m., upon entry to the facility, a small black flying insect was observed crawling on the COVID-19 screening table and flying around the table. On 10/4/21 at 10:38 a.m., during the initial facility tour, the following was observed: a. Room A19 observed with a bag of trash on the floor in front of the television stand, a soiled brief on the floor nearest the window bed, and inflatable booties on the floor between the beds. An isolation tote was observed outside the doorway. b. Room A22, the bed nearest the doorway observed to have strips of blue plastic from a disposable under pad on the floor near the doorway. At 2:46 p.m., a second observation of the room, additional pieces of the blue plastic were observed between the bed and doorway. c. Room A21, the bed nearest the window was unmade and bedding wadded up. Dirty clothing, a tissue box, white paper, and a soiled mask were under the bed. Popcorn debris was on the floor between the beds. d. The carpeted floors throughout the A hallway were littered with paper, plastic debris, and straw	F 0921	F921 SS=E **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The residents affected will have their rooms deep cleaned immediately. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected. A facility wide deep cleaning schedule will be implemented **What Measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The entire housekeeping staff will be educated on proper	11/05/2021

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	papers. e. Room B22, the carpeted floor on the window side of room was heavily soiled with food debris. f. Resident H's room, food and paper debris around and under the bed, and a cloth mask near the bed on the floor. There was a white box on floor near the bathroom door Resident H indicated was a mouse trap, and 2 white boxes on an over the bed table on the empty side of the room, one of them dated 6/10/21, the resident indicated were to trap fruit flies. Resident H indicated there was no daily housekeeping in her room or hallway as there was only 1 housekeeper and another had just been hired. One housekeeper could not sufficiently clean the rooms as she had only time to hit and miss the middle of the floor occasionally and cleaned one wing daily. Resident H pointed out what she described as a fruit fly buzzing around her room. She had been in the room since 2013 and never had flies and mice like now. A prior maintenance man had been working on the infestations, but he no longer worked in the facility. There was a lady who occasionally came in and would run a sweeper in the middle of the floor, but she did not dust, wipe anything down, deep clean or move things and run the sweeper. Resident H indicated she liked to have her over the bed table wiped down, but it did not happen. g. Room B14, the carpeted floor on the door side of the room was littered with paper debris, a used straw, soiled blue glove, plastic cup under the bed, and the over the bed table was sticky. The bed nearest the window was observed to have soiled bed linens, wet towels, and soiled washrags on the floor at the end of the bed. On 10/4/21 at 12:09 p.m., room B16 was observed with a soiled glove on the floor near the doorway, and an alcohol prep paper under the		cleaning process, schedules, and cleaning products The executive Director will review the deep cleaning schedule to ensure all rooms and offices are included Housekeeping Supervisor will reestablish staff schedule to reflect off hour and weekend staffing. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director/designee will complete at least 3 random room audits (Mon- Fri) for four (4) weeks; then three times (3x) a week for the following four (4) weeks; two-time (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved **By what date the systemic changes by completed:** November 5, 2021	

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	bed. The outside of the trashcan was heavily soiled with an unidentified white substance spilled and dried down the front and sides. On 10/4/21 at 12:10 p.m., room B17 was observed with straw papers and pages of white paper littering the carpeted floor. On 10/4/21 at 12:11 p.m., room B20 the over the bed table nearest the door was observed to be littered with dark food debris, and a large piece of plastic beside the bed. On 10/4/21 12:19 p.m., room B13 was observed with 3 bottles of cleaner under the bedside stand, and a used plastic spoon on the floor. On 10/4/21 at 12:23 p.m., there was no housekeeper observed on A hallway or the short end of the B hallways during the surveyor process. On 10/4/21 at 12:30 p.m., the Housekeeping Supervisor was observed running a sweeper on the front hallway of B wing. She was not observed to clean or sweep in any resident room. On 10/4/21 at 2:41 p.m., gnats were observed in the hallway near the B hallway medication cart. On 10/4/21 at 2:55 p.m., gnats were observed in hallway near the conference room door on A hallway. On 10/4/21 at 2:56 p.m., gnats were observed in the hallway near room B22. On 10/4/21 at 2:58 p.m., the Housekeeping Supervisor was observed taking a trash bag out of room B11. She indicated she had taken the			

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	housekeeping supervisor position 2 weeks before, had no other housekeeping staff, had not been able to hire more housekeeping staff at this time, and was doing the best she could to clean. On 10/4/21 at 3:20 p.m., Room D9 was observed with an unbagged nebulizer mask on top of a refrigerator among her personal items. The room was observed to have a large area of the floor with flood smashed into the carpet. On 10/4/21 at 3:21 p.m., gnats were observed flying over the D wing medication cart near the entrance door to the unit. On 10/4/21 at 3:23 p.m., in room D11 there was a medication bottle on a bedside stand behind the bed near the window, labeled as H2O2 (hydrogen peroxide). An over the bed table for the resident nearest the window was stacked with dirty items to include, but were not limited to, 6 soiled bowls, 5 styrofoam cups, 5 cartons of milk, 10 cups of juice, 2 styrofoam containers with food, a bottle of hot sauce, 4 single use containers of butter, multiple condiment packets, and 5 packets of lubricating jelly. The 2 bowls on top contained remainder of unidentified dark smelly liquid. The top of the resident refrigerator was observed to be stacked with 3 opened cereal boxes, a bottle of steak sauce, a bowl full of butter and condiment packets, a gallon baggie of condiments, 5 bowls with unidentified food and liquid, and a jar of food seasoning. On 10/6/21 at 10:12 a.m., the Administrator in Training (AIT) indicated she was unaware of the hoarding situation. On 10/4/21 at 3:33 p.m., the vending machine lounge at the end of D hallway was observed to have 2 opened soda cans on the floor near a			

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chair, and an opened potato chip bag on a table.

On 10/4/21 at 3:35 p.m., room D24 carpeted floor beside the bed nearest the doorway was heavily soiled with an unidentified black substance in an area approximately 4 feet by 6 feet.

Small black flying insects were observed throughout the D hallways.

On 10/4/21 at 3:42 p.m., the resident lounge nearest room C16 was observed to be littered with food debris on the floor. An unoccupied table was observed to have an unwrapped straw, napkin and styrofoam cup with a straw.

Maintenance Requisition Logs, dated 9/1/21 and 10/2/21, indicated no documentation regarding rodents or bugs.

There was observation of gnats throughout the survey on all hallways.

On 10/6/21 at 10:02 a.m., the Maintenance Supervisor indicated he had been working in this facility for the past 3 weeks. He had not heard of any current concerns with pest. There was a schedule for the pest control company to visit at least monthly. Any concerns for gnats or rodents should be given to him in writing on a work order so he could follow up.

On 10/6/21 at 10:08 a.m., the AIT indicated she had personally been following up with residents, and there were no recent reports of mice, except for Resident H. The pest control company continued to treat for gnats, and staff were monitoring resident rooms for excess uncovered food, and they were giving out plastic bowls.

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	Managers went around and wiped down bedside table, removed used bowls, and offered resident lids. Managers rounded every am to look at rooms to identify problems. A Housekeeping Schedule, dated 9/26/21 - 10/4/21, indicated documentation of 5 employee names assigned on random days for housekeeping duties. The Executive Director (ED) indicated the schedule did not reflect staff who had called off, been pulled to other departments, or terminated from the schedule. On 10/5/21 at 2:17 p.m., the Executive Director provided a Resident Rooms with High Touch Areas Cleaning Policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...To provide consistent surface cleaning and disinfecting of high touch areas in resident rooms to reduce risk of healthcare acquired infections [HAI's]..." This Federal tag relates to Complaint IN00363081. 3.1-19(f)(5)			