STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365046	A. BUILDING _____ B. WING _____	C 11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTEFIORE HOME THE	**ONE DAVID N MYERS PARKWAY BEACHWOOD, OH 44122**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT INVESTIGATION MASTER COMPLAINT NUMBER OH00117160 COMPLAINT NUMBER OH00116951 COMPLAINT NUMBER OH00116871 COMPLAINT NUMBER OH00116858 COMPLAINT NUMBER OH00116766 COVID 19 FOCUSED INFECTION CONTROL SURVEY ADMINISTRATOR: Lori Lozier, #4497 CERTIFIED BED CAPACITY: 233 CENSUS IN HOUSE: 183 The following deficiencies are based on the COVID 19 Focused Infection Control Survey and complaint investigation completed on 11/24/20. The facility also remains out of compliance from the survey dated 10/19/20.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		

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

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of the facility Abuse policy and procedure and interview the facility failed to ensure Resident #67 and Resident #70 were free from staff abuse. This affected two residents (#67 and #70) of two residents reviewed for abuse.

Findings include:

1. Review of Resident #67's medical record revealed an admission date of 06/05/20 and medical diagnoses including fractured left femur and left humerus, atrial fibrillation, and hemiplegia (paralysis)/hemiparesis (weakness) following cerebral infarction affecting left non-dominant side.

Review of the Minimum Data Set (MDS) 3.0 assessment, dated 09/18/20 revealed Resident #67 was cognitively intact and required one person physical assist for activity of daily living care.

On 11/12/20 at 2:21 P.M. and 11/19/20 at 2:44 P.M. Resident #67 was observed sitting in a wheelchair in her room. Interview with the resident during these times revealed concerns related to an incident of abuse. The resident reported on 10/28/20 at 5:00 A.M. a State Tested Nursing Assistant (STNA) she did not know entered her room to provide incontinence care. The STNA roughly rolled her onto her side pushing her fractured left arm and fractured left leg (surgery included plates and screws). The resident stated she cried out in pain. The resident stated the STNA asked her if she hurt her and she replied, "why do you think I cried out

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F 600	Continued From page 2	F 600		

in pain". Resident #67 stated the STNA came back an hour later to "change me". The resident reported, the STNA again roughly turned her onto her side pushing on her left arm and left "broken" leg. Resident #67 stated she cried out again and the STNA said "stop your yelling". Resident #67 stated she told the STNA to "get out" of her room and the STNA replied "no one wants to come in here anyway". Resident #67 further stated she was in the facility to get better, not to have someone abuse her. Resident #67 stated a couple days after the incident an X-ray was taken of her left fractured leg that had plates and screws in it and the X-ray was OK. Resident #67 stated she was "sore" after the incident and took pain pills, but did not have any bruises or marks on her.

On 11/17/20 at 4:30 P.M. interview with Administrator #410 revealed on 10/28/20 around 11:00 A.M., Unit Manager (UM) #305 reported Resident #67 made an allegation of abuse at 5:00 A.M. Resident #67 stated an STNA (identified to be STNA #606) entered her room to provide care, rolled her onto her side causing pain to her left arm and leg, Resident #67 cried out in pain, and was told to stop screaming. Administrator #410 stated UM #305 was told about the incident around 8:00-8:30 A.M., interviewed Resident #67 and did a skin assessment at 9:00 A.M. Administrator #410 further revealed a full investigation was not done immediately because the facility had five days to conduct it. Administrator #410 stated Resident #67 did not have an apparent injury so she did not think it had to be reported right away, and did not remember the time it was actually reported to the State Agency. Administrator #410 did not interview staff members or additional residents regarding

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the abuse allegation from Resident #67.

On 11/19/20 at 10:13 A.M. interview with UM #305 revealed a physical abuse allegation involving Resident #67 was reported to her by Licensed Practical Nurse (LPN) #608 on 10/28/20 in the morning. UM #305 stated she interviewed Resident #67 around 11:00 A.M. and was told a STNA that Resident #67 did not know, roughly turned her to her side while providing care and made her left arm and leg hurt at 5:00 A.M. UM #305 stated she did not see any bruises on Resident #67 and the resident did not complain of any pain at that time. UM #305 watched the surveillance camera footage, identified the STNA as STNA #606, an agency STNA, as she entered Resident #67's room at 5:00 A.M. and tried to call her unsuccessfully for an interview. UM #305 did not interview any other staff members or other residents regarding the abuse allegation from Resident #67. At that point UM #305 took the allegation to the Director of Nursing (DON).

On 11/19/20 at 11:30 A.M. interview with the DON confirmed UM #305 reported an allegation of abuse concerning Resident #67. The DON stated she did not interview the resident, or any staff members and did not report the abuse to the State Agency. The DON stated she gave the abuse information to Administrator #410 to report to the State Agency. The DON further stated the nursing agency was informed not to assign STNA #606 to the facility in the future.

On 11/20/20 at 7:45 A.M. interview with LPN #608 revealed on 10/28/20 in the morning an STNA reported to her Resident #67 made an abuse allegation concerning another aide, and she immediately reported it to UM #305. LPN #608

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stated she interviewed Resident #67, did a full body assessment checking for bruises and marks and did not find any. Resident #67 stated an aide on night shift turned her causing pain two times, hurting her and she told the aide to leave her room.

On 11/20/20 at 11:05 A.M. interview with Licensed Independent Social Worker (LISW) #609 revealed she interviewed Resident #67 on 10/28/20 regarding the physical abuse allegation and turned in a report to UM #305. A couple days later the DON asked her to interview other residents on the unit Resident #67 resided on for allegations of abuse.

Review of facility Self Reported Incident Form, dated 10/28/20, time stamped 3:38 P.M., tracking number 198444, revealed an allegation of physical abuse had been made by Resident #67. The investigation revealed on 10/28/20 at 5:00 A.M. the resident stated an STNA she was not familiar with came into her room to change her. The resident stated the STNA was rough. The investigation documentation revealed the facility did not find any signs of rough care. The report was signed by UM #305 and LISW #609.

Review of the facility policy titled, Abuse, Neglect, Involuntary Seclusion, Misappropriation, revised 11/2018 revealed it was the policy of the facility that each resident would be free from abuse. No abuse or harm of any type would be tolerated.

2. Review of Resident #70's medical record revealed an admission date of 04/08/09 with diagnoses including schizophrenia, dementia and hypertension. Review of the MDS 3.0 assessment, dated 10/23/20 revealed Resident

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#70 had moderate cognitive impairment, required one person physical assistance for activity of daily living care and resided on the dementia unit.

On 11/24/20 at 11:01 A.M. interview with the Director of Nursing (DON) and Administrator #410 revealed an allegation of abuse was made involving Resident #70. The incident occurred on 11/19/20 at 11:30 A.M. in the shower area. STNA #638 and Student NA #639 were giving a shower to Resident #70. Student NA #639 stated she saw STNA #638 hit Resident #70 in the chest and deliberately spray water on Resident #70's face. Interview of STNA #638 revealed she was repositioning Resident #70 and water on her face occurred while her face was washed. Administrator #410 stated STNA #638 was immediately suspended and the allegation was reported to the State Agency.

On 11/24/20 at 11:56 A.M. interview with Registered Nurse/Unit Manager (RN/UM) #600 revealed Student NA #639 stated she saw STNA #638 slap Resident #70 on the chest and spray water in her face. When interviewed, STNA #638 denied she slapped the resident or sprayed water on her face. RN/UM #600 stated she did not see any bruises or marks on Resident #70 when a full body assessment was done. RN/UM #600 further stated she had no complaints about STNA #638 from other staff or residents and STNA #638 had been employed at the facility for seven months.

On 11/24/20 at 12:20 P.M. a telephone interview with STNA #638 revealed on 11/19/20 at 11:30 A.M. she was with Student NA #639 in the shower area bathing Resident #70. STNA #638 stated she turned the shower on so the water would be

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warm, washed Resident #70's face with clean water, and Student NA #639 assisted with bathing. STNA #638 stated during the shower, Resident #70 leaned forward and she held her shoulder until the bath was finished.

On 11/24/20 at 12:40 P.M. Resident #70 was observed sitting in the hallway outside her room in a wheelchair. Resident #70 did not respond when spoken to and was not able to be interviewed.

On 11/24/20 at 1:00 P.M. interview with Student NA #639 revealed she was with STNA #638 preparing to give Resident #70 a shower. Student NA #639 stated during the care, STNA #638 spoke to Resident #70 in a rude, slow, loud demeaning way, and yelled at her to hurry up. Student NA #639 walked away to get sheets, and when she came back Resident #70 was alone. STNA #638 walked back to shower area and proceeded to push Resident #70 hurriedly into the shower room, Resident #70 cried out and said her foot was stuck on something. After making sure Resident #70's foot was not injured the bathing continued. Student NA #639 observed Resident #70 attempt to wash her own face and STNA #638 then sprayed water on Resident #70's face causing her to gag and almost choke. Resident #70 leaned forward and STNA #638 slapped her on the chest to make her sit back. Student NA #639 stated she wanted to tell her instructor what happened because she was upset the way STNA #638 treated Resident #70, couldn't find her (the instructor) so she told RN/UM #600 what happened.

Review of Student NA #639's witness statement, dated 11/19/20 corroborated the interview as

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F 600	Continued From page 7 noted above. Review on 11/19/20 of LISW #621 and RN/UM #600's abuse investigation notes revealed Resident #70 stated a woman was rude, too rough when washing her chest and her arms hurt when she was assisted to put her arms through the sleeves of her gown. LISW #621 also included with the exception of Resident #70, other residents on the unit were not able to be interviewed due to impaired cognition. This deficiency substantiates Complaint Number OH00116871.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §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.	F 609		

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§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.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of the facility Abuse policy and procedure and interview the facility failed to ensure an allegation of physical and verbal abuse involving Resident #67 was immediately reported to the State agency as required. This affected one resident (#67) of two residents reviewed for abuse.

Findings include:

Review of Resident #67's medical record revealed an admission date of 06/05/20 and medical diagnoses including fractured left femur and left humerus, atrial fibrillation, and hemiplegia (paralysis)/hemiparesis (weakness) following cerebral infarction affecting left non-dominant side.

Review of the Minimum Data Set (MDS) 3.0 assessment, dated 09/18/20 revealed Resident #67 was cognitively intact and required one person physical assist for activity of daily living care.

On 11/12/20 at 2:21 P.M. and 11/19/20 at 2:44 P.M. Resident #67 was observed sitting in a wheelchair in her room. Interview with the resident during these times revealed concerns related to an incident of abuse. The resident reported on 10/28/20 at 5:00 A.M. a State Tested

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Nursing Assistant (STNA) she did not know entered her room to provide incontinence care. The STNA roughly rolled her onto her side pushing her fractured left arm and fractured left leg (surgery included plates and screws). The resident stated she cried out in pain. The resident stated the STNA asked her if she hurt her and she replied, "why do you think I cried out in pain". Resident #67 stated the STNA came back an hour later to "change me". The resident reported, the STNA again roughly turned her onto her side pushing on her left arm and left "broken" leg. Resident #67 stated she cried out again and the STNA said "stop your yelling". Resident #67 stated she told the STNA to "get out" of her room and the STNA replied "no one wants to come in here anyway". Resident #67 further stated she was in the facility to get better, not to have someone abuse her. Resident #67 stated a couple days after the incident an X-ray was taken of her left fractured leg that had plates and screws in it and the X-ray was OK. Resident #67 stated she was "sore" after the incident and took pain pills, but did not have any bruises or marks on her.

On 11/17/20 at 4:30 P.M. interview with Administrator #410 revealed on 10/28/20 around 11:00 A.M., Unit Manager (UM) #305 reported Resident #67 made an allegation of abuse at 5:00 A.M. Resident #67 stated an STNA (identified to be STNA #606) entered her room to provide care, rolled her onto her side causing pain to her left arm and leg, Resident #67 cried out in pain, and was told to stop screaming. Administrator #410 stated UM #305 was told about the incident around 8:00-8:30 A.M., interviewed Resident #67 and did a skin assessment at 9:00 A.M. Administrator #410 further revealed a full

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investigation was not done immediately because the facility had five days to conduct it. Administrator #410 stated Resident #67 did not have an apparent injury so she did not think it had to be reported right away, and did not remember the time it was actually reported to the State Agency. Administrator #410 did not interview staff members or additional residents regarding the abuse allegation from Resident #67.

On 11/19/20 at 10:13 A.M. interview with UM #305 revealed a physical abuse allegation involving Resident #67 was reported to her by Licensed Practical Nurse (LPN) #608 on 10/28/20 in the morning. UM #305 stated she interviewed Resident #67 around 11:00 A.M. and was told a STNA Resident #67 did not know roughly turned her to her side while providing care and made her left arm and leg hurt at 5:00 A.M. UM #305 stated she not see any bruises on Resident #67 and the resident did not complain of any pain at that time. UM #305 watched the surveillance camera footage, identified the STNA as STNA #606 an agency STNA as she entered Resident #67's room at 5:00 A.M. and tried to unsuccessfully call her for an interview. UM #305 did not interview any other staff members or other residents regarding the abuse allegation from Resident #67. At that point UM #305 took the allegation to the Director of Nursing (DON).

On 11/19/20 at 11:30 A.M. interview with the DON confirmed UM #305 reported an allegation of abuse concerning Resident #67. The DON stated she did not interview the resident, or any staff members and did not report the abuse to the State Agency. The DON stated she gave the abuse information to Administrator #410 to report to the State Agency. The DON further stated the

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nursing agency was informed not to assign STNA #606 to the facility in the future.

On 11/20/20 at 7:45 A.M. interview with LPN #608 revealed on 10/28/20 in the morning an STNA reported to her Resident #67 made an abuse allegation concerning another aide, and she immediately reported it to UM #305. LPN #608 stated she interviewed Resident #67, did a full body assessment checking for bruises and marks and did not find any. Resident #67 stated an aide on night shift turned her causing pain two times, hurting her and she told the aide to leave her room.

On 11/20/20 at 11:05 A.M. interview with Licensed Independent Social Worker (LISW) #609 revealed she interviewed Resident #67 on 10/28/20 regarding the physical abuse allegation and turned in a report to UM #305. A couple days later the DON asked her to interview other residents on the unit Resident #67 resided on for allegations of abuse.

Review of facility Self Reported Incident Form, dated 10/28/20, time stamped 3:38 P.M., tracking number 198444, revealed an allegation of physical abuse had been made by Resident #67. The investigation revealed on 10/28/20 at 5:00 A.M. the resident stated an STNA she was not familiar with came into her room to change her. The resident stated the STNA was rough. The investigation documentation revealed the facility did not find any signs of rough care. The report was signed by UM #305 and LISW #609.

Review of the facility policy titled, Abuse, Neglect, Involuntary Seclusion, Misappropriation, revised 11/2018 revealed it was the policy of the facility

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F 609	Continued From page 12 that each resident would be free from abuse. No abuse or harm of any type would be tolerated. In addition, the policy indicated the Nursing Home Administrator, Abuse Coordinator, or designee would report "abuse" to the State agency per State and Federal Requirements. This deficiency substantiates Complaint Number OH00116871.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility Abuse policy and procedure and interview the facility failed to ensure allegations of abuse involving Resident #67 and Resident #70 were timely and thoroughly investigated. This affected two residents (#67 and #70) of two	F 610		

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residents reviewed for abuse.

Findings include:

1. Review of Resident #67's medical record revealed an admission date of 06/05/20 and medical diagnoses including fractured left femur and left humerus, atrial fibrillation, and hemiplegia (paralysis)/hemiparesis (weakness) following cerebral infarction affecting left non-dominant side.

Review of the Minimum Data Set (MDS) 3.0 assessment, dated 09/18/20 revealed Resident #67 was cognitively intact and required one person physical assist for activity of daily living care.

On 11/12/20 at 2:21 P.M. and 11/19/20 at 2:44 P.M. Resident #67 was observed sitting in a wheelchair in her room. Interview with the resident during these times revealed concerns related to an incident of abuse. The resident reported on 10/28/20 at 5:00 A.M. a State Tested Nursing Assistant (STNA) she did not know entered her room to provide incontinence care. The STNA roughly rolled her onto her side pushing her fractured left arm and fractured left leg (surgery included plates and screws). The resident stated she cried out in pain. The resident stated the STNA asked her if she hurt her and she replied, "why do you think I cried out in pain". Resident #67 stated the STNA came back an hour later to "change me". The resident reported, the STNA again roughly turned her onto her side pushing on her left arm and left "broken" leg. Resident #67 stated she cried out again and the STNA said "stop your yelling". Resident #67 stated she told the STNA to "get out" of her room

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and the STNA replied "no one wants to come in here anyway". Resident #67 further stated she was in the facility to get better, not to have someone abuse her. Resident #67 stated a couple days after the incident an X-ray was taken of her left fractured leg that had plates and screws in it and the X-ray was OK. Resident #67 stated she was "sore" after the incident and took pain pills, but did not have any bruises or marks on her.

On 11/17/20 at 4:30 P.M. interview with Administrator #410 revealed on 10/28/20 around 11:00 A.M., Unit Manager (UM) #305 reported Resident #67 made an allegation of abuse at 5:00 A.M. Resident #67 stated an STNA (identified to be STNA #606) entered her room to provide care, rolled her onto her side causing pain to her left arm and leg, Resident #67 cried out in pain, and was told to stop screaming. Administrator #410 stated UM #305 was told about the incident around 8:00-8:30 A.M., interviewed Resident #67 and did a skin assessment at 9:00 A.M. Administrator #410 further revealed a full investigation was not done immediately because the facility had five days to conduct it. Administrator #410 stated Resident #67 did not have an apparent injury so she did not think it had to be reported right away, and did not remember the time it was actually reported to the State Agency. Administrator #410 did not interview staff members or additional residents regarding the abuse allegation from Resident #67.

On 11/19/20 at 10:13 A.M. interview with UM #305 revealed a physical abuse allegation involving Resident #67 was reported to her by Licensed Practical Nurse (LPN) #608 on 10/28/20 in the morning. UM #305 stated she interviewed

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Resident #67 around 11:00 A.M. and was told a STNA Resident #67 did not know roughly turned her to her side while providing care and made her left arm and leg hurt at 5:00 A.M. UM #305 stated she not see any bruises on Resident #67 and the resident did not complain of any pain at that time. UM #305 watched the surveillance camera footage, identified the STNA as STNA #606 an agency STNA as she entered Resident #67's room at 5:00 A.M. and tried to unsuccessfully call her for an interview. UM #305 did not interview any other staff members or other residents regarding the abuse allegation from Resident #67. At that point UM #305 took the allegation to the Director of Nursing (DON).

On 11/19/20 at 11:30 A.M. interview with the DON confirmed UM #305 reported an allegation of abuse concerning Resident #67. The DON stated she did not interview the resident, or any staff members and did not report the abuse to the State Agency. The DON stated she gave the abuse information to Administrator #410 to report to the State Agency. The DON further stated the nursing agency was informed not to assign STNA #606 to the facility in the future.

On 11/20/20 at 7:45 A.M. interview with LPN #608 revealed on 10/28/20 in the morning an STNA reported to her Resident #67 made an abuse allegation concerning another aide, and she immediately reported it to UM #305. LPN #608 stated she interviewed Resident #67, did a full body assessment checking for bruises and marks and did not find any. Resident #67 stated an aide on night shift turned her causing pain two times, hurting her and she told the aide to leave her room.

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On 11/20/20 at 11:05 A.M. interview with Licensed Independent Social Worker (LISW) #609 revealed she interviewed Resident #67 on 10/28/20 regarding the physical abuse allegation and turned in a report to UM #305. LISW #609 revealed a couple days later the DON asked her to interview other residents on the unit Resident #67 resided on for allegations of abuse. LISW #609 stated Resident #167 shared an unpleasant experience with an STNA, but did not know the name of the STNA. LISW further stated she did not interview any staff members regarding the abuse allegation.

Review of resident interviews, from residents who resided on the same unit as Resident #67, dated 11/02/20 revealed Resident #12, #86, #141, and #167 had been interviewed in regards to staff abuse. Resident #12, #86, and #141 did not have concerns related to the allegation. Resident #167 reported an unidentified staff person entered her room this past week and the resident thought she was from an agency. Resident #167 had not seen this staff person before. Resident #167 asked the individual about her medications, and the person was rude and told her "I don't work here anyway. I don't know anything about that." After saying that the individual walked out of the room and did not help Resident #167.

Review of facility Self Reported Incident Form, dated 10/28/20, time stamped 3:38 P.M., tracking number 198444, revealed an allegation of physical abuse had been made by Resident #67. The investigation revealed on 10/28/20 at 5:00 A.M. the resident stated an STNA she was not familiar with came into her room to change her. The resident stated the STNA was rough. The investigation documentation revealed the facility

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did not find any signs of rough care. The report was signed by UM #305 and LISW #609.

Review of the facility policy titled, Abuse, Neglect, Involuntary Seclusion, Misappropriation, revised 11/2018 revealed it was the policy of the facility that each resident would be free from abuse. No abuse or harm of any type would be tolerated and that all allegations of abuse would be thoroughly investigated.

2. Review of Resident #70's medical record revealed an admission date of 04/08/09 with diagnoses including schizophrenia, dementia and hypertension. Review of the MDS 3.0 assessment, dated 10/23/20 revealed Resident #70 had moderate cognitive impairment, required one person physical assistance for activity of daily living care and resided on the dementia unit.

On 11/24/20 at 11:01 A.M. interview with the Director of Nursing (DON) and Administrator #410 revealed an allegation of abuse was made involving Resident #70. The incident occurred on 11/19/20 at 11:30 A.M. in the shower area. STNA #638 and Student NA #639 were giving a shower to Resident #70. Student NA #639 stated she saw STNA #638 hit Resident #70 in the chest and deliberately spray water on Resident #70's face. Interview of STNA #638 revealed she was repositioning Resident #70 and water on her face occurred while her face was washed. Administrator #410 stated STNA #638 was immediately suspended and the allegation was reported to the State Agency.

On 11/24/20 at 11:56 A.M. interview with Registered Nurse/Unit Manager (RN/UM) #600 revealed Student NA #639 stated she saw STNA

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#638 slap Resident #70 on the chest and spray water in her face. When interviewed, STNA #638 denied she slapped the resident or sprayed water on her face. RN/UM #600 stated she did not see any bruises or marks on Resident #70 when a full body assessment was done. RN/UM #600 further stated she had no complaints about STNA #638 from other staff or residents and STNA #638 had been employed at the facility for seven months.

On 11/24/20 at 12:20 P.M. a telephone interview with STNA #638 revealed on 11/19/20 at 11:30 A.M. she was with Student NA #639 in the shower area bathing Resident #70. STNA #638 stated she turned the shower on so the water would be warm, washed Resident #70's face with clean water, and Student NA #639 assisted with bathing. STNA #638 stated during the shower, Resident #70 leaned forward and she held her shoulder until the bath was finished.

On 11/24/20 at 12:40 P.M. Resident #70 was observed sitting in the hallway outside her room in a wheelchair. Resident #70 did not respond when spoken to and was not able to be interviewed.

On 11/24/20 at 1:00 P.M. interview with Student NA #639 revealed she was with STNA #638 preparing to give Resident #70 a shower. Student NA #639 stated during the care, STNA #638 spoke to Resident #70 in a rude, slow, loud demeaning way, and yelled at her to hurry up. Student NA #639 walked away to get sheets, and when she came back Resident #70 was alone. STNA #638 walked back to shower area and proceeded to push Resident #70 hurriedly into the shower room, Resident #70 cried out and said

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F 610	Continued From page 19 her foot was stuck on something. After making sure Resident #70's foot was not injured the bathing continued. Student NA #639 observed Resident #70 attempt to wash her own face and STNA #638 then sprayed water on Resident #70's face causing her to gag and almost choke. Resident #70 leaned forward and STNA #638 slapped her on the chest to make her sit back. Student NA #639 stated she wanted to tell her instructor what happened because she was upset the way STNA #638 treated Resident #70, couldn't find her (the instructor) so she told RN/UM #600 what happened. Review of Student NA #639's witness statement, dated 11/19/20 corroborated the interview as noted above. Review on 11/19/20 of LISW #621 and RN/UM #600's abuse investigation notes revealed Resident #70 stated a woman was rude, too rough when washing her chest and her arms hurt when she was assisted to put her arms through the sleeves of her gown. LISW #621 also included with the exception of Resident #70, other residents on the unit were not able to be interviewed due to impaired cognition. However, there was no evidence which staff or that all staff were interviewed regarding this allegation of abuse. This deficiency substantiates Complaint Number OH00116871.	F 610		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		

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The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, facility policy review and interview the facility failed to ensure all residents had current and complete physician orders for oxygen administration and failed to ensure oxygen tubing was changed and dated at least weekly. This affected three residents (#22, #67 and #121) of three residents reviewed for oxygen therapy.

Findings include:

1. Review of Resident #22's medical record revealed an admission date of 07/08/20 with diagnoses including cerebral infarction, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction affecting the left non-dominant side and chronic obstructive pulmonary disease.

Review of Resident #22's Minimum Data Set (MDS) 3.0 assessment, dated 11/07/20 revealed the resident had severe cognitive impairment and required one person physical assist for activity of daily living care.

Review of Resident #22's physician orders revealed an order, dated 10/04/20 to discontinue oxygen two to six liters per minute via nasal cannula for comfort and to maintain oxygen saturation greater than 89 %. The medication

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administration record (MAR) for October 2020 reflected the resident's oxygen had been discontinued on 10/04/20. Further review of the October 2020 MAR revealed no evidence of oxygen tubing changes for the resident.

Review of Resident #22's electronic medical record revealed documentation revealed entries on 10/14/20, 10/30/20, 11/03/20 and 11/04/20 of oxygen via nasal cannula and oxygen saturation percentages.

Review of the physician's orders revealed an order, dated 11/05/20 for oxygen every shift. The order did not specify liters per minute, the mode of delivery, or to check oxygen saturation percentages.

Review of Resident #22's electronic medical record from 11/07/20 through 11/16/20 revealed 21 entries of oxygen via nasal cannula and oxygen saturation percentages. Review of the November 2020 MAR revealed entries of oxygen every shift and oxygen saturation percentages every shift from 11/06/20 through 11/16/20.

Further review of Resident #22's November 2020 MAR and treatment administration record (TAR) revealed no evidence the resident's oxygen tubing was being changed.

On 11/12/20 at 2:07 P.M. interview and observation with Registered Nurse/ Nurse Manager (RN/NM) #600 revealed Resident #22 had oxygen at three liters per minute via nasal cannula per an oxygen concentrator. Resident #22's oxygen tubing and nasal cannula did not have the date written on the tubing or a sticker with a date marked on it stating when the tubing

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was last changed. RN/NM #600 confirmed the observation and stated oxygen tubing was usually changed once a week. RN/NM #600 verified the resident's current physician orders for oxygen therapy did not include liters per minute, the mode of delivery, or to check oxygen saturation percentages.

Review of the facility policy titled, Respiratory Therapy and Care of Equipment, revised 09/2017 revealed oxygen tubing and delivery device (nasal cannula or mask) would be changed routinely once a week.

2. Review of Resident #67's medical record revealed an admission date of 06/05/20 with diagnoses including fractured left femur, atrial fibrillation, and hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side.

Review of Resident #67's physician's orders, dated 09/12/20 revealed an order for oxygen at three liters per minute via nasal cannula and check oxygen saturation and respiratory rate every shift.

Review of Resident #67's medication and treatment administration records for October and November 2020 revealed no evidence the resident's oxygen tubing had been changed.

On 11/12/20 at 2:21 P.M. observation and interview with RN #210 revealed Resident #67 had oxygen at three liters per minute via nasal cannula per oxygen concentrator. Further observation revealed Resident #67's oxygen tubing and nasal cannula did not have the date written on the tubing or a sticker with the date

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marked on it stating when the tubing was last changed. RN #210 further stated tubing should be changed once every seven days by a nurse.

Review of the facility policy titled, Respiratory Therapy and Care of Equipment, revised 09/2017 revealed oxygen tubing and delivery device (nasal cannula or mask) would be changed routinely once a week.

3. Review of Resident #121's medical record revealed an admission date of 12/19/19 with diagnoses including congestive heart failure, nonrheumatic aortic stenosis and paroxysmal atrial fibrillation.

Review of the 09/07/20 quarterly MDS 3.0 assessment revealed the resident was independent for daily decision making and was not receiving oxygen. The resident tested positive for COVID-19 on 10/22/2020.

Review of the resident's physician's orders revealed an order, dated 12/19/19 for continuous oxygen at five liters per minute (LPM) and a 01/18/20 order to wean off oxygen keeping oxygen saturation above 92 percent. There was a 03/07/20 order to discontinue oxygen. The same day, 03/07/20, an order was written for oxygen as needed to keep oxygen saturation above 92 percent. Administer 1-3 LPM as needed via nasal cannula/mask. Check and record oxygen saturation and respiratory rate. The oxygen was discontinued on 10/30/20. There was not a current oxygen order after the oxygen was discontinued on 10/30/20.

Review of oxygen saturation documentation revealed on 10/27/2020 at 02:30 A.M. the resident's oxygen saturation was 92% with

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oxygen via nasal cannula. The oxygen saturation documentation on 10/28/20, 10/29/20, 10/30/20, 11/01/20, 11/02/20, 11/03/20, 11/04/20 and 11/05/20 indicated the resident was on oxygen.

Review of the October 2020 treatment and medication administration records revealed oxygen as needed was not signed off as administered during the month. There was no evidence of an order to change the oxygen nasal cannula or tubing or that tubing changes were completed.

Review of the November 2020 treatment and medication records revealed there was no order for oxygen on the records.

On 11/10/20 at 11:58 A.M. interview with the Director of Nursing (DON) revealed the facility did not have an oxygen policy. The DON also verified Resident #121 did not have any order or evidence of oxygen tubing or nasal cannula changes for sanitation. The DON verified Resident #121's record indicated the resident was on oxygen in October 2020 when it was not signed off on the administration record. Verification also occurred the November 2020 oxygen saturations indicated the resident was on oxygen when there was not a current order for oxygen. On 11/10/20 at 1:21 P.M. the DON revealed the facility did not have standing orders for the use of oxygen.

Review of the facility policy titled, Respiratory Therapy and Care of Equipment, revised 09/2017 revealed oxygen tubing and delivery device (nasal cannula or mask) would be changed routinely once a week.

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F 695	Continued From page 25 This deficiency substantiates Complaint Number OH00117160 and Complaint Number OH00116766.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its 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. This REQUIREMENT is not met as evidenced	F 755		

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by:
Based on closed record review and interview the facility failed to provide pharmaceutical services to ensure the timely and accurate acquiring and administration of medication to Resident #179. This affected one resident (#179) of three residents reviewed for medication errors.

Findings include:

Review of Resident #179's closed medical record revealed an admission date of 07/21/20 and diagnoses including congestive heart failure, chronic obstructive pulmonary disease (COPD) and depression.

Per pharmacy information, Resident #179 had a physician order, dated 07/21/20 for Incruse Ellipta Inhaler 62.5 micrograms (mcg), one inhalation orally one time a day for shortness of breath/wheezing. Incruse Ellipta is a prescription medication used long term to treat chronic obstructive pulmonary disease (COPD), including chronic bronchitis, emphysema or both, for better breathing and fewer flare-ups.

The resident's electronic medical record physician's orders did not include an order for the Incruse Ellipta Inhaler.

Review of the Minimum Data Set (MDS) 3.0 assessment, dated 10/24/20 revealed Resident #179 was cognitively intact and required one person physical assist for activities of daily living

On 11/12/20 at 11:30 A.M. during an interview with Resident #179's family, Family Member (FM) #603 the family member voiced concerns regarding the administration of a "breathing"

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medication for the resident. FM #603 revealed Resident #179 had tested positive for COVID-19 earlier in the month, while residing in the facility. The resident was subsequently transferred to the hospital where she passed away on 11/09/20. During the interview, FM #603 revealed Resident #179 had reported to her that she was not getting her "breathing" medication (name of med not given) and had not received the medication for a full two weeks in October 2020. FM #603 stated she did not know the name of the breathing medication, but stated it was ordered for the resident's COPD FM #603 revealed she felt the unavailability of the medication could have contributed to Resident #179's health decline resulting in the hospitalization and subsequent death. FM #603 revealed she reported this concern to facility staff (date not provided) and was told by the Licensed Independent Social Worker (LISW) the medication was not available from the pharmacy but that staff were trying to get it and Unit Manager (UM) #622 was trying to get a second inhaler of the same medication to put in the nursing office as a "back-up" so the medication would be available for the resident.

On 11/17/20 at 10:09 A.M. interview with LISW #621 and LISW Supervisor #620 verified FM #603 had contacted the facility in regards to Resident #179's breathing medication. LISW #621 revealed she thought the nurses were having trouble getting an inhaler (Incruse Ellipta) for Resident #179 and thought this was sometime mid to late October 2020.

On 11/18/20 at 12:00 P.M. interview with Administrator #410 and the Director of Nursing (DON) revealed they were unaware Resident #179 had not received her inhalation medication,

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but they were both new to the facility and not in their positions until the middle of October. Administrator #410 further revealed no information could be obtained from UM #622, as the UM was no longer employed by the facility as of this date. No additional information was provided by the facility related to the administration of this medication for Resident #179. There was no evidence of an investigation of a medication error or evidence an investigation at the time FM #603 reported the resident's concerns to LISW staff.

On 11/23/20 at 2:46 P.M. telephone interview with Pharmacy Representative (PR) #632 revealed an order for Incruse Ellipta Inhaler 62.5 microgram (mcg) was originally received for Resident #179 on 07/21/20 and a 30 day supply was sent to the facility. On 08/20/20 a seven day supply of the medication was sent. However, another order for the Incruse Ellipta Inhaler was not sent until 10/06/20. On 10/06/20 a seven day supply was sent to the facility. On 10/13/20 Resident #179's Incruse Ellipta Inhaler medication was returned to the pharmacy by the facility for an unknown reason. On 10/19/20 and 10/27/20 a seven day supply for Resident #179 was sent to the facility. Another shipment was sent out on 10/28/20 to be delivered as soon as possible as PR #632 revealed the facility reported they did not receive the 10/27/20 medication that was sent to the facility. During the interview, PR #632 denied any concerns with medication availability from the pharmacy.

Review of Resident #179's September 2020 medication administration record revealed staff documented Resident #179 was administered the Incruse Ellipta Inhaler once a day. However,

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from approximately 09/20/20 through 09/30/20 the medication was not even available to be given.

Review of Resident #179's October 2020 medication administration record revealed staff documented the Incruse Ellipta Inhaler was administered every day for the month except for on 10/20/20. However, the medication was not available to administer from 10/01/20 through 10/06/20 or from 10/13/20 through 10/19/20.

Facility information contained on a Medication Administration Audit Report for Resident #179 and dated 10/20/20 revealed Registered Nurse #623 noted she administered the Incruse Ellipta Inhaler on this date at 12:04 P.M. A corresponding nursing progress note, dated 10/20/20 at 12:04 P.M. revealed documentation by Registered Nurse (RN) #623 that the Incruse Ellipta Inhaler was "pending availability". However, interview with PR #632 revealed the medication had been sent to the facility on 10/19/20.

There was no evidence the facility investigated why the medication sent from the pharmacy on 10/13/20 was returned. No evidence the facility identified or investigated why staff were documenting the medication had been administered when there was no medication available to give, no evidence the facility resolved why there was no physician order for the medication and no evidence the medication was obtained and administered to meet the resident's needs.

This deficiency substantiates Complaint Number OH00117160 and Complaint Number

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F 755	Continued From page 30 OH00116858.	F 755		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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: §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	F 880		

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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 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.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, review of the facility Coronavirus (COVID-19) policy, review of the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) Memo QSO-20-38-NH, updated 08/26/20, review of the Centers for Disease Control and Prevention (CDC) guidelines and interview the facility failed to ensure proper

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COVID-19 screening and use of hand sanitizer upon entrance to the facility was consistently implemented to prevent the spread of COVID-19. The facility failed to ensure all residents were monitored for COVID-19 symptoms. The facility failed to maintain proper infection control practices including the appropriate use of personal protective equipment (PPE) when caring for residents to prevent the spread of COVID-19, failed to ensure residents utilized proper PPE (mask use) when out of their room, failed to ensure physician orders for COVID-19 testing were in place, failed to place residents refusing COVID-19 testing on transmission based precautions, failed to ensure residents who displayed symptoms of COVID-19 were placed on transmission based precautions timely and failed to ensure appropriate actions were taken following the identification of COVID-19 symptoms for staff. This had the potential to affect all 183 residents residing in the facility.

Findings include:

1. On 11/10/20 at 2:45 P.M. the surveyor arrived to the facility and observed Front Entrance Screener (FES) #612 sitting at a screening station, with a bottle of hand sanitizer on the station in front of her. FES #612 took the surveyors temperature, asked if the surveyor had any symptoms and offered an N95 respirator mask. FES #612 did not request hand sanitizer be used by the surveyor or ask specific COVID-19 screening questions. FES #612 did not wipe (clean or disinfect) the thermometer after taking the surveyor's temperature.

On 11/10/20 at 2:50 P.M. State Tested Nursing Assistant (STNA) #610 and Life Enhancement

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Staff Member (LE) #611 entered the facility and stopped at the screening station. FES #612 took both employee's temperature, asked if they had "any symptoms", and offered an N95 respirator mask to each of them. FES #612 did not instruct STNA #610 and LE #611 to use hand sanitizer, or cleanse/sanitize the thermometer after talking the temperatures. STNA #610 and LE #611 walked past the screening station on the way to their assigned work area.

On 11/10/20 at 2:51 P.M. interview with STNA #610 and LE #611 confirmed they did not use hand sanitizer at the screening station.

On 11/10/20 at 2:52 P.M. interview with FES #612 confirmed she did not ask the surveyor, STNA #610 or LE #611 to use hand sanitizer at the screening station. FES #612 also confirmed she did not wipe (clean/sanitize) the thermometer between uses because she did not actually touch the thermometer to the person's forehead, but only came close to the person. FES #612 revealed she did not ask anyone entering the facility to use hand sanitizer and the question asked was "do you have any symptoms?". FES #612 further stated she did not ask specific COVID-19 screening questions including do you have a fever, cough, shortness of breath, loss of taste or smell or diarrhea.

On 11/12/20 at 1:00 P.M. observation and interview with FES #612 revealed FES #612 was sitting at the screening station with a bottle of hand sanitizer on the station in front of her. At the time the surveyor entered the facility and after being screened, the surveyor was not instructed to use hand sanitizer after her temperature was taken and COVID-19 screening questions were

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asked. FES #612 confirmed she did not instruct the surveyor to use hand sanitizer.

2. Review of Resident #51's medical record revealed an admission date of 04/29/18 with diagnoses including Alzheimer's Disease, hypertension and depression.

Review of the Minimum Data Set (MDS) 3.0 assessment, dated 10/09/20 revealed Resident #51 had severe cognitive impairment and required supervision with set up assistance from staff for activities of daily living.

On 11/12/20 at 3:15 P.M. Resident #51 was observed standing in the entrance to her room. Attempts to interview Resident #51 was unsuccessful as the resident was not interviewable due to impaired cognition.

Record review revealed on 11/05/20, Resident #51 tested positive for COVID-19. Record review revealed the resident was no having symptoms at the time the COVID-19 test was obtained.

Review of Resident #51's medical record, including the administration records for November 2020 revealed no evidence the resident's temperature and oxygen saturation, which were ordered to be obtained every shift was completed on 11/06/20 or 11/07/20 during the day shift. Vital signs, which were ordered to be obtained every four hours were not completed on 11/18/20 at 12:00 P.M.

On 11/24/20 at 11:01 A.M. interview with Administrator #410 and the Director of Nursing (DON) confirmed the resident's temperature, oxygen saturation and vital signs were not

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completed as ordered on the dates noted above. Vital sign monitoring is necessary to early detect COVID-19 symptoms in residents and to ensure residents with COVID-19 were stable from an infection control standpoint.

3. Review of Resident #45's medical record revealed an admission date of 01/27/20 with diagnoses including macular degeneration left eye, vascular dementia and depression.

Review of the MDS 3.0 assessment, dated 09/15/20 revealed Resident #45 had severe cognitive impairment and required one person physical assist for activities of daily living.

Record review revealed Resident #45 tested positive for COVID-19 on 09/20/20. No additional COVID-19 testing had been completed for the resident through 11/18/20.

Review of Resident #45's medical record, including the administration records for November 2020 revealed the resident was to have a temperature taken and oxygen saturation checked every shift. Record review revealed this was not completed on day shift on 11/05/20, 11/06/20 or 11/09/20 and was not done during the evening or night shift on 11/06/20.

On 11/18/20 at 3:00 P.M. interview with the (DON) confirmed the resident's temperature and oxygen saturation were not completed as ordered on the dates noted above. Vital sign monitoring is necessary to early detect COVID-19 symptoms in residents and to ensure residents with COVID-19 were stable from an infection control standpoint.

In addition, on 11/18/20 at 10:38 A.M. interview

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with State Tested Nursing Assistant (STNA) #615 revealed concerns Resident #45 was often out of her room and moving around in the facility without wearing a mask.

Review of Resident #45's electronic record progress notes from 11/02/20 through 11/09/20 revealed on 11/02/20 at 4:32 P.M. the resident required reminders to wear a mask when out of her room. On 11/08/20 at 5:24 P.M. documentation revealed Resident #45 was not feeling well and a chest X-ray was done. On 11/09/20 at 12:53 P.M. Resident #45 was placed on respiratory isolation due to left lower lobe pneumonia. The resident was not re-tested for COVID-19 at that time because she had a positive COVID-19 test on 09/20/20.

There was no evidence the facility implemented additional infection control interventions when it was identified the resident frequently came out of her room without wearing a mask.

4. Review of a facility "Covid Case Summary", dated 11/17/20 revealed sixteen residents, Resident #5, #32, #34, #51, #57, #65, #66, #84, #109, #110, #119, #132, #149, #161, #178, #179 and #180 from one facility unit had COVID-19 positive test results from 11/03/20 through 11/15/20 which contributed to the facility doing outbreak testing.

In addition, on 11/18/20 at 10:38 A.M. interview with STNA #615 revealed concerns Resident #20, #149 and #174 were also often out of their rooms and throughout the facility without wearing a mask.

Review of the Centers for Disease Control (CDC)

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guidance related to the implementation of source control measures revealed residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above cloth face coverings should not be placed on children under 2.

a. Review of Resident #20's medical record revealed an admission date of 02/18/11 with diagnoses including chronic obstructive pulmonary disease, depression and dementia.

Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/12/20 revealed Resident #20 had severe cognitive impairment and required one staff assistance for activities of daily living.

Review of Resident #20's progress notes revealed documentation COVID-19 testing was refused 10/20/20, 10/27/20, and 11/03/20 and included documentation on 11/10/20 at 3:02 P.M. that the resident resisted encouragement to wear masks, refused COVID testing, all despite much encouragement and explanations by staff. Further review of Resident #20's progress notes revealed documentation on 11/14/20 at 7:05 P.M. Resident #20 kept coming out into the common areas without wearing a mask and interacting with staff and other residents.

Record review and review of Resident #20's physician orders revealed no evidence the

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resident was ordered transmission based precautions due to refusing COVID-19 testing. In addition, there was no evidence the facility implemented additional infection control interventions when it was identified the resident frequently came out of her room without wearing a mask. There was no evidence Resident #20 could not tolerate wearing a mask.

Review of the Center for Medicare and Medicaid Services (CMS), QSO-20-38-NH memo, dated 08/26/20 revealed if a resident has symptoms consistent with COVID-19, had been exposed to COVID-19, or if there was a facility outbreak and the resident declined testing, he or she should be placed on or remain on transmission based precautions (TBP) until he or she meets the symptom-based criteria for discontinuation. The memo also revealed in accordance with 42 CFR § 483.50(a)(2)(i), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing.

b. Review of Resident #149's medical record revealed an admission date of 01/05/12 with diagnoses including type two diabetes mellitus, dementia, and hemiplegia (paralysis) and hemiparesis(weakness) following cerebrovascular disease affecting the right dominant side.

Review of the MDS 3.0 assessment, dated 10/16/20 revealed Resident #149 had moderate cognitive impairment and required one person physical assistance for activities of daily living.

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Review of Resident #149's electronic progress notes revealed Resident #149 refused COVID-19 testing 10/20/20, 10/27/20, 11/03/20 and 11/11/20.

Further review of Resident #149's electronic progress notes on 11/14/2020 at 6:38 A.M. revealed Resident #149's result for COVID-19 returned positive and to transfer her immediately to the COVID-19 unit.

Review of Resident #149's physician's orders did not reveal an order for transmission based precautions due to refusal of COVID-19 testing. Further review of Resident #149's physician orders revealed an order 11/13/20 for nasophyaryngeal swab to detect coronavirus every Tuesday, but no orders from mid October through 11/13/20 for coronavirus testing.

Review of the Center for Medicare and Medicaid Services (CMS), QSO-20-38-NH memo, dated 08/26/20 revealed if a resident has symptoms consistent with COVID-19, had been exposed to COVID-19, or if there was a facility outbreak and the resident declined testing, he or she should be placed on or remain on transmission based precautions (TBP) until he or she meets the symptom-based criteria for discontinuation. The memo also revealed in accordance with 42 CFR § 483.50(a)(2)(i), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing.

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c. Review of Resident #174's medical record revealed an admission date of 08/12/17 with diagnoses including dementia, hypertension and cerebrovascular disease.

Review of the Minimum Data Set (MDS) 3.0 assessment, dated 08/28/20 revealed Resident #174 had severe cognitive impairment and required one person physical assist for activities of daily living.

Review of Resident #174's electronic progress notes revealed on 11/03/20 the resident refused COVID-19 testing. On 11/12/20 at 3:22 A.M. Resident #174 had large liquid, light yellow diarrhea documented by RN #616 with no evidence the physician was notified. On 11/16/20 Resident #174 was observed removing linens from the linen cart and was "re-oriented" by staff about COVID-19 and assisted back to her room. On 11/18/20 Resident #174's had an axillary temperature of 100.6 Fahrenheit. At this time, the resident's physician was notified and the resident was placed on droplet precautions for possible COVID-19.

COVID-19 test results dated, 11/18/20 revealed Resident #174 tested positive for COVID-19. On 11/19/20 (the next day) Resident #174 was transferred to the facility COVID-19 isolation unit.

Review of Resident #174's physician's orders did not reveal an order for transmission based precautions due to refusal of COVID-19 testing. Further review of Resident #174's physician orders revealed an order 11/13/20 for nasopharyngeal swab to detect coronavirus every Tuesday, but no previous orders for coronavirus testing for mid October through 11/13/20.

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Review of the Center for Medicare and Medicaid Services (CMS), QSO-20-38-NH memo, dated 08/26/20 revealed if a resident has symptoms consistent with COVID-19, had been exposed to COVID-19, or if there was a facility outbreak and the resident declined testing, he or she should be placed on or remain on transmission based precautions (TBP) until he or she meets the symptom-based criteria for discontinuation. The memo also revealed in accordance with 42 CFR § 483.50(a)(2)(i), the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing.

5. On 11/19/20 at 2:07 P.M. interview with STNA #617 revealed she worked the facility COVID-19 unit and on Sunday 11/15/20 she reported for work and started her day working. As the day went on the Assistant Director of Nursing (ADON) #615 mandated her to leave the COVID-19 unit and float to another unit to work. STNA #617 stated she did not know why she would be floated, but wore the same uniform to the next unit she had wore on the COVID-19 unit (she was not provided with a change in clothes). She stated she was on the unit for about an hour and was mandated to leave that unit and go to another unit, and worked on that unit for the rest of her work shift. STNA #617 stated she worked on 11/15/20 on the two units where all the residents then tested positive from the COVID-19 testing done on 11/17/20. The STNA voiced specific concerns that she had specifically taken care of Resident #173 (who was COVID-19

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negative and asymptomatic of COVID-19 symptoms) "all day" on 10/15/20 because she needed to be monitored. STNA #617 revealed she felt so bad about this, feeling she had given COVID-19 to the resident and had been crying all day. The STNA reported that working the COVID-19 unit very stressful.

Review of positive COVID-19 resident test results for the testing done on 11/17/20 revealed seven residents, Resident #64, #68, #142, #162, #170, #173 and #174 were all from the two units in the facility where STNA #617 worked after first working at the beginning of the shift on the COVID-19 unit. There was no evidence the facility completed contact tracing to determine if these residents had in fact possibly contracted COVID-19 from STNA #617.

6. On 11/20/20 at 9:01 A.M. and during a follow up interview at 6:10 P.M. with Nurse #618 revealed she worked night shift 11/11/20 (7:00 P.M. to 7:00 A.M.) and during her shift (exact time not provided) she lost her sense of taste and smell. Nurse #618 revealed she told Supervisor #619 of her (possible COVID-19) symptoms but was not sent home at that time and and finished working her entire shift.

Continued interview with Nurse #618 revealed she subsequently tested for COVID-19 and was told she was COVID-19 positive on 11/12/20. Nurse #618 revealed she returned to work on 11/16/20, even though she had not been cleared by the local health department to return to work. She stated her supervisor told her she could return and work on the facility COVID-19 unit. Nurse #618 revealed she did not consider losing her sense of taste and smell a real symptom and

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felt she could go back to work.

Review of the facility policy titled COVID-19 Testing, revised 07/2020 revealed any resident or staff member exhibiting signs or symptoms of COVID-19 would be immediately quarantined. Staff would be sent home immediately and advised to self quarantine until tested and results had been verified. The policy indicated any staff member who had a positive COVID-19 result must self quarantine for at least 14 days or longer if symptomatic. Staff member must be symptom free before returning to work.

Review of the Center for Disease Control and Prevention (CDC) Coronavirus Disease 2019 (COVID-19), Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance), updated 08/10/20 revealed return to work criteria for Health Care Professionals (HCP) with SARS-CoV-2 Infection, symptom-based strategy for determining when a HCP could return to work. HCP with mild to moderate illness who were not severely immunocompromised: At least 10 days had passed since symptoms first appeared and at least 24 hours had passed since last fever without the use of fever-reducing medications and symptoms (e.g., cough, shortness of breath) have improved.

7. Record review revealed Resident #123 had diagnoses including schizophrenia, diabetes mellitus, bipolar disorder and depression. The admission Minimum Data Set (MDS) 3.0 assessment, dated 10/19/20 revealed Resident #123 was cognitively intact and required supervision for activity of daily living (ADL) care.

Review of physician's orders for November 2020

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revealed Resident #123 was on isolation precautions for signs and symptoms of COVID-19. Resident #123 tested positive for COVID-19 on 11/20/20.

On 11/18/20 at 12:30 P.M. observation of the lunch meal revealed STNA # 250 obtained Resident #123's meal tray from the hall cart, walked into Resident 123's room, set the tray on the tray table and then walked out of the room. STNA #250 had an N95 mask and goggles on when entering the room. However, the STNA did not first apply a gown or gloves before entering the room. STNA #123 exited the room and did not change her mask, sanitize her hands or disinfect her goggles. The room was clearly marked "droplet precautions" and PPE was stocked in a bin outside the room.

On 11/18/20 at 12:30 P.M. interview with STNA #250 revealed she was not required to apply a gown or gloves because she was not providing direct care.

On 11/18/20 at 12:45 P.M. during an interview with the unit manager/Licensed Practical Nurse (LPN) #270, the LPN revealed STNA #250 would receive additional education regarding proper PPE use.

At the time of the observation, the facility identified four additional residents, Resident #2, #67 #117 and #163 who were receiving care from STNA #250 who were not in isolation for COVID-19.

Review of the facility policy titled Menorah Park Coronavirus Plan, dated February 2020 revealed health care workers and visitors should don (put

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F 880	Continued From page 45 on) the following PPE prior to entering the room: gown, N-95 respirator, eye protection and gloves. Review of the CDC's Coronavirus disease fact sheet titled, Use of Personal Protective Equipment (PPE) when caring for Patients with Confirmed or Suspected COVID-19, dated 2019, revealed isolation gown, mask, goggles/face shield, and gloves should be donned prior to entering patient room. Prior to exiting the room, gloves and gown were removed, hand hygiene was performed and face shield/goggles and masks were removed. This deficiency substantiates Complaint Number OH00116951, Complaint Number OH00116871, Complaint Number OH00116858 and Complaint Number OH00116766. This deficiency is also an example of continued non-compliance from the survey dated 10/19/20.	F 880		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with	F 886		

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COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

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§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state
and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on the unprecedented global pandemic that resulted in the Presidential declaration of a State of National Emergency dated 03/13/20, Department of Health and Human Services, Centers for Medicare & Medicaid (CMS) Memo (QSO 20-38-NH), review of the facility Infection Surveillance Plan, review of the facility memo Process and Approach Strategy for Mandatory COVID-19 Testing in Nursing Homes, review of a facility investigative summary and staff interview, the facility failed to ensure COVID-19 testing was completed as required. This resulted in Immediate Jeopardy on 10/13/20 when the facility failed to ensure resident specific accurate COVID 19 testing was done for 35 residents on the Mandel 3 Unit resulting in inaccurate results when Director of Nursing (DON) #600 and Assistant Director of Nursing (ADON) #605 failed to collect samples from the affected residents and submitted false samples to the laboratory. This falsification in testing, done by DON #600 and ADON #605 placed the facility in a situation which delayed identification of COVID-19 positive results and had the potential to delay proper infection control measures to prevent the spread of COVID 19. Upon re-testing on 10/17/20, 22 residents, many of whom displayed symptoms, tested positive. Swift identification of confirmed COVID-19 cases allows the facility to take immediate action to remove exposure risks to nursing home residents and staff. The lack of

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effective and accurate COVID-19 testing practices during a COVID-19 outbreak in the facility placed all 183 residents at risk for the likelihood of harm, complications and/or death. This affected 35 residents, #3, #16, #23, #29, #40, #41, #42, #45, #50, #54, #71, #76, #78, #80, #91, #96, #103, #104,#106, #111, #113, #116, #120, #121, #130, #133, #145, #147, #150, #155, #157, #169, #174, #175, #176 residing on the Mandel 3 and had the potential to affect all 183 residents residing in the facility. The facility census was 183.

On 11/04/2020 at 12:22 P.M. the Interim Administrator, Infection Preventionist #301, Interim Director of Nursing (DON) and Assistant Director of Nursing (ADON) were notified that the Immediate Jeopardy began on 10/13/20 when DON #600 and ADON #605, who are no longer employed by the facility, failed to collect samples for COVID-19 from residents on the Mandel 3 unit and submitted false samples to the laboratory which delayed identification of COVID-19 positive results and had the potential to delay proper infection control measures to prevent the spread of COVID 19.

The Immediate Jeopardy was removed on 10/31/20 when the facility implemented the following corrective action:

On 10/13/20 COVID-19 testing was to be completed in the facility due to a current outbreak. This testing included testing of 35 residents on Mandel 3 unit. On 10/14/20 tests returned negative for all residents but one from this unit. However, residents on this unit began/continued to exhibit symptoms of COVID-19.

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On 10/13/20 Licensed Practical Nurse (LPN) #200 reported concerns to Unit Manager Registered Nurse (RN) #305 related to the COVID-19 testing done on 10/13/20 on the Mandel 3 unit. The LPN indicated she did not believe the staff responsible for the testing (DON #600 and ADON #605) had been on the unit to complete the testing, but yet testing specimens were sent to the laboratory.

On 10/17/20 COVID-19 testing completed in the facility for all residents, including the residents on the Mandel 3 unit as part of the facility COVID-19 outbreak testing cadence revealed 22 residents (who had tested negative on 10/13/20) who resided on the Mandel 3 unit had tested positive.

On 10/19/20, per the facility investigative summary report, LPN #200 reported to Administrator #400 a concern with the COVID-19 testing done for the residents on the Mandel 3 unit on 10/13/20. The concern was reported to Compliance Officer #500 and an investigation was initiated at that time.

On 10/22/20 Administrator #400, DON #600 and ADON #605 were suspended pending result of the investigation.

On 10/22/20, a new Interim Administrator and Infection Preventionist #301 were assigned to the facility.

On 10/23/20, the members of the Ohio Department of Health (ODH) Strike team and Cuyahoga County Local Health Department (CCPH) initiated baseline resident and staff testing at the facility. Residents and staff were

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tested by CCPH team and nurses.

On 10/23/20 an Interim DON was assigned to the facility.

As of 10/27/20 the facility investigation was still on-going but contained evidence DON #600 and ADON #605 had not obtained COVID-19 testing specimens from the 35 residents on Mandel 3 on 10/13/20 and that the testing specimens sent to the laboratory on that date had been falsified.

On 10/27/20 Administrator #400, DON #600 and ADON #605 were terminated from employment. The Board of Executives of Long-Term Services and Supports (BELTSS) and the Ohio Board of Nursing were notified of the incident by the facility.

On 10/27/20 the facility obtained the services of two expert consultant infection preventionists (IPs) with a plan for one to be onsite on 10/28/20. The plan was for the IPs to conduct an infection control self-assessment and building tour, develop and implement recommendations based on the assessment and other information related to this investigation. In addition, the IPs would develop staff educational programs based on their review and findings.

On 10/29/20, an Ad Hoc Quality Assurance (QA) meeting was held with the Interim Administrator, Interim DON, the facility Media Employee and additional department heads to discuss the facility plan and plan for in-servicing staff. Although not present for the meeting, the medical director was contacted and updated with the facility plan.

On 10/29/20 a letter from the President and Chief

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Executive Officer (CEO) was issued to all residents and families regarding the falsification of testing done in the facility.

On 10/30/20 Infection Preventionist #301 and Staff Development Nurse #305 provided staff education via handouts. Materials included COVID-19 exposure and symptoms; COVID-19 prevention (hand hygiene, social distancing, staying home when sick); how to apply and remove PPE, and on the following policies: Isolation Precautions; Applying and removing a mask; PPE and Disinfection; Admitting, Readmitting, Room Changing, and Quarantine; Admitting Clients Previously Positive for COVID-19; Prevention of Infection Transmission during Aerosolized Treatments. As of 11/09/20 Staff Development Nurse #305 revealed of the facility 300 employees, 141 employees had acknowledged the training materials.

On 10/30/20 Infection Preventionist #301 and Staff Development Nurse #305 provided infection control binders at five nursing stations (Myers 1, 2 and 3 and Mandel 2 and 3) for staff to review. The binders included the facility coronavirus policy, which included how to identify potentially infected patients and on obtaining a proper swab sample to test for COVID-19. As of 11/09/20 Staff Development Nurse #305 revealed of the facility 300 employees, 79 employees had acknowledged the training materials. Staff Development Nurse #305 revealed she was in the process of following up with this training as she believed some staff had reviewed the training materials but had not yet acknowledged it. A plan was in place for the status of each employee's education to be determined upon arrival to the facility during COVID-19 screening, any employee

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working who had not acknowledged the above training materials, would do so at that time. This plan would continue until all staff had reviewed the training materials.

On 10/30/20 a plan for Infection Preventionist #301, the ADON and the Interim DON to audit nurses obtaining COVID test samples to ensure they were obtained appropriately, staff compliance with use of PPE, patient assessments for COVID symptoms, and hand hygiene was initiated. The facility indicated the audits would be completed daily with no end date provided.

Although the Immediate Jeopardy was removed on 10/31/20, the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was still in the process of implementing their corrective actions and monitoring to ensure on-going compliance.

Findings include:

Review of the facility survey history revealed on 10/19/20 a complaint survey and COVID 19 Focused Infection Control survey were completed which identified concerns related to the facility's failure to maintain self-quarantine precautions and proper hand hygiene to prevent the spread of COVID-19.

Review of the Centers for Medicare and Medicaid Services (CMS) Quality Safety and Oversight (QSO) Memo 20-38-NH, dated August 26, 2020 revealed guidance to nursing homes related to COVID-19 testing. The memo included the

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following information: On August 25, 2020, CMS published an interim final rule with comment period (IFC), CMS-340- IFC, entitled Medicare and Medicaid Programs, Clinical Laboratory Improvement Amendments of 1988 (CLIA), and Patient Protection and Affordable Care Act; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency". CMS's recommendation at this time was to test with authorized nucleic acid or antigen detection assays as an important addition to other infection prevention and control (IPC) recommendations aimed at preventing COVID-19 from entering nursing homes, detecting cases quickly, and stopping transmission. Swift identification of confirmed COVID-19 cases allows the facility to take immediate action to remove exposure risks to nursing home residents and staff. CMS has added this requirement at 42 CFR § 483.80(h) which requires that the facility test all residents and staff for COVID-19.

The QSO memo also included the following information: Collecting and handling specimens correctly and safely is imperative to ensure the accuracy of test results and prevent any unnecessary exposures. The specimen should be collected and, if necessary, stored in accordance with the manufacturer's instructions for use for the test and CDC guidelines.

Review of the facility census revealed on 10/13/20 there were 35 residents, Resident #3, #16, #23, #29, #40, #41, #42, #45, #50, #54, #71, #76, #78, #80, #91, #96, #103, #104,#106, #111, #113, #116, #120, #121, #130, #133, #145, #147, #150, #155, #157, #169, #174, #175, #176 residing on the Mandel 3 unit and two additional residents, Resident #7 and #74 who were

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hospitalized related to Covid-19.

During the onsite investigation, beginning on 10/29/20 at 11:40 A.M. review of a resident list provided by Infection Control Preventionist #301 revealed there were currently confirmed cases of COVID-19 in the facility. The facility identified seven current residents, Resident #29, #103, #121, #150, #155, #158 and #178 who were in isolation after testing positive for COVID-19 and two current residents, Resident #62 and #171 currently in insolation after exhibiting signs/symptoms of COVID-19. Of the 183 residents currently residing in the facility, 27 additional residents had tested positive for COVID-19 and were considered to be recovered as of this date. Of the residents who had tested positive for Covid-19 six residents, Resident #3, #25, #96, #145, #147 and #174 remained hospitalized related to Covid-19. Three residents, Resident #130, #175 and #178 expired from Covid-19 related symptoms.

On 10/29/20 at 12:00 P.M. interview with the Interim Administrator revealed she had only been in her role at the facility since 10/22/20. At the time of the interview, the Interim Administrator revealed the facility had an ongoing investigation into an allegation of falsification of COVID-19 testing associated with residents residing on the facility Mandel 3 unit. The Interim Administrator revealed the situation began when LPN #200 brought concerns to the former Administrator (Administrator #400) and facility Compliance Officer #500 that COVID-19 testing supposedly performed by the previous DON (DON #600) and previous ADON (ADON #605) on 10/13/20 was not done and the swabs submitted to the laboratory for testing were falsified.

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The Interim Administrator further explained the nurse managers were typically responsible for swabbing residents for COVID-19 testing on their units and if there was no nurse manager for that particular unit, the DON or ADON would do the swab testing. The Interim Administrator revealed in the situation of the 10/13/20 testing, DON #600 and ADON #605 allegedly swabbed 35 residents on Mandel 3 Unit, labeled the swabs and sent the swabs into the laboratory per the facility normal process. The Interim Administrator revealed at that time, on the Mandel 3 Unit, there were residents who were symptomatic for COVID-19. The Interim Administrator revealed LPN #200 voiced concerns to Administrator #400 and facility Compliance Officer #500 regarding medical record documentation that indicated DON #600 and ADON #605 had swabbed 35 residents on the Mandel 3 unit for COVID-19 on 10/13/20 at approximately 4:00 A.M. that morning. The Interim Administrator indicated LPN #200 was suspicious because she had only briefly seen these staff on the unit and indicated it would have been difficult for them to perform testing on 35 residents and not been seen entering or exiting any of the resident rooms. The Interim Administrator revealed once LPN #200 took her concerns to Administrator #400 and Compliance Officer #500, a facility investigation began. The Interim Administrator revealed Compliance Officer #500 was conducting an ongoing investigation into the incident and could provide additional information.

Review of the facility Summary Investigative Report, completed by Administrator #405, dated 10/27/20 revealed on 10/19/20 it was reported by Administrator #400 that a nurse (LPN #200) on

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the Mandel 3 unit reported to him that she was concerned regarding whether the 10/13/20 COVID-19 testing for the residents on that unit were actually obtained by DON #600 and ADON #605. The summary revealed DON #600 and ADON #605 came to the facility early in the morning (approximately 5:00 A.M.) to complete outbreak testing, but LPN #200 indicated she did not observe them going into any resident rooms.

The summary report revealed an interview with Administrator #400 done by Compliance Officer #500 revealed when the allegation was made to him on 10/19/20 he reported it to Administrator #405 and Vice President of Human Resources #700 and denied any knowledge of the issue. Administrator #400 also reported he watched the hall (video) tapes for the time in question and did not observe DON #600 or ADON #605 go into any resident rooms. Administrator #400 was interviewed again on 10/21/20 and admitted at that time that he was aware the testing was not performed on Mandel 3 residents on 10/13/20, even though the test swabs for the Mandel 3 residents were delivered to the laboratory and showed negative results. Administrator #400 revealed he was informed by DON #600 and ADON #605 "not to worry" that they would all be negative ("and they winked indicating that the swabs were not obtained for the residents") and further admitted he told DON #600 and ADON #605 to send the swabs to the lab, knowing the actual tests had not been performed on the Mandel 3 residents.

Continued review of the summary report revealed information from Unit Manager RN #305 that LPN #200 had actually reported concerns to her on 10/14/20 that she did not believe any of the

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residents (on Mandel 3) were tested (on 10/13/20) and that staff and families were suspicious of this.

As a result of the testing samples sent to the laboratory on 10/13/20, from the testing completed by DON #600 and ADON #605 the following COVID-19 test results were obtained: 33 negative (Resident #3, #16, #23, #29, #40, #41, #42, #45, #50, #54, #71, #76, #78, #80, #91, #96, #103, #104, #106, #113, #116, #120, #121, #130, #133, #145, #147, #150, #155, #157, #169, #174, #175), one positive (Resident #176) , two residents with no test provided (hospitalized residents #70 and #74) and one resident whose specimen leaked (Resident #111) for a total of 37 residents. The facility investigation revealed Unit Manager RN #305 had obtained the specimen from Resident #176.

On 10/17/20 testing samples sent to the laboratory for the residents residing on the Mandel 3 unit revealed the following results: Nine negative, 22 positive (Resident #3, #16, #23, #40, #41, #45, #50, #54, #71, #78, #91, #104, #106, #111, #116, #120, #121, #130, #133, #147, #174 and #175), five residents with no test provided and one that indicated "specific incorrect" for a total of 37 residents.

On 10/29/20 the facility President and Chief Executive Office (CEO) issued a letter to residents and family members. The letter was titled Re: Important Update: COVID-19 Testing at Montefiore. The letter included the following communication:

"In mid-October, a number of Montefiore residents in one of our units began exhibiting

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symptoms of COVID-19. Tests were conducted, but the results were negative. After rerunning the tests, several residents tested positive. Fearing that we might be facing a widespread outbreak on our campus, we immediately called in resources from throughout the county and the state to assist us. We were able to retest all the residents in question, confirm positive diagnoses in 34 residents and transfer them to a separate unit for special care".

"As we were addressing this situation, we also began investigating information provided by a member of the nursing staff in the affected unit, who alerted her manager as well as Human Resources that the original tests might not have been conducted appropriately. I am very sorry to report that after conducting a number of interviews with staff, confirming lab results and reviewing patient records, our investigator concluded that Montefiore's Director of Nursing and the Assistant Director of Nursing actually submitted false tests, thereby failing to follow official protocols and procedures related to COVID-19 and failing to follow nursing standards of practice as it related to conducting the tests. I am also sorry to tell you that Montefiore's Administrator failed to oversee the situation appropriately" ... "In this case, these three individuals clearly failed to meet that standard. They violated the values that are at the core of our organization and we've terminated their employment".

On 11/03/20 at 11:45 A.M. interview with Compliance Officer #500 revealed the facility had an ongoing investigation related to the COVID-19 testing on the Mandel 3 unit on 10/13/20 at this time. Compliance Officer #500 revealed she had

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conducted interviews with the staff involved and the investigation was currently being conducted on a "different level". Compliance Officer #500 revealed LPN #200 had notified her nurse manager (RN #305) and then Administrator #400 and then Administrator #400 notified Administrator #405 (the Administrator of a sister facility) who notified her. She stated this all happened very quickly. Compliance Officer #500 reiterated similar information as the Interim Administrator and then stated she did not know if Administrator #400, DON #600 or ADON #605 ultimately admitted to any wrongdoing but after she obtained interviews from them, there were mostly cohesive statements from those involved with the exception of variations from DON #600 and ADON #605. She said the statements were detailed and substantiated the concerns. Compliance Officer #500 revealed there had been video footage in the facility from 10/13/20, but she did not view any of it.

On 11/03/20 at 12:05 P.M. attempts to interview Unit Manager RN #305 were unsuccessful as the RN was off work due to illness.

On 11/03/20 at 7:00 P.M. interview with LPN #200 revealed she worked on the Mandel 3 unit on 10/13/20 from 7:00 P.M. until 7:00 A.M. LPN #200 indicated Tuesdays were the regular COVID-19 testing days for residents. LPN #200 indicated on 10/13/20 there were residents on the Mandel 3 Unit showing signs/symptoms of COVID-19 who had been placed in isolation. LPN #200 stated on 10/13/20 between 4:45 A.M. and 5:00 A.M., she observed DON #600 and ADON #605 in Unit Manager RN #305's office gathering COVID-19 testing supplies. DON #600 and ADON #605 indicated they would be

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performing resident testing on the unit. LPN #200 stated she observed DON #600 and ADON #605 on the unit for approximately 30 minutes before they left. LPN #200 indicated she did not observe either staff enter or exit any resident rooms. LPN #200 indicated Unit Manager RN #305 came onto the unit at approximately 6:00 A.M. and asked LPN #200 for assistance swabbing Resident #176. LPN #200 stated she asked Unit Manager RN #305 if they were going to test all of the residents. LPN #200 indicated the unit manager responded DON #600 told her she and ADON #605 had already done the testing for the other 34 residents on the unit and only one resident (Resident #176) remained to be done. LPN #200 stated she voiced her concern to Unit Manager RN #305 that she had not seen DON #600 and ADON #605 perform any testing that morning. Unit Manager RN #305 then confirmed she was told testing of the residents had been done. LPN #200 stated she continued to be concerned about the validity of the testing after test results were returned indicating all residents tested by DON #600 and ADON #605 had tested negative for COVID-19 although residents were showing signs and symptoms (of COVID-19). LPN #200 again indicated she voiced her concerns to Unit Manager RN #305 who then obtained an order on 10/15/20 to have nine residents showing signs/symptoms tested for influenza as well as COVID-19 and stated some of these results came back positive for COVID-19. LPN #200 indicated the remaining residents and staff were tested on 10/17/20 and on 10/20/20 with more results starting to come back positive. LPN #200 indicated she then contacted the facilities sister facility and received a call back from a Human Resources employee. LPN #200 also stated she had voiced her concerns to Administrator #400

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who thanked her and indicated someone from Human Resources would be contacting her.

Review of facility policy titled Infection Surveillance Plan, revised December 2019, indicated the Infection Preventionist conducts ongoing surveillance for Healthcare Associated Infections (HAI), Community Acquired Infections (CAI), and other epidemiologically significant infections that have a substantial impact on potential resident and patient outcomes and that may require transmission-based precautions and other preventative interventions, to guide appropriate interventions and to prevent future infections. Residents and patients are monitored for signs and symptoms that suggest an infection, according to current criteria of infections, and are to document and report suspected infections to the Charge Nurse immediately. The Charge Nurse notifies the Attending Physician or Practitioner who determines if laboratory tests are indicated, and whether precautions are warranted. The Infection Preventionist determines if the infection is reportable to the (State Agency) or local agencies. The Attending Physician and interdisciplinary team determines the treatment plan for the resident or patient.

Review of a facility memo, titled Process and Approach Strategy for Mandatory COVID-19 Testing in Nursing Homes, dated 06/16/20, revised 08/05/20 and revised "August 31, 2021" revealed effective May 27, 2020, all nursing home facilities are subject to the Ohio Department of Health (ODH) Director's Order and Guidelines for Testing of Nursing Home Residents and Staff. The memo also included testing language from CMS QSO-20-38-NH. The memo included that the facility meets the requirements of the order by

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