STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAMPLIGHT INN OF FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00333181, IN00333322, IN00333522, IN00333693, IN00333760, IN00334408, IN00334452, IN00334959, and IN00336420. This visit included a COVID -19 focused Infection COntrol Walk Through. Complaint IN00333181 - Substantiated. No findings related to the allegations are cited. Complaint IN00333322 - Substantiated. State Residential Finding related to the allegations is cited at R0240. Complaint IN00333522- Substantiated. No findings related to the allegations are cited. Complaint IN00333693 - Substantiated. No findings related to the allegations are cited. Complaint IN00333760 - Substantiated. State Residential Finding related to the allegations is cited at R0406. Complaint IN00334408 - Substantiated. State Residential Findings related to the allegations is cited at R0406. Complaint IN00334452 - Substantiated. No findings related to the allegations are cited. Complaint IN00334959 - Substantiated. State Residential Findings related to the allegations is cited at R0241. Complaint IN00336420 - Substantiated. State Residential Findings related to the allegations is cited at R0050	R 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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Unrelated deficiencies are cited at R0349 and R0356. Survey dates: September 3, 4, 8, and 9, 2020 Facility number: 012288 Residential Census: 118 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 15, 2020			
R 0050 Bldg. 00	410 IAC 16.2-5-1.2(t)(1-10) Residents' Rights - Noncompliance (t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs. Management does not include the safekeeping of personal items. If the facility agrees to manage the resident ' s funds, the facility must: (1) provide the resident with a quarterly accounting of all financial affairs handled by the facility; (2) provide the resident, upon the resident ' s request, with reasonable access, during normal business hours, to the written records of all financial transactions involving the individual resident ' s funds; (3) provide for a separation of resident and facility funds; (4) return to the resident, upon written request and within no later than fifteen (15) calendar days, all or any part of the resident ' s funds given the facility for safekeeping;			

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	(5) deposit, unless otherwise required by federal law, any resident ' s personal funds in excess of one hundred dollars ($100) in an interest-bearing account (or accounts) that is separate from any of the facility ' s operating accounts and that credits all interest earned on the resident ' s funds to his or her account (in pooled accounts, there must be a separate accounting for each resident ' s share); (6) maintain resident ' s personal funds that do not exceed one hundred dollars ($100) in a noninterest-bearing account, interestbearing account, or petty cash fund; (7) establish and maintain a system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident ' s personal funds entrusted to the facility on the resident ' s behalf; (8) provide the resident or the resident ' s legal representative with reasonable access during normal business hours to the funds in the resident ' s account; (9) provide the resident or the resident ' s legal representative upon request with reasonable access during normal business hours to the written records of all financial transactions involving the individual resident ' s funds; (10) provide to the resident or his or her legal representative a quarterly statement of the individual financial record and provide to the resident or his or her legal representative a statement of the individual financial record upon the request of the resident or the resident ' s legal representative; and (11) convey, within thirty (30) days of the death of a resident who has personal funds deposited with the facility, the resident ' s funds and a			

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	final accounting of those funds to the individual or probate jurisdiction administering the resident ' s estate. Based on observation, interview, and record review, the facility failed to ensure 45 of 118 residents had access to their personal funds account managed by the facility. (Resident G) Findings include: Upon entrance to the facility on 9-3-2020 at 9:05 a.m., a sign was observed to be posted on the plexiglass at the front desk. It indicated the bank was closed until 9-8-2020. An interview with Receptionist 1 on 9-3-2020 at 1:15 p.m., indicated the bank was closed. He was unsure why. The receptionist indicated there was not a current Business Office Manager and the ED (Executive Director) was out of the building. An interview with the DON (Director of Nursing) on 9-3-2020 at 2:20 p.m., indicated the residents' funds would not be accessible until 9-8-2020. The DON indicated the President and Vice President of the company let her know while the ED was on vacation, the bank would be closed from 9-1-2020 through 9-8-2020. An interview with the DON on 9-3-2020 at 2:53 p.m., indicated the residents usually did get their checks deposited between the 1st and the 3rd of the month. She indicated she was notified by the ED that she would be in on 9-5-2020 to distribute the resident funds, or on 9-6-2020 at the latest. The DON indicated the residents have not had access to their money since 9-1-2020. On 9-4-2020 at 9:05 a.m., Resident G indicated he	R 0050	- The facility ensured the deficiency was corrected by establishing set banking hours and notifying the residents in written of the availability banking hours as well as posted them at the front desk. The set banking hours outline accessibility during business hours and on multiple days. Resident funds are managed through National Data Care where money is credited to each resident account and debited electronically. Residentshave access to their statement upon request and quarterly, as per the Resident Rights and the stateregulation. Statements were printed on 10/2/2020 and give to all residents and will be given December 1,2020and quarterly thereafter. Executive director will audit in monthly in quality assurance checks monthly for the next 6 months. We are striving for 100 percent compliance and resident satisfaction. Current and ongoing.	09/09/2020

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	was not able to access his money because the bank was closed. A copy of the list of residents who had personal funds accounts with the facility was provided by Receptionist 4 on 9-4-2020 at 9:12 a.m. An interview with the DON on 9-4-2020 at 9:20 a.m., indicated she was not able to verify the accuracy of the list of residents who had a personal fund account at the facility. The DON indicated the previous Business Office Manager did not provide statements or invoices on the residents' accounts. She indicated some residents manage their own bank accounts and they can go to the ATM (Automated Teller Machine) to get money. She indicated she could not accurately tell how many residents had a personal fund account with the facility. A phone interview with the ED on 9-4-2020 at 11:28 a.m., indicated she had only been in facility for a month. She indicated the resident trust fund was not in order, but she could access the trust fund and the DON had a key to get money for a resident if they would need/ request money from their account. She indicated the facility was getting a scanner to speed up the process of getting the residents' checks deposited to their accounts. She indicated she did not know who put up the sign at the receptionist desk about the bank being closed until 9-8-2020, but she was coming in on Sunday (9-6-2020) to take care of the resident fund accounts. She indicated most residents can't get their money until the 5th of the month anyway, but did not explain why. A confiodential interview with 4 residents on 9-8-2020 at 8:55 a.m., indicated they did not have a personal fund account with the facility, but they			

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	did know the ED was at the facility on 9-6-2020 for the residents to access their money. A confidential interview during the survey indicated the ED had made the staff aware that the bank was going to be closed. The confidential interview further indicated the ED had placed the sign at the front desk that the bank was going to be closed until 9-8-2020. The staff were instructed to make excuses about the funds not being available. On 9-8-2020 at 9:48 p.m., the ED provided an updated list of residents who had personal funds account with the facility. She indicated the residents named on the list with a zero balance really did not have a personal fund account. There were 20 residents listed with zero balances and that left 45 residents who had a personal fund account with the facility. On 9-4-2020 at 9:20 a.m., the DON provided a current, undated copy of the "Rights of Residents in Assisted Living Residences." The rights printed were with abbreviated categories for each area. For the resident fund access, the rights indicated every resident shall have the right to manage his or her own financial affairs. There was no further information in the rights regarding access of funds or provision of statements. This State Residential Finding relates to Complaint IN00336420.			
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview, and record review, the facility	R 0240	Resident's level of care will be	09/25/2020

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	failed to ensure the safety of a resident during Activities of Daily Living, for 1 of 4 resident's reviewed for falls. (Resident C) Findings include: A review of Resident C's record on 9/9/2020 at 12:30 p.m., indicated they were cognitively intact. The information was obtained from a BIMS Assessment dated 6/19/2020. Diagnoses included, but were not limited to: seizures, anxiety, and depression, amd osteporosis (weak, brittle bones). During an interview on 9/9/2020 at 1:10 p.m., Resident C indicated on 7/20/2020, a Monday night, he was lying on the floor in his room, and 2 CNA's (Certified Nurse Aide) came into the room, they picked him up, and dropped him. He indicated they were pulling him up by his hands, and then let go, causing him to land on his left side. He indicated he asked them, "why do you want me off the floor?" Resident C indicated he did not need help to get up, he was able to do that on his own. The resident indicated he was having pain over the next few days and requested to have xrays. A resident of the facility, who wished to remain anonymous, was in the room at the time of the incident on 7/20/2020 and witnessed the CNA's drop Resident C. The anonymous resident indicated the 2 CNA's were with agency staffing and no longer come to the facility. A Progress Note, dated 7/23/2020 at 2:17 p.m., indicated the resident had returned from the hospital with a left side rib fracture, and new prescriptions for pain medication.		updated with their current needs, on 9/25/2020 as their needs change, and every 6 months. Care task sheets will be developed for the nursing staff based on the individual resident needs as per the level of care assessments. Staff in-serviced on reportable events by 10/1/2020. Director of nursing will audit residents care plans for accuracy monthly with the quality assurance checklist for a duration of 6 months. We are striving for 100 percent compliance. Current and ongoing..	

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	A Nurse Practitioner Note, dated 7/24/2020 at 5:56 p.m., indicated Resident C was seen for a routine follow up and had reproted he had broken ribs after being dropped by a CNA. A review of a Level of Service Determination, dated 7/14/2020, indicated Resident C was able to transfer and change positions consistently, but needed direct assistance less than 3 times in a 7 day period. The assessment indicated the resident needed cueing for safety. The assessment further indicated Resident C could get around inside the facility without assistance, but needed assistance from another person when going outside the facility. A review of a Level of Service Assessment, dated 8/18/2020, indicated Resident C was totally independent for mobility, and was able to transfer himself without assistance from anyone. A review of the Emergency Department Discharge Instructions (Patient), from a local hospital, dated 7/23/2020 at 11:59 a.m., indicated the following diagnosis: Fracture of rib of left side; Rib pain on left side. There were no Progress Note documented regarding the incident on 7/20/2020. A current facility policy, Fall Risk Evaluation, undated, was provided on 9/9/2020 at 1:18 p.m., by the ED (Executive Director) 2, but indicated no guidance regarding documenting incidents. During an interview on 9/9/2020 at 1:20 p.m., the ED indicated there was no state reportable documented of the incident. This State Residential Finding relates to			

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	Complaint IN00333322.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure Physician Orders were obtained and followed for resulting in a major injury for 1 of 3 resident's reviewed. (Resident B) Findings include: On 9/3/2020 at 3:10 p.m., Resident B was observed in her room, sitting in her wheelchair. Her left hand was wrapped with a bandage. On 9/3/2020 at 4:09 p.m., Resident B was observed in her room, sitting in her wheelchair, her left hand was wrapped with a bandage, and she was talking to another resident (Resident F). Resident F was observed to be sitting in a wheelchair. A review of Resident B's record on 9/3/2020 at 3:33 p.m., indicated the resident was identified as alert, oriented, and interviewable by the facility staff. Diagnoses included, but were not limited to: kidney disease, diabetes, osteomyelitis, and depression. A review of Progress Notes indicated the following:	R 0241	Resident's care-plans have been or will be (9/25/20) updated, physician orders obtained and followed. Staff (or will be by 10-31-20) in-serviced on physician orders and AL scope of practice.	09/25/2020

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	On 6/16/2020 at 10:07 a.m., the NP documented Resident B was seen for follow up for cellulitis of the left ring finger, and indicated Resident B was having ongoing pain and swelling to the finger. The NP documented there was some eschar tissue (dead tissue). 6/16/2020 at 3:06 p.m., a new Physician Order was received for Keflex (antibiotic) 500 mg (milligram) administer 1 capsule by mouth before meals and at bedtime for cellulitis to the left ring finger. 6/18/2020 at 2:28 p.m., Resident B continued on the antibiotic for cellulitis of the left ring finger, some redness was noted, but no drainage. On 6/19/2020 at 2:30 p.m., Resident B continued on an antibiotic for cellulitis to the left 4th digit (finger). On 6/23/2020 at 10:03 a.m., the NP documented Resident B was seen for cellulitis and reported the finger was less swollen and less painful. On 6/24/2020 at 11:17 a.m., Resident B continued on an antibiotic for cellulitis to the left 4th digit, and no drainage was noted. On 7/13/2020 at 7:56 p.m., the rounding Physician had documented recurrent episodes of infection to the left ring finger, and Resident B would continue treatment and antibiotic therapy. Resident B indicated it was painful, and the Physician documented it could not be drained. On 7/14/2020 at 8:23 p.m., Resident B was upset that she had not received her antibiotic for her finger and complained of the finger being very painful.			

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	On 7/17/2020 at 6:43 a.m., a new Physician Order was documented for Keflex 500 mg, give one tab BID (twice daily) times 7 days for left ring finger abscess. On 7/21/2020 at 8:39 p.m., the NP described Resident B's left ring finger looked like "raw hamburger meat." On 8/11/2020 at 11:41 a.m., Resident B was seen by the NP for follow up with cellulitis to the left ring finger. On 8/11/2020 at 2:04 p.m., nursing had documented that wound care on the left ring finger had been completed. On 8/12/2020 at 6:06 a.m., nursing had documented that wound care had been completed to the left ring finger. On 8/13/2020 at 2:05 p.m., wound care was completed to the left ring finger. On 8/13/2020 at 8:24 p.m., a new Physician Order for Clindamycin (antibiotic) 300 mg was started for left ring finger infection. On 8/13/2020 at 8:25 p.m., the rounding Physician documented Resident B's left ring finger was necrotic (dead tissue), and referral was to be made to a Wound Care Physician. On 8/17/2020 at 11:15 a.m., wound care was completed, the wound was painted with betadine solution (antiseptic), wrapped with Kerlix gauze bandage and secured with Coban (sticks to self) wrap. On 8/18/2020 at 10:30 a.m., a new Physician Order			

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	was documented for Santayl (ointment) to the left ring finger, and an Xray was ordered of the finger due to worsening. On 8/18/2020 at 12:25 p.m., the NP indicated the left ring finger wound was getting worse, necrotic and slough(dead) tissue had increased. On 8/19/2020 at 11:25 a.m., the NP was notified of the xray results of the left ring finger that indicated osteomyelitis (bone infection). New orders were given to send Resident B to the hospital for an MRI and treatment. On 8/19/2020 at 10:29 p.m., Resident B was admitted to the hospital. On 8/24/2020 at 4:30 p.m., Resident B returned to the facility, left hand was dressed and bandaged. On 9/1/2020 at 8:52 a.m., the NP had documented Resident B talked about her surgery and was feeling angry over it. On 9/2/2020 at 7:54 a.m., Resident B was status post left ring finger amputation. Her entire hand remained wrapped until follow up with the surgeon. On 9/2/2020 at 3:33 p.m., the current DON documented Resident B was to have a follow up appointment for her finger amputation, but transportation had not shown up. The current DON and staff had attempted other transportation but was unsuccessful, and was waiting to reschedule the appointment. A review of the Radiology Report, dated 8/18/2020 indicated the following results: There is lucency and erosion at the 4th distal phalanx (finger) with			

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	mild soft tissue calcifications. Conclusion: Erosive changes to the 4th phalanx, suspect osteomyelitis. A review of the Patient Discharge Instructions from Resident B's hospital stay indicated Discharge Diagnoses included, but not limited to: necrotic ulceration of fingers, osteomyelitis of finger of left hand, and non-healing wound of left upper extremity. On 8/13/2020 the facility had reported the incident to the Indiana State Department of Health. During an interview on 9/3/2020 at 3:10 p.m., Resident B indicated the former DON had used a razor, 'that you shave your legs with" to cut a boil (pus filled bump under the skin) that was beneath the fingernail of her left ring finger. Resident B indicated she had told the DON to stop because it hurt. The DON continued to cut and told Resident B to "quit being a baby". Resident B indicated the second time the DON cut on her left ring finger, she used a box cutter. Resident B indicated she had told the DON to stop because it hurt, but the DON continued to cut. Resident B indicated she felt the former DON should lose her license, because she had lost her finger. Resident B indicated her left ring finger was amputated in August 2020. Resident B indicated the issues with her left hand ring finger began in May 2020, but she could not remember exact dates. During an interview on 9/3/2020 at 3:35 p.m., the current facility DON indicated there had never been a Physician Order written to lance or debride a wound on Resident B's left ring finger. During an interview on 9/3/2020 at 4:09 p.m., Resident F(identified as alert, oriented, and			

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	interviewable by facility staff) indicated he had witnessed the former DON cutting on Resident B's finger both times, but was unable to remember the exact dates. He indicated the former DON was doing this in the nurses station on the 2nd floor. The first time, Resident F indicated the former DON had used a razor, like what you shaved with. The second time, Resident F indicated the former DON used a box cutter. Resident F had indicated neither of these razors were sterile. The second time when the former DON had used the box cutter, she had indicated that one boil had "popped". Resident F indicated that when the former DON was cutting on Resident B's finger, Resident B was screaming that it hurt so bad and requested the DON to stop. Resident F indicated the former DON responded by telling Resident B "don't be a wuss". Resident F indicated that there was so much blood during that second time, that he thought the DON had cut off Resident B's finger. There was no documented Progress Notes in Resident B's record that the former DON had attempted cutting off the boil area. The facility provided no Policy for following Physician Orders. This State Residential Finding relates toComplaint IN00334959.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:			

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	(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on interview and record review, the facility failed to ensure resident records were accurate, complete and accessible for 118 of 118 residents who resided in the facility. Findings include: On 9-3-2020 at 2:15 p.m., three resident paper records were requested from Nurse 5. An interview with Nurse 5 and the DON (Director of Nursing) indicated there were no paper records for the residents. They indicated there were no contacts listed, advanced directives, Post forms, Power of Attorney papers, or guardian papers. Nurse 5 indicated the former DON and the former ED (Executive Director) were starting to scan records into the computer system and it was not completed prior to them leaving the facility. Nurse 5 indicated prior to the former ED leaving the facility, she and the DON did something with the actual physical charts which held the resident documents and the chart/binders have not been found. Nurse 5 indicated the papers inside the hard chart/binder were just gone. The DON indicated they were trying to re-build the records. Staff 6 was working on getting the Post forms completed. Nurse 5 indicated she was getting the resident assessments and the level of care plans completed for the residents. The DON indicated what was in the computer was all they had. A phone interview with the ED on 9-4-2020 at 11:28 a.m., indicated they were trying to update each resident's information. She indicated the residents' records were just gone.	R 0349	Establish complete medical charts for all residents meeting the state regulations. (ED, DON, ADON, 11/30/2020)	11/30/2020

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	An interview with the ED on 9-8-2020 at 9:00 a.m., indicated they had found parts of charts in the basement and in the medication room. She indicated nothing had been destroyed, but they would have to search for what they needed. An interview with the DON on 9-8-2020 at 9:21 a.m., indicated some of the resident's thinned records were in the file cabinets in the medication room as she proceeded to look through 4 file cabinets. She was unable to open one. She indicated they were also creating new records for each resident and they had started getting complete information for the face sheets for the Emergency Book. An interview with the ED on 9-8-2020 at 9:00 a.m., indicated the facility would follow the State Residential rules for maintaining resident records.			
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the			

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	resident). (8) Copy of advance directives, if available. Based on interview and record review, the facility failed to ensure the resident emergency binder was accurate, complete, and current which had the potential to affect 118 of 118 residents who resided in the facility. Findings include: The facility Emergency Binder with resident information was reviewed on 9-3-2020 at 3:00 p.m. The contents of the binder contained 147 resident face pages dated 7-29-2020 and the current census was 118. Each resident page was observed with a picture of the resident. The face page lacked Advanced Directive information for 70 residents and there was no contact information listed for 43 residents. None of the 147 residents had a hospital preference listed on the face page. There was a discrepancy of 29 more resident face pages than the 118 residents who were residing in the building. An interview with the DON (Director of Nursing) on 9-4-2020 at 9:41 a.m., indicated there was no one assigned to keep the Emergency Binder current. A phone interview with the ED (Executive Director) on 9-4-2020 at 11:28 a.m., indicated she was informed about the Emergency Binder with resident information lacking Advanced Directives, contact information and hospital preference. She indicated the Emergency Book had not been updated as they were trying to update each residents information. She indicated the residents' records were just gone. An interview with the DON on 9-8-2020 at 9:21	R 0356	Establish an emergency binder for all residents meeting the state regulations. Don will complete 10/1/2020)	10/01/2020

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	a.m., indicated they had started getting complete information for the face sheets for the Emergency Binder. An interview with the ED on 9-8-2020 at 9:00 a.m., indicated the facility followed the State Residential rules for keeping of resident records and the resident Emergency file.			
R 0406 Bldg. 00	410 IAC 16.2-5-12(a) Infection Control - Offense (a) The facility must establish and maintain an infection control practice designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed during the Covid-19 pandemic. This had the potential to affect 118 of 118 residents who resided in the facility. (Resident G, Resident H, Resident J and Resident K) Findings include: Upon arrival at the facility on 9-3-2020 at 9:05 a.m., a housekeeping staff was observed to walk through the lobby and out the front door with trash in her hands. Her mask was observed down to her chin and not covering her mouth or nose. The DON (Director of Nursing) was also observed at this time with her mask not covering her nose. Receptionist 1 was observed with the top of his mask down under his chin, his mouth and nose were not covered. An unidentified staff member walked up to the front desk without her mask donned at all and was instructed by Receptionist	R 0406	Staff were in-serviced on infection control related to COVID on September 18th, 2020, by DON and ED. Education will be provided by DON/ED by 10/1/2020 to the residents on COVID safety and community/state regulations. Resident symptom tracker created to monitor resident's daily. DON to check daily of any resident with change in symptoms. Residents displaying symptoms will go into isolation tracked in a log. Immediately and ongoing.	10/01/2020

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	1 that someone had been calling for assistance. The unmasked staff then proceeded to the elevator. Several residents were observed in a group by the elevators, some without masks and not socially distanced. A housekeeper was observed by her cart at the elevator. The top of her mask was below her nose. Screening by the facility included taking temperature and signing into the Visitor Log with the visitor's name, resident's name, company name, and time in and out. There were no other screening questions asked by the facility to assess the visitor's risk of Covid-19 virus. An observation in the second floor therapy room on 9-3-2020 at 10:55 a.m., indicated one staff member was working with one resident and neither of them had masks donned. Upon leaving the therapy room, a staff member was observed with her mask not covering her nose as she wheeled the resident on the second floor with other residents in the area within less than 6 feet. An observation outside the medication room on the second floor of the facility on 9-3-2020 at 10:56 a.m., indicated a staff member had her cloth mask donned and her nose was exposed. The staff member was speaking with a resident who had the top of his mask down under his chin exposing his mouth and nose. The resident and the staff were not observed to be socially distanced. The staff member was observed to enter the nurse medication room, then opened the door, and looked out. She was observed without a mask donned. An observation inside the medication room at this time indicated, another staff member inside the room without a mask covering her face. There were 2 additional residents observed outside the medication room on the 2nd floor, one with their face covering below their nose and the			

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	other resident had his face covering below his chin.Neither were encouraged or instructed to wear theri masks over their mouth and nose. An observation on 9-3-2020 at 10:57 a.m., indicated a staff member was walking in the lobby carrying a mask. There were residents present in the lobby. Some residents had masks donned not covering their nose and some residents were observed without masks. The staff member was observed to walk up the stairs without a mask covering her face. An observation on 9-3-2020 at 12:20 p.m., indicated an activity staff was observed in the lobby with her cloth face covering her mouth but with her nose exposed. An observation at the front desk on 9-3-2020 at 1:10 p.m., indicated several residents were at the front desk and not socially distanced. One resident in a motorized wheel chair was observed without a mask and one resident was observed without a mask. He was observed holding goggles with a face shield. An interview with Resident G on 9-4-2020 at 9:05 a.m., indicated the staff did not check his temperature or ask about signs and symptoms of the virus on a daily basis. An observation of a sign on the front desk on 9-4-2020 at 9:10 a.m., indicated the following: "Please be advised that all staff, residents and guests must be screened upon entering the building until further notice. The staff will be screened at the beginning of each shift, as well as each resident will be screened at the end of each shift which the times are 6a, 2p and 10p, so therefore all QMA's (Qualified Medication Aide)			

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	and CNA's (Certified Nurse Aide) will be responsible for checking each resident before your shift is over, which includes checking everyone's temperature." An interview with the DON on 9-4-2020 at 9:12 a.m., indicated all staff were screened at the beginning of their shift for temperature, and the questions were asked regarding traveling out of the country, cough, fever, shortness of breath and contact with anyone with Covid-19. She indicated the visitor form also had the screening questions. At this time, the DON was made aware screening for visitors included temperature and no other screening questions regarding Covid-19 were asked. The DON provided a blank copy of the visitor sign in form which did not ask for a temperature, or about signs and symptoms of the Covid - 19 virus. The DON was interviewed about resident assessment for signs and symptoms of the virus and she indicated there was not any screening of the residents for temperature and/or signs and symptoms. She indicated if a resident signed out on the sign out log, when they returned, the resident would be screened for temperature only. The DON indicated there were no residents or staff with Covid-19 virus in the facility at this time. She indicated the facility had not done or required any Covid-19 testing for any residents or staff. The DON indicated they had facemasks (surgical) available and it was the staff members preference whether they wore a cloth face covering or a facemask. During the interview, the DON was observed to pull her cloth face covering down exposing her nose and mouth and then she was observed to pull it back up again, more than once. An interview with the DON on 9-4-2020 at 11:03 a.m., indicated the facility did not provide			

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	Covid-19 education in their current orientation for new staff. She provided an inservice list nurses completed on 8-24-2020, which included the cleaning of medications carts with bleach spray and for staff to remind residents to wear their masks. During a phone interview with the ED on 9-4-2020 at 11:38 a.m., the ED indicated she had not provided education to the staff on Covid-19, as they should have been educated. She indicated Covid-19 was not her priority when she came to the facility, as there were other issues that needed fixed. Further interview with the ED, indicated she was asked if staff were educated about the proper way to don and wear a mask and she indicated there had not been any issues that she observed. The ED was made aware there were some staff observed with the top of their masks under the nose, pulled down to their chin, and some without masks while in the building. She indicated she can't 100% comment on staff on how to wear their masks, but they should be wearing their masks. The ED indicated staff should have masks donned while in the building including in the medication room and nursing office. The ED indicated she assumed the nursing staff were assessing residents for Covid-19 virus during medication pass. She indicated the facility had not tested any staff or residents. A random interview of four unidentified residents on 9-8-2020 at 8:55 a.m., indicated the facility did not take their temperature daily and did not assess them for signs and symptoms of the Covid-19 virus. One resident indicated the staff did not check anything. Upon entry to the facility on 9-8-2020 at 8:58 a.m., a staff member was observed with a mask on			

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	which did not cover her nose. There was a resident at the desk did not have a face covering. During an observation on the second floor outside the medication room on 9-8-2020 at 9:15 a.m., a QMA was observed to administer medication to a resident. The QMA's face mask did not cover her nose. An interview with the ED on 9-8-2020 at 9:52 a.m., indicated she had found 2 folders for education completed prior to her coming to the facility. There were 25 signed sheets for staff and 32 signed forms by residents acknowledging the education, but the ED indicated she did not have the education that went with these sign in sheets. Further interview with the ED, indicated she thought the staff were assessing residents for signs and symptoms of the Covid-19 virus and taking the resident's temperature during the medication pass, but she was not aware if the documentation for the Covid-19 screens was in the residents' records. She indicated since she came to the facility, the residents come and go as they please and her focus had not been on Covid-19 because they haven't had any cases in staff or residents. She indicated she has had 2 staff test negative for the virus, as they were tested because they had close contact with someone who tested positive for the virus. She indicated as a whole, no other staff or residents were symptomatic or had been tested for the virus. An interview with the ED on 9-8-2020 at 10:33 a.m., indicated she had a computer file of Covid-19 policies from Corporate, but she has not had the chance to implement any of it since she has been here. She indicated the previous management did not have the education for Covid-19 documented			

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	and no education documentation to reflect Covid-19 education had been completed. She indicated she planned on having an inservice with all staff and planned to include the Covid-19 education. An interview with QMA 7 on 9-8-2020 at 11:05 a.m., indicated residents were assessed with temperatures and signs and symptoms for the virus during medication pass. QMA 7 indicated the information was documented in the MAR (Medication Administration Record). An interview with Resident H on 9-8-2020 at 11:20 a.m., indicated staff did not check her temperature daily nor did they ask her about signs and symptoms of the Covid-19 virus. At this time, the resident was observed outside the main dining room waiting to enter for lunch. Her cloth mask was observed below her nose and mouth. Several other residents were also observed in the hall area outside dining room without social distancing. Three residents were observed sitting along the wall without masks and two residents were sitting next to each other with masks not socially distanced. On 9-8-2020 at 2:44 p.m., the MARs/TARs (Treatment Administration Record) for September 2020 were reviewed for the following residents: Resident H, J and K, all lacked documentation in the September MAR/TAR for daily temperatures and assessment of the signs and symptoms of Covid-19 and no current temperatures of the residents were listed in the vitals section of the computer system. An observation in the common area/lobby of the facility on 9-9-2020 at 2:04 p.m., indicated a staff member was walking through the lobby without			

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	her mask covering her nose. The staff member was observed to walk within 6 feet of a resident seated in a wheelchair and the resident did not have a face covering. The most current CDC (Center for Disease Control) guidance, "Considerations for Preventing Spread of Covid-19 in Assisted Living Facilities" updated May 29, 2020, indicated, "...To prevent spread of Covid-19 in their facilities, ALF's (Assisted Living Facilities) should take the following actions...Educate residents, family members and personnel about Covid-19...provide information about Covid-19 (including information about signs and symptoms) and strategies for managing stress and anxiety...Describe actions the facility is taking to protect residents and personnel...Describe actions resident and personnel can take to protect themselves in the facility, emphasizing the importance of social (physical) distancing, hand hygiene, respiratory hygiene and cough etiquette and source control...Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with Covid-19 before starting each shift/when they enter the building...personnel should wear a facemask (or cloth face covering if facemasks are not available or only source control required) at all times while in the facility...when available, facemasks are generally preferred over cloth face coverings for healthcare personnel as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others...remind residents to remain at least 6 feet apart from others when they are outside their room...designate one or more facility employees to ensure all residents have been asked at least daily about fever and			

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	symptoms consistent with Covid-19...." This State Residential Finding relates to Complaints IN00334408 and IN00333760.			