STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 A COVID-19 Focused Infection Control Survey and two (2) Complaint Investigation (CI), CI MS #17301 and CI MS #17496 was conducted by the State Agency (SA) on 1/19/21 through 1/23/21. During the survey, the facility was found to not be in compliance with infection control regulations and had not implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Deficiencies were cited at F 880, F882, and F865. The SA identified an Immediate Jeopardy (IJ) that began on 1/19/21, when the facility failed to follow the Infection Control guidelines by not donning Personal Protective Equipment (PPE) before entering COVID-19 positive rooms and observation rooms, not wearing face mask correctly, not disinfecting medical equipment before leaving a COVID-19 positive hall, not washing hands in resident rooms, or using hand sanitizer before exiting, having laundry on the floor at entrance of laundry room and COVID-19 positive resident room door not being closed. The facility also failed to have an Infection Control Preventionist on staff who had completed specialized training in Infection Prevention and Control prior to SA entering the facility and failed to implement and maintain an effective Quality Assurance and Performance Improvement (QAPI) program to focus on the facilities three (3) COVID-19 outbreaks. The facility had a total of 89 residents and 68 staff tested positive for COVID-19. The facility had a total of nine (9) deaths from 11/1/20/ thru 1/17/21.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/18/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1	F 000		

The facilities failure to follow Infection Control guidelines, have an Infection Control Preventionist on staff, and implement an effective QAPI program placed all residents at risk, in a situation that was likely to cause serious harm, injury, impairment, or death.

On 1/21/21, at 11:35 AM, the SA notified the Administrator of the Immediate Jeopardy (IJ) and the IJ template was provided to the Interim Administrator.

The IJ existed at:
42 CFR(s): 483.80(a)(1)(2)(e)(f)-Infection Prevention and Control (F880)
42 CFR(s): §483.80(b)(4)(c)- Infection Preventionist (F882)
42 CFR §483.75 (a)(1)(b)(1)(2)(3)(f)(1)(2)(3)(4)(5)(6)(i)-Quality Assurance and Performance Improvement (QAPI) program (865)

The facility submitted an acceptable Removal Plan on 1/22/21 in which they alleged all corrective actions to remove the IJ were completed on 1/22/21 and the IJ was removed on 1/22/21.

The SA validated the facility's Immediate Jeopardy Removal Plan on 1/23/21 and determined the IJ was removed on 1/22/21 prior to the exit on 1/23/21. Therefore, the scope and severity for 42 CFR(s) 483.80(a)(1)(2)(e)(f)-Infection Control (F880), 42 CFR(s) §483.80(b)(4)(c)- Infection Preventionist (F882), and 42 CFR §483.75 (a)(1)(b)(1)(2)(3)(f)(1)(2)(3)(4)(5)(6)(i)-QAPI (F865) were lowered from "L" to a scope and severity of a "F" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure

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F 000	Continued From page 2 the facility sustains compliance with regulatory requirements. CI #17301 was not substantiated for medical records (accident report) not being released to resident representative. CI #17496 was not substantiated for neglect. The census at the time of the survey was 75 with a license for 105.	F 000		
F 865 SS=L	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to provide documented evidence that it has, through its Quality Assurance and Performance Improvement (QAPI) Program, failed to call	F 865	Quapi Program/Plan, Disclosure/Good Faith Attempt *The Quality Assurance Performance Improvement (QAPI) Program was	3/9/21

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F 865	Continued From page 3 meetings to review and analyze data regarding the three (3) COVID-19 outbreaks within the facility in an effort to prevent the continued spread of COVID-19 prior to the State Agency (SA) entering the facility on 1/19/21, for a COVID-19 survey. This had the potential to affect 75 of 75 residents in the facility. The failure of the facility to utilize the QAPI program to determine the root cause of the COVID-19 outbreaks and identify deficient practices was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) which began on 1/19/2021, when the SA entered the facility and identified the failure of the facility's QAPI Committee to meet, review, and analyze data to develop corrective actions to decrease the spread of COVID-19. The facility's Interim Administrator was notified of the IJ on 1/21/2021. An acceptable, credible Removal Plan was provided on 1/22/2021, in which the facility alleged all corrective actions were completed on 1/21/2021, and the IJ was removed on 1/22/2021. The State Agency validated the Removal Plan on 1/23/2021 and determined the IJ was removed on 1/22/2021, prior to exit. Therefore, the scope and severity for 42 CFR §483.75 (a)(1)(b)(1)(2)(3)(f)(1)(2)(3)(4)(5)(6)(i) was lowered from a "L" to a "F", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:	F 865	implemented and root cause analysis was conducted on 1/21/2021 for three (3) Covid-19 outbreaks and failure to implement a QAPI program in the facility. **All residents are at risk for this same deficient practice. ***Starting 1/26/2021 quality assurance (QA) nurse will conduct and maintain QAPI meetings and direct performance and improvement plan. Staring on 2/9/2021 the administrator and director of nursing will monitor the progress and completion of plans. A QAPI program book will be kept in the quality assurance office; the book will be comprised of attendance report sheets, progress of performance improvement plans and implementation of programs set forth starting 1/26/2021. ****To ensure improvements are sustained, starting 2/9/2021, the QA nurse will review QAPI plans with the administrator, director of nursing and medical director during the monthly QA meeting. This monitoring will start on 2/9/2021. QA committee will review findings and make recommendations and changes as needed, but no less than annually. The QAPI committee will meet beginning 1/26/2021, once weekly for one (1) month, then bi-monthly for three (3) months, then monthly for six (6) months, then quarterly	

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F 865	Continued From page 4 The facility's policy, "Quality Assurance and Performance Improvement", dated 02/28/2018, states, "It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life." On 1/21/21, at 9:40 AM, in an interview with the Interim Director of Nursing (IDON), she stated the purpose of a QAPI committee is to provide organization of information and understanding of the situation. She stated that they should have had a QAPI meeting to discuss COVID-19. On 1/21/21, at 9:57 AM, in a phone interview with the Administrator, she stated that a QAPI meeting is on a list of things to do. We have discussed COVID-19, but not held a QAPI meeting. She stated the importance of a QAPI meeting is to get to the root cause of the problem and fix them or correct it to the best of their ability. She stated the facility can benefit from the QAPI meeting by finding out why things keep happening and make them better for the residents. She stated the facility would benefit from having QAPI meetings to discuss COVID-19. On 1/21/21, at 10:23 AM, in an interview with Medical Director, he stated that they have talked about having a QAPI meeting to discuss COVID-19, but they have not had one yet. He stated that he feels that it is important to have QAPI meetings to discuss COVID-19. He further stated they are planning to have a QAPI meeting at the facility soon. On 1/19/2021, at 4:35 PM, in an interview with	F 865	and as needed.	

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F 865	Continued From page 5	F 865		

Licensed Practical Nurse/Quality Assurance Nurse (LPN)#1, she stated that they have not had any Quality Assurance and Improvement (QAPI) committee meetings about COVID-19. She stated, the last QAPI meeting was about admissions and was on 11/19/2020. She stated that she understands the purpose of meetings is to discuss what is working and what is not working. Then the committee should plan ways to monitor identified issues for a certain amount of time to determine if a new policy is needed. She stated she is responsible for organizing the QAPI meetings, but every time that she has tried to plan a meeting to discuss COVID-19, staff were unavailable to attend the meetings.

On 1/21/2021, at 4:45 PM, the (IDON) stated we have not done a root cause analysis related to COVID-19. She stated that we monitor situations and identify a problem and then we just try to figure out how to fix it.

A record review of the facility's most recent QAPI committee meeting, dated 11/19/2020, revealed that the meeting was held to discuss the facility's admission process. Upon review of the previously held QAPI meetings, there was no mention of COVID-19.

The facility provided an acceptable Removal Plan on 1/22/21. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan
Immediate Jeopardy (IJ) called on 01/21/2021 at 11:35 AM. The State Agency notified the Interim Administrator that an IJ had been identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 865	Continued From page 6	F 865		

The facility failed to provide a certified Infection Preventionist who had completed specialized training in infection prevention and control to follow infection control guidelines prior to State Agency entering the facility on 01/19/2021. The facility failed to follow infection control guidelines to prevent the spread of COVID-19 due to the failure to don Personal Protective Equipment (PPE) before entering COVID-19 positive and observation resident rooms and proceeding to enter unexposed residents' rooms, performing hand hygiene following resident care, disinfection of medical equipment upon exiting a COVID-19 positive room, and by causing contamination of laundry by allowing it to come in contact with the floor. The facilities Quality Assurance and Performance Improvement (QAPI) Committee failed to put forth good faith attempts to identify the root cause of three different COVID-19 outbreaks and identify corrective actions to prevent further spread of COVID-19 cases and thereby decrease the likelihood for additional COVID-19 cases and deaths.

Corrective Action:

1. The facility immediately disinfected the contaminated equipment in addition to all other potentially contaminated equipment in the facility upon notification of deficiency on 1-21-2021. The facility's Infection Preventionist immediately reviewed the documentation of the residents' signs and symptoms log for COVID-19 exhibited over the last 48 hours on 1-21-2021. The facility began receiving the results from Polymerase Chain Reaction (PCR) testing that was conducted on 48 residents on 1-19-2021. Of the 48 residents tested lab results revealed that nine (9) additional residents tested positive and 39 were negative.

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F 865	Continued From page 7	F 865		

The facility employees were tested on 1-18-2021 using rapid test and eight (8) staff members tested positive. On 1-20-2021 five (5) staff members were questioned at the screening desk and were tested due to being symptomatic and all five (5) tested positive. All remaining employees were tested on 1-21-2021 with one (1) dietary staff member testing positive.

2. The facility's Infection Preventionist, the acting interim Director of Nursing (DON)/Registered Nurse (RN) #1, completed the required modules and passed the Infection Preventionist specialized training after State Agency had entered the building on January 19, 2021 at 1:00 PM and presented certificate to the State Agency on January 19, 2021 at 1:30 PM. On January 21, 2021, the facility was in possession of the following PPE: 3,035 N-95 masks; 1,840 surgical masks; 1,800 face shields; 2800 gowns; 1,900 bouffant cap; and gloves 8,500.

3. The Infection Preventionist reviewed all testing procedures and the results of the test that had been completed. The facility started in-service training with all employees of the facility that were currently working on January 21, 2021 at 2:00 PM. The training was initiated by the Interim Administrator, Licensed Practical Nurse (LPN) #4, RN #4, and LPN #5. The working staff members were in-serviced on the following: hand hygiene, soiled linen handling, storage of soiled linen, cleaning and disinfecting of resident care equipment and the donning and doffing of Personal Protective Equipment (PPE). A total of 22 employees were in-serviced: two (2) RN's, six (6) LPN's, eight (8) Certified Nursing Assistants (CNA), one (1) maintenance, four (4)

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F 865	Continued From page 8	F 865		

housekeeping/laundry agency staff members, and one (1) administrative staff were completed at 3:20 PM. The facility will not allow any employee to work until they have completed all the in-services on the CDC Guidelines of appropriately donning and doffing PPE when entering and exiting isolation and observation rooms, appropriate hand hygiene, appropriate disinfection of medical equipment, and appropriate handling of laundry in the facility to prevent the spread of COVID-19 and other potential infectious diseases.

4. The facility on January 21, 2021 at 12:45 PM, held a QAPI committee meeting. The interim Administrator, RN #1, RN #4, LPN #1, LPN #4, LPN #5 Housekeeping Contractor #3, Dietary #1 and Maintenance #4 were all in attendance. The Medical Director and Administrator attended via telephone conference. The committee discussed the deficient performance in the facility which are the following: failure to provide a certified Infection Preventionist, failure to don PPE before entering COVID-19 positive rooms and observation resident rooms, performing hand hygiene following resident care, disinfection of medical equipment upon exiting a COVID-19 positive room, and by causing contamination of laundry by allowing it to come in contact with the floor. After the information provided by the State Agency was discussed and reviewed, it was determined that the root cause of the facility's deficient practice stemmed from the facility's failure to follow the policies regarding the surveillance and tracking and trending of COVID-19 and other infectious diseases. The QAPI Committee discussed and developed a plan to correct and monitor all deficient practices. Recommendations were made for Quality

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F 865	Continued From page 9 Assurance (QA) to monitor and implement all CDC approved training to bring into compliance all facility staff and contracted services. It is the responsibility of the QA nurse, administrative nurses, charge nurses, interim DON/ Infection Preventionist and interim Administrator to visually monitor and audit staff every shift daily for three weeks on the following: hand hygiene, soiled linen handling, storage of soiled linen, cleaning and disinfecting of resident care equipment, donning and doffing of personal protective equipment. The QAPI committee will reconvene on January 26, 2021 at 9:30 AM, to further develop the facility's long term plan to improve infection prevention through auditing, staff education, and modifications of policies and procedures to ensure evidence-based practice are followed within the facility. 5. The facility alleges that all corrective actions are completed on 1-21-21 and the IJ was removed on 1-22-21.	F 865		
F 880 SS=L	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:	F 880		3/9/21

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F 880	Continued From page 10 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 11 §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, staff interviews, record reviews, and policy reviews, the facility failed to follow the guidelines of the Center for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility failed to follow infection control guidelines by not donning Personal Protective Equipment (PPE) before entering COVID-19 positive rooms and observation rooms, not wearing face mask correctly, not disinfecting medical equipment before leaving a COVID-19 positive hall, not washing hands in resident rooms, or using hand sanitizer before exiting, laundry on the floor at entrance of laundry room and COVID-19 positive resident room door not being closed. The facility had 97 residents and 68 staff to test positive for COVID-19. The facility had a total of nine (9) deaths related to COVID-19 from 11/1/21 through 1/20/21. These deficient practices had the likelihood to affect 75 of 75 residents who currently reside in the facility. The facility's failure to ensure that the recommended guidelines set by the CDC practices to prepare for COVID-19 for Infection	F 880	Infection Prevention and Control *A Quality Assurance Performance Improvement (QAPI) meeting was held 1/21/2021 for three (3) Covid-19 outbreaks and failure to comply with infection prevention and control procedures and a plan to correct deficient practices was started on 1/26/21. An infection in-service education program was started by Quality Assurance nurse, Minium Data Set (MDS) nurse and Administration on 1/21/2021 at 1425 and will end on 03/01/2021 for all current facility staff, addressing donning/doffing personal protective equipment, isolation precautions policy, hand hygiene, cleaning and disinfection of resident equipment and soiled linen handling and storage policy. License Practical Nurse (LPN) #1, Health screener #2, Certified Nursing Assistant (CNA) #1, Register Nurse (RN) #3, LPN #2, CNA #3, RN #2 and Laundry	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 12 Control were followed placed all residents at risk, and in a situation that was likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) which began on 1/19/21 when observations of non-compliance with Infection Control occurred. The facility's Interim Administrator was notified of the IJ on 1/21/21, at 11:35 AM. The facility provided an acceptable Removal Plan on 1/22/21, in which the facility alleged all corrective actions were completed to remove the IJ on 1/22/21. The State Agency (SA) validated the Immediate Jeopardy Removal Plan on 1/23/21, and determined the IJ was removed on 1/22/21, prior to exit on 1/23/21. Therefore, the scope and severity for 42 CFR(s) 483.80(a)(1)(2)(e) (f)-Infection Control (F880) was lowered from a "L" to a scope and severity of a "F", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Failure to Wear PPE per Guidance: A review of the facility's policy, titled "Infection Prevention and Control Program", revised 12/26/19, revealed, "Policy: This facility has established and maintains 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. Policy Explanation and Compliance Guidelines: 4.	F 880	Department was educated on the infection control in-service education program started on 1/21/2021. The facility immediately disinfected the contaminated equipment in addition to all other potentially contaminated equipment in the facility upon notification of deficiency on 1-21-2021. The facility's Infection Preventionist immediately reviewed the documentation of the residents' signs and symptoms log for COVID-19 exhibited over the last 48 hours on 1-21-2021. The facility began receiving the results from Polymerase Chain Reaction (PCR) testing that was conducted on 48 residents on 1-19-2021. Of the 48 residents tested lab results revealed that nine (9) additional residents tested positive and 39 were negative. The facility employees were tested on 1-18-2021 using rapid test and eight (8) staff members tested positive. On 1-20-2021 five (5) staff members were questioned at the screening desk and were tested due to being symptomatic and all five (5) tested positive. All remaining employees were tested on 1-21-2021 with one (1) dietary staff member testing positive. The facility's Infection Preventionist, the acting interim Director of Nursing (DON)/Registered Nurse (RN) #1, completed the required modules and passed the Infection Preventionist specialized training after State Agency had entered the building on January 19, 2021 at 1:00 PM and presented certificate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 880	Continued From page 13 Standard Precautions: a. All staff should assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. B. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. C. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. 5. IsolationTransmission-Based Precautions: a. A resident with an infection or communicable disease shall be placed on isolation/transmission-based precautions as recommended by current CDC guidelines." A review of the facility's policy," Transmission-Based Precautions", revised 12/18/19, revealed, "Policy: It is our policy to take appropriate precautions to prevent transmission of infectious agents, based on the agents' modes of transmission. Policy Explanation and Compliance Guidelines: 1. Prompt recognition of need: a. All staff receive training on transmission-based upon hire and at least annually. .3. Contact Precautions: c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination. 4. Droplet Precautions- d. Healthcare personnel wear a mask for close contact with infectious resident." A review of the facility's policy titled, "Hand	F 880	to the State Agency on January 19, 2021 at 1:30 PM. The facility started in-service training with all employees of the facility that were currently working on January 21, 2021 at 2:00 PM. The training was initiated by the Interim Administrator, Licensed Practical Nurse (LPN) #4, RN #4, and LPN #5. The working staff members were in-serviced on the following: hand hygiene, soiled linen handling, storage of soiled linen, cleaning and disinfecting of resident care equipment and the donning and doffing of Personal Protective Equipment (PPE). A total of 22 employees were in-serviced: two (2) RN's, six (6) LPN's, eight (8) Certified Nursing Assistants (CNA), one (1) maintenance, four (4) housekeeping/laundry agency staff members, and one (1) administrative staff were completed at 3:20 PM. The facility did not allow any employee to work until the current employee had completed all the in-services on the CDC Guidelines of appropriately donning and doffing PPE when entering and exiting isolation and observation rooms, appropriate hand hygiene, appropriate disinfection of medical equipment, and appropriate handling of laundry in the facility to prevent the spread of COVID-19 and other potential infectious diseases. **All residents are at risk for this deficient practice. ***A checklist that will include "Infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 14 Hygiene Policy", undated, revealed, "Purpose: Hand hygiene is the primary means of preventing the transmission of infection. Hand hygiene refers to the use of hand washing, antiseptic hand wash, antiseptic hand rub, or surgical hand antisepsis. Policy: ...Hand washing with soap and water must be performed when: After removing gloves or gowns before and after assisting residents with meals." On 1/19/21, at 10:51 AM, in an interview with Licensed Practical Nurse (LPN) #1/Quality Assurance (QA) Nurse, her mask came down below her nose twice. LPN #1 continued to talk with SA while her face mask was below her nose. The SA asked her to pull her mask up. On 1/19/21, at 3:20 PM, in an observation and interview, Health Screener #2 was in the building without a face mask on. She stated she did not have one to put on. Health Screener #1 gave Health Screener #2 a mask to put on. Health Screener #2 stated she knew she was supposed to have a mask on. She stated, "I know it causes infection not wearing a mask, but I didn't have one." On 1/19/21, at 3:29 PM, in an interview with LPN #1/QA Nurse stated the mask is used to prevent transmission of infection. She stated not having a mask on properly or pulling it down can cause infection to spread. It could cause someone get an infection. She stated she had training on the proper way to wear a mask. She stated, "I thought the surveyor could not hear me, that is why I pulled it down." On 1/19/21, at 5:05 PM, an observation of the 300 COVID-19 Hall revealed Certified Nursing	F 880	Control In-service" that will be comprised of: CMS Covid-19 training and infection control in-service education program, to be completed for all new hires before being scheduled to work, will start on 3/1/2021. An infection control in-service education program started on 1/21/2021 and will continue for all new staff by Quality Assurance nurse, MDS nurse and Administration, addressing donning/doffing personal protective equipment, isolation precautions policy, hand hygiene, cleaning and disinfection of resident equipment and soiled linen handling and storage policy. Quality Assurance nurse and Administration began CMS targeted Covid-19 training for frontline nursing home staff on 1/21/2021 for all current staff and will be complete on 2/24/2021. CMS targeted Covid-19 training for frontline nursing home staff will be provided and required for all newly hired staff during the orientation process. All vendors entering the facility starting 2/19/21 will be required to read and comply with facility policies prior to entering the facility that will address donning/doffing personal protective equipment, infection prevention and control program, hand hygiene, cleaning and disinfection of resident equipment and soiled linen handling and storage policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 880	Continued From page 15 Assistant (CNA) #1 assisting Residents #20, #22, and #23 while not wearing PPE. CNA #1 did not have any gloves on, and she did not wash her hands before exiting resident room or use hand sanitizer on the wall in the hallway. Resident #23 tested positive for COVID-19 on 1/9/2021. Resident # 20 tested positive for COVID-19 on 1/11/21. Resident #22 tested positive for COVID-19 on 1/6/21. On 1/19/21, at 5:23 PM, an observation of the COVID-19 hall revealed CNA #2 was feeding Resident #19. The resident was on observation for COVID-19, with the door open. CNA #2 had her face mask pulled down below her nose and mouth. CNA #2 exited the room and did not wash her hands or use hand sanitizer in the hallway. On 1/20/21, at 12:00 PM, an observation of the 200 Hall revealed RN#3, LPN #2 and CNA #3 were passing out lunch trays to all residents on the 200 Hall without wearing PPE. This included Residents #6, #10, #11, #12, #13, #15, #16, #17, #18, and #19 who were on observation for COVID-19 and Residents #7, #8, #9 and #14 who were all positive for COVID-19. On 1/20/21 at 3:30PM, an observation of RN #2 entering rooms on the 200 Hall, that she entered two COVID-19 positive rooms (Residents #7 and #8) and one (1) observation room (Resident #16) without donning PPE. On 1/20/21, at 4:23 PM, in an interview with RN #2, she stated that there are two (2)-three (3) residents on the 200 Hall that are COVID-19 positive. RN#2 was unaware of which residents were positive and which were on observation. She stated that she entered observation rooms	F 880	****Starting on 1/26/2021 CMS targeted Covid-19 training for frontline nursing home staff will be maintained annually by nursing staff support team and will be reviewed during the monthly quality assurance meeting for completion. Vendors inservice will begin 2/19/2021 at 0845 and will end on 8/01/2021. Vendors inservice will be brought to the daily interdisciplinary meeting for monitoring. All new hire checklist will be monitored by QA department and findings brought to the monthly quality assurance meeting for review starting 3/2/2021. The QA nurse, admininstrative nurses, charge nurses, DON, infection preventionist and administrator will visually monitor for donning/doffing personal protective equipment, isolation precautions policy, hand hygiene, cleaning and disinfection of resident equipment and soiled linen handling and storage, began on 1/26/2021 and will continue daily for four (4) weeks, then three (3) times a week for one (1) month, then one (1) time a week for three (3) months. To ensure improvements are sustained, all monitoring will brought by the QA nurse for review at the monthly QA meeting starting on 3/2/2021 and will present the findings to the QA committee for review to make recommendations and changes as needed, monthly for six (6) months, then quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 16	F 880		

without PPE. RN #2 stated she was told that the residents had been tested and did not have COVID-19. She stated that from her knowledge as a nurse, she should have put PPE on. She stated that not putting on PPE and going from room to room can cause cross contamination. She stated the purpose of PPE is to protect herself and other residents.

On 1/20/21, at 4:36 PM, in an interview with CNA #2, she stated that they told me that we have some residents on the 200 Hall that are COVID-19 positive. They did not tell me that the other residents on the hall are on observation. They told me either the residents are positive or not positive. She stated that she should have used precautionary measures with residents on observation, because they could be positive. She stated the purpose of PPE is to protect herself from getting positive and to keep her from passing COVID-19 to residents. She stated that she pulled down her mask so that the resident could hear her, because the resident could not hear well. She stated that the resident was on observation, so by pulling down her mask she could have exposed the resident and herself to COVID-19.

On 1/20/21, at 4:52 PM, in an interview with CNA #1, she stated that all the residents have been positive for COVID-19 at one point. She stated she should have had PPE on because they have not reached their 10 days isolation period. She stated the purpose of PPE is to help prevent the spread of disease. She stated there is a possibility of spreading infection when you go from room to room without wearing PPE.

On 1/21/21, at 8:40 AM, in an interview with RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 17	F 880		

#3, she stated that she was not paying attention to what rooms she was going in during tray pass on 1/20/21. She stated that she was just grabbing trays and going into the resident's rooms to give them their tray. She stated she normally works on the 400 and 500 halls. She stated she had no idea why the other residents are on the 200 Hall. She stated if she knew that the residents were on observation, she would have fully dressed out in PPE. She stated if you do not wear PPE you could spread COVID-19. She stated if an elderly resident gets COVID-19 they could die.

On 1/21/21, at 9:00 AM, in an interview with CNA #3 regarding lunch tray pass on 1/20/21, she stated the nurses told me that the residents on the 200 Hall were on droplet precautions. She stated that droplet precautions mean, "I guess they are under observation for COVID-19". She stated that they are more likely to develop COVID-19 and she should have put on PPE. She stated that by not having PPE on, she could spread COVID-19 from room to room. She stated that the main concern is that residents getting COVID with underlying conditions could die. She stated she was just trying to get the lunch trays passed out. She stated she had to work both 100 and 200 halls today. She stated she knew that some of the residents were COVID-19 positive. She stated that the resident care is more important than getting food out.

On 1/21/21, at 9:15 AM, in an interview with LPN #2 regarding tray pass on 1/20/21, he stated that he was aware some of the residents had COVID-19. He stated yesterday was his first day working at the facility. He stated RN#3 told me four (4) of the residents were positive on the hall and the rest of the residents were negative. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 18	F 880		

stated that not putting on PPE was a mistake, and he should have put on PPE. He stated by not putting on PPE and going from room to room could cause cross contamination. He stated RN#3 did not tell him anything else about the other residents on the hall. He stated that resident's immune systems are low, and they could get COVID-19 and die. He stated that he was being oriented by RN #3.

Record review of the Residents' Face Sheets revealed the following:

Resident #6 was admitted to the facility on 11/15/19. The resident was exposed to COVID-19 on 1/11/21 and placed on observation.

Resident #7 was admitted to the facility on 9/01/16. The resident was diagnosed with COVID-19 on 1/11/21 and was placed on Droplet Precautions.

Resident #8 was admitted to the facility on 10/18/19. The resident was diagnosed with COVID-19 on 1/11/21 and was placed on Droplet Precautions.

Resident #9 was admitted to the facility on 2/10/20. The resident was diagnosed with COVID-19 on 1/11/21 and placed on Droplet Precautions.

Resident #10 was admitted to the facility on 3/30/20. Resident #10 was exposed to COVID-19 on 1/11/21 and placed on observation.

Resident #11 was admitted to the facility on 10/28/16. The resident was exposed to COVID-19 on 1/11/21 and placed on observation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 19	F 880		

Resident #12 was admitted to the facility on 5/01/20. The resident was exposed to COVID-19 on 1/11/21 and placed on observation.

Resident #13 was admitted to the facility on 1/07/21. The resident was exposed to COVID-19 on 1/11/2021 and placed on observation.

Resident #14 was admitted to the facility on 6/02/20. The resident was exposed on COVID-19 on 1/11/21 and on 1/19/21, when tested, the resident was positive for COVID-19.

Resident #15 was admitted to the facility on 12/01/20. The resident was exposed to COVID-19 on 1/11/2021 and was placed on observation.

Resident #16 was admitted to the facility on 3/27/21. The resident was exposed to COVID-19 on 1/11/21 and was placed on observation.

Resident #17 was admitted to the facility on 12/13/18. The resident was diagnosed with COVID-19 on 1/04/21 and placed on Droplet Precautions.

Resident #18 was admitted to the facility on 5/21/15. The resident was exposed to COVID-19 on 1/11/2021 was and placed on observation.

Resident #19 was admitted to the facility on 9/9/19. The resident was exposed to COVID-19 on 1/11/2021 and was placed on observation.

Resident #20 was admitted to the facility on 9/09/19. The resident was diagnosed with COVID-19 on 1/11/2021 was and placed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 20	F 880		

Droplet Precautions.

Resident #22 was admitted to the facility on 12/21/2020. The resident was diagnosed with COVID-19 on 1/06/2021 and placed on Droplet Precautions.

Resident #23 was admitted to the facility on 3/21/18. The resident was diagnosed with COVID-19 on 1/09/2021 and placed on Droplet Precautions.

Failure to Follow Infection Control Precautions:

A review of the facility's policy titled, "Cleaning and Disinfectant of Resident-Care Equipment", revised 5/19/20, revealed, "Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection."

A record review of the facility's policy, titled, "Soiled Linen Handling and Storage Policy", revised 01/06/2020, revealed, "Policy: It is the policy of this facility that linens will be handled as follows: Never placed on the floor. Clean linen should be kept covered at all times."

A review of the facility's policy titled, "Coronavirus Surveillance", dated 5/19/20, revealed, "Policy: This facility will implement heightened surveillance activities for coronavirus illness during periods of transmission in the community and/or during a declared public health emergency for the illness Policy Explanation and Compliance Guidelines: 8. The Infection Preventionist, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 21	F 880		

designee, will track the following information: d. Employee compliance with hand hygiene. e. Employee compliance with standard and transmission-based precautions. f. Employee compliance with cleaning and disinfection policies and procedures."

On 1/19/2021, at 3:00 PM, an observation revealed a large, uncovered laundry cart in the hallway next to the entrance door of the laundry department. The cart was full of clean resident positioning bolsters and heel protectors. There was a pair of blue heel protectors on the floor next to the cart along with a glove and a large amount of dust. In an interview at this time, Housekeeping Supervisor #1 stated the linen in the cart was not being used right now.

On 1/19/21, at 5:10 PM, an observation of the 300 COVID-19 Hall revealed an X-ray Technician came out of Resident #21's room, with an X-ray machine. He did not sanitize the machine before leaving the COVID-19 Hall. He went through the facility without disinfecting the X-ray machine and exited through the facility entrance. Resident #21 tested positive for COVID-19 on 1/9/2021.

On 1/21/21, at 11:20 AM, in a phone interview with the X-ray Technician #1 stated, he cleans his medical equipment before putting it in the car. He stated that going down the hall without cleaning equipment before exiting the COVID-19 Hall could cause the spread of infection. He stated he should have cleaned the medical equipment before leaving the hall.

Record review of the Face Sheet for Resident #21 was admitted to the facility on 3/24/2017. The resident was diagnosed with COVID-19 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 22	F 880		

1/09/2021 and placed on Droplet Precautions.

Failure to Follow Isolation Precautions:

A review of facility's policy titled, "Isolation Precautions", revised 12/18/2019, revealed, "It is our policy to take appropriate precautions, including isolation, to prevent transmission of infectious agents."

On 1/19/21, at 8:45 AM, an observation on the 500-Hall revealed that the door of Resident #24's room was not closed. There was a sign on the door for droplet precautions. Resident #24 tested positive for COVID-19 on 1/11/21.

On 1/19/21, at 11:22 AM, an observation of the 500-Hall revealed Resident #25's door was not closed. There was a sign on the door for droplet precautions. Resident #25 tested positive for COVID-19 on 1/11/21. At that time, LPN #4 was on the 500-Hall at the medication cart.

On 1/19/21, at 1:23 PM, in an interview, LPN #4 stated the doors needed to be kept closed to the COVID-19 positive resident's rooms under quarantine to keep the infection from spreading in the building. He stated that the doors not being closed can cause the resident's coughed droplets to get into the hallway and could spread. He stated that droplets are anything that be coughed and spread airborne, including sputum.

On 1/19/21, at 5:21 PM, an observation of the COVID-19 hall revealed that the doors of Residents #11, #12, #18, and #19, all of whom were on observation for COVID-19, were open.

Record review of the Residents' Face Sheets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 23	F 880		

revealed the following:

Resident #24 was admitted to the facility on 11/20/20. The resident was diagnosed with COVID-19 on 1/11/21 and placed on Droplet Precautions.

Resident #25 was admitted to the facility on 12/28/20. The resident was diagnosed with COVID-19 on 1/11/21 and placed on Droplet Precautions on 1/11/21.

On 1/19/21, at 3:38 PM, in an interview with Interim Director of Nursing (IDON)/Infection Control Preventionist, she stated the resident's doors should be closed when the residents are on droplet precautions. She stated that anyone passing the door can be exposed to COVID-19. She stated when staff masks are down, it defeats the purpose of wearing a mask when you pull it down. She stated you could be asymptomatic and still spread COVID-19. She stated the mask is not only to protect the staff, but it is to prevent from spreading COVID-19. She stated Health Screener #2 should have had a mask on before entering the facility. She stated by her not having a mask on it could cause infection to spread. She stated we had an in-service on PPE. She stated Health Screener #2 has been spoken to about not wearing her mask. This is not Health Screener #2's first time not wearing a mask. She stated that as of 1/19/21, they have had a total of 89 residents who have tested positive for COVID-19. The first resident tested positive was July 21, 2020. The first staff tested positive was 7/8/2020. She stated they have had a total of 63 staff tested positive as of 1/19/21. One staff expired due to COVID-19. This prompted us to do facility wide testing in July and we had three (3) staff positive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

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F 880	Continued From page 24	F 880		

for COVID-19. The IDON stated, that there were two (2) residents on the 200 COVID-19 Hall that were positive for COVID-19, the other residents were left on the 200 Hall due to exposure on 1/11/21.

On 1/21/21, at 9:40 AM, in an interview with the IDON, she stated that the staff should not have gone into COVID-19 positive rooms and residents under observation without wearing PPE. She stated that is an issue. She stated when a resident is under observation, the staff should put on PPE before entering resident's room. She stated the staff's actions can cause cross contamination. She stated the elderly have underlying health conditions that increase their chances of dying. She stated when you have COVID-19 positive and pending residents receiving care from a staff member who does not don PPE before giving care, it is an issue.

On 1/21/21, at 9:57 AM, in a phone interview with the Administrator, she stated that the reason for using PPE is to slow down the spread of COVID-19 or Influenza. She stated when a resident is placed on droplet precautions that it means that the staff should wear PPE to prevent the spread of disease. She stated if staff enter a room without PPE on, they can spread infection from room to room. She stated staff should wear a face mask when they enter the facility to prevent spreading the infection. She stated laundry on the floor is cross contamination.

On 1/21/21, at 10:23 AM, in an interview with the Medical Director (MD), he stated that he was aware of all the outbreaks of COVID-19 in the facility and that either myself or the Nurse Practitioner are in the facility daily. He stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 880	Continued From page 25	F 880		

has made changes but it has been a struggle. He stated it is hard to control. Employees have contact with their families and others and bring it in. Resident are isolated and tested if they have signs and symptoms of COVID-19 and staff are tested 2 times a week and screened for signs and symptoms. Some don't have signs and symptoms but have it and bring it in.

On 1/21/2021, at 2:30 PM, in an interview with the Administrator stated that he was only able to get three (3) of the eight (8) death certificates that the SA requested. He stated that the remainder of the death certificates were not available as they were not complete at this time.

In a record review, of a list provided by the facility revealed that nine (9) residents had expired from COVID-19 between November 1, 2020 and January 20, 2021. The record review reveals that Residents #26, #27, #28, #29, #30, #31, #32, #33, and #34 expired from COVID-19.

A record review of the last in-service revealed that the in-service on 9/14/20 included COVID, Isolation and Handwashing. The in-service was conducted by the previous DON. Review of the sign-in sheet revealed that CNA #4 attended.

The facility provided an acceptable Removal Plan on 1/22/21. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan
Immediate Jeopardy (IJ) called on 01/21/2021 at 11:35 AM. The State Agency notified the interim Administrator that an IJ had been identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 26	F 880		

The facility failed to provide a certified Infection Preventionist who had completed specialized training in infection prevention and control to follow infection control guidelines prior to State Agency entering the facility on 01/19/2021. The facility failed to follow infection control guidelines to prevent the spread of COVID-19 due to the failure to don Personal Protective Equipment (PPE) before entering COVID-19 positive and observation resident rooms and proceeding to enter unexposed residents' rooms, performing hand hygiene following resident care, disinfection of medical equipment upon exiting a COVID-19 positive room, and by causing contamination of laundry by allowing it to come in contact with the floor. The facilities Quality Assurance and Performance Improvement (QAPI) Committee failed to put forth good faith attempts to identify the root cause of three different COVID-19 outbreaks and identify corrective actions to prevent further spread of COVID-19 cases and thereby decrease the likelihood for additional COVID-19 cases and deaths.

Corrective Action:

1. The facility immediately disinfected the contaminated equipment in addition to all other potentially contaminated equipment in the facility upon notification of deficiency on 1-21-2021. The facility's Infection Preventionist immediately reviewed the documentation of the residents' signs and symptoms log for COVID-19 exhibited over the last 48 hours on 1-21-2021. The facility began receiving the results from Polymerase Chain Reaction (PCR) testing that was conducted on 48 residents on 1-19-2021. Of the 48 residents tested lab results revealed that nine (9) additional residents tested positive and 39 were negative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

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F 880	Continued From page 27	F 880		

The facility employees were tested on 1-18-2021 using rapid test and eight (8) staff members tested positive. On 1-20-2021 five (5) staff members were questioned at the screening desk and were tested due to being symptomatic and all five (5) tested positive. All remaining employees were tested on 1-21-2021 with one (1) dietary staff member testing positive.

2. The facility's Infection Preventionist, the acting interim Director of Nursing (DON)/Registered Nurse (RN) #1, completed the required modules and passed the Infection Preventionist specialized training after State Agency had entered the building on January 19, 2021 at 1:00 PM and presented certificate to the State Agency on January 19, 2021 at 1:30 PM. On January 21, 2021, the facility was in possession of the following PPE: 3,035 N-95 masks; 1,840 surgical masks; 1,800 face shields; 2800 gowns; 1,900 bouffant cap; and gloves 8,500.

3. The Infection Preventionist reviewed all testing procedures and the results of the test that had been completed. The facility started in-service training with all employees of the facility that were currently working on January 21, 2021 at 2:00 PM. The training was initiated by the Interim Administrator, Licensed Practical Nurse (LPN) #4, RN #4, and LPN #5. The working staff members were in-serviced on the following: hand hygiene, soiled linen handling, storage of soiled linen, cleaning and disinfecting of resident care equipment and the donning and doffing of Personal Protective Equipment (PPE). A total of 22 employees were in-serviced: two (2) RN's, six (6) LPN's, eight (8) Certified Nursing Assistants (CNA), one (1) maintenance, four (4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 880	Continued From page 28	F 880		

housekeeping/laundry agency staff members, and one (1) administrative staff were completed at 3:20 PM. The facility will not allow any employee to work until they have completed all the in-services on the CDC Guidelines of appropriately donning and doffing PPE when entering and exiting isolation and observation rooms, appropriate hand hygiene, appropriate disinfection of medical equipment, and appropriate handling of laundry in the facility to prevent the spread of COVID-19 and other potential infectious diseases.

4. The facility on January 21, 2021 at 12:45 PM, held a QAPI committee meeting. The interim Administrator, RN #1, RN #4, LPN #1, LPN #4, LPN #5 Housekeeping Contractor #3, Dietary #1 and Maintenance #4 were all in attendance. The Medical Director and Administrator attended via telephone conference. The committee discussed the deficient performance in the facility which are the following: failure to provide a certified Infection Preventionist, failure to don PPE before entering COVID-19 positive rooms and observation resident rooms, performing hand hygiene following resident care, disinfection of medical equipment upon exiting a COVID-19 positive room, and by causing contamination of laundry by allowing it to come in contact with the floor. After the information provided by the State Agency was discussed and reviewed, it was determined that the root cause of the facility's deficient practice stemmed from the facility's failure to follow the policies regarding the surveillance and tracking and trending of COVID-19 and other infectious diseases. The QAPI Committee discussed and developed a plan to correct and monitor all deficient practices. Recommendations were made for Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 880	Continued From page 29 Assurance (QA) to monitor and implement all CDC approved training to bring into compliance all facility staff and contracted services. It is the responsibility of the QA nurse, administrative nurses, charge nurses, interim DON/ Infection Preventionist and interim Administrator to visually monitor and audit staff every shift daily for three weeks on the following: hand hygiene, soiled linen handling, storage of soiled linen, cleaning and disinfecting of resident care equipment, donning and doffing of personal protective equipment. The QAPI committee will reconvene on January 26, 2021 at 9:30 AM, to further develop the facility's long term plan to improve infection prevention through auditing, staff education, and modifications of policies and procedures to ensure evidence-based practice are followed within the facility. 5. The facility alleges that all corrective actions are completed on 1-21-21 and the IJ was removed on 1-22-21.	F 880		
F 882 SS=L	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification;	F 882		3/9/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 882	Continued From page 30 §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews and facility policy review, the facility failed to have an Infection Preventionist on staff, that had completed specialized training in Infection Prevention and Control, prior to State Agency (SA) entering the facility on 1/19/21, for a COVID-19 survey. This had the potential to affect 75 of 75 residents in the facility. The failure of the facility to ensure that the facility had an Infection Preventionist who had completed specialized training in Infection Control, prior to SA entering the facility on 1/19/21 caused all residents to be at risk, and in a situation that was likely to cause serious injury, harm, impairment or death. . The situation was determined to be an Immediate Jeopardy (IJ) which began on 1/19/21, when the SA entered the facility. The facility Interim Administrator was notified of the IJ on 1/21/21, at 11:35 AM. An acceptable, credible Removal Plan was provided on 1/22/21 in which the facility alleged all corrective actions were completed	F 882	Infection Preventionist Qualification/Role *The Infection Preventionist training and certification was completed on 1/19/2021 at 1300, by the interim Director of Nursing (DON). **All residents are at risk for this same deficient practice. *** Starting on 1/19/2021 three (3) staff members from administration will have completed the Infection Preventionist training and certification by 4/1/2021. ****Infection Preventionist training and certification will be maintained and audited by Quality Assurance nurse. The Quality Assurance nurse will bring these findings to the monthly Quality Assurance meeting for review beginning 2/9/2021. The Quality Assurance Committee will monitor the Infection Preventionist job performance, implementation of programs, review of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 882	Continued From page 31 1/21/21 and the IJ was removed on 1/22/21. The SA validated the facility's Immediate Jeopardy Removal Plan on 1/23/21 and determined the IJ was removed on 1/22/21, prior to the exit on 1/23/21. Therefore, the scope and severity 42 CFR(s) §483.80(b)(4)(c)- Infection Preventionist (F882) was lowered from "L" to a scope and severity of a "F", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: The Facility's hiring policy, titled "Infection Prevention Nurse", undated, maintain current knowledge of federal, state, and local regulations and ensure that the facility leaders are informed of appropriate issues, understand and comply with infection control, safety and Occupational Safety and Health Administration (OSHA) procedures and regulations. On 1/19/21, at 8:35 AM, in an interview with Interim Director of Nursing (IDON)/ Infection Control Nurse, she stated she has completed the Infection Preventionist training. She stated she would go to the site and print out certificates. On 1/19/21 at 10:00AM, in an interview with the IDON/Infection Control Preventionist, she stated, "I did not know there was a final test to take for the certification. I took the test and made 74 percent out of the 100 percent." She stated she had to make 80 percent to pass the test. She stated she was not sure if the current Licensed Practical Nurse (LPN)#3/Infection Control Nurse	F 882	documentation, tracking/trending, daily rounds for infection control concerns and infection preventionist immediate in-services of any and all infection control concerns found during rounds. QA will monitor monthly and present the findings to the QA committee for review beginning 2/9/2021 and make recommendations and changes as needed for six (6) months, then quarterly and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 882	Continued From page 32	F 882		

had completed the certification.

On 1/19/21, at 12:58 PM, in an interview with IDON/Infection Control Preventionist, she stated she was the Infection Control Nurse March of 2020 through September 2020.

On 1/21/21, at 9:40 AM, in an interview with the IDON/Infection Control Preventionist, she stated the purpose of an Infection Preventionist is to control and prevent infections. She stated the role of the Infection Preventionist is to control the outbreak and identify the cause of the outbreak. She stated a nurse who has not completed all specialized training, does not have all the knowledge needed to do the job.

On 1/21/21 at 9:57 AM in a phone interview with the Administrator, she stated it is important for the Infection Control Nurse to have a certification. She stated she was not aware that the nurse had not completed the necessary training.

On 1/21/21 at 11:05 AM, in an interview with IDON/Infection Control Preventionist, she stated LPN # 3 is the current Infection Control Nurse. She has not completed the specialized training. She stated that LPN #3 is out due to COVID-19.

A record review of LPN #3/ Infection Control Nurse's Certificates of Training revealed certificates for Module one (1), Module two (2) through four (4) dated 9/20/20, Module five (5) through six A (6)dated 9/27/20, Modules 6 B and seven (7) dated 9/28/20, Modules eight (8) through ten (10) dated 10/4/20, Modules 11A through 11 D, dated 10/11/20,and Modules 12 through 15, dated 10/18/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 882	Continued From page 33	F 882		

A record review of IDON Certificates of Training revealed certificates for Module 1 dated 2/17/20, Module 2 dated 2/18/20, Module 3 dated 2/24/20, Module 4 dated 2/24/20, Module 5 dated 2/25/20, Module 6A dated 2/27/20, Module 6 B dated 3/9/20, Module 7 dated 3/12/20, Module 8 dated 3/13/20, Module 9 dated 3/16/20, Module 10A and 10B dated 3/19/20, Module 10C dated 3/20/20, Module 10 D dated 4/8/20, Module 11A,dated 4/23/20, Module11B, dated 4/24/20,Module 11C,dated 5/5/20, Module 11D dated 5/6/20, Module 12A dated 9/21/20, Module 12B,13 and 14, dated 9/23/20 and Module 15, dated 10/02/20.

A record review of the IDON/ Infection Preventionist Specialized Training Certification certificate was dated for 1/19/21.

The facility provided an acceptable Removal Plan on 1/22/21. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ:

Removal Plan
Immediate Jeopardy (IJ) called on 01/21/2021 at 11:35 AM. The State Agency notified the interim Administrator that an IJ had been identified.

The facility failed to provide a certified Infection Preventionist who had completed specialized training in infection prevention and control to follow infection control guidelines prior to State Agency entering the facility on 01/19/2021. The facility failed to follow infection control guidelines to prevent the spread of COVID-19 due to the failure to don Personal Protective Equipment (PPE) before entering COVID-19 positive and observation resident rooms and proceeding to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 882	Continued From page 34	F 882		

enter unexposed residents' rooms, performing hand hygiene following resident care, disinfection of medical equipment upon exiting a COVID-19 positive room, and by causing contamination of laundry by allowing it to come in contact with the floor. The facilities Quality Assurance and Performance Improvement (QAPI) Committee failed to put forth good faith attempts to identify the root cause of three different COVID-19 outbreaks and identify corrective actions to prevent further spread of COVID-19 cases and thereby decrease the likelihood for additional COVID-19 cases and deaths.

Corrective Action:

1. The facility immediately disinfected the contaminated equipment in addition to all other potentially contaminated equipment in the facility upon notification of deficiency on 1-21-2021. The facility's Infection Preventionist immediately reviewed the documentation of the residents' signs and symptoms log for COVID-19 exhibited over the last 48 hours on 1-21-2021. The facility began receiving the results from Polymerase Chain Reaction (PCR) testing that was conducted on 48 residents on 1-19-2021. Of the 48 residents tested lab results revealed that nine (9) additional residents tested positive and 39 were negative. The facility employees were tested on 1-18-2021 using rapid test and eight (8) staff members tested positive. On 1-20-2021 five (5) staff members were questioned at the screening desk and were tested due to being symptomatic and all five (5) tested positive. All remaining employees were tested on 1-21-2021 with one (1) dietary staff member testing positive.

2. The facility's Infection Preventionist, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 882	Continued From page 35	F 882		

acting interim Director of Nursing (DON)/Registered Nurse (RN) #1, completed the required modules and passed the Infection Preventionist specialized training after State Agency had entered the building on January 19, 2021 at 1:00 PM and presented certificate to the State Agency on January 19, 2021 at 1:30 PM. On January 21, 2021, the facility was in possession of the following PPE: 3,035 N-95 masks; 1,840 surgical masks; 1,800 face shields; 2800 gowns; 1,900 bouffant cap; and gloves 8,500.

3. The Infection Preventionist reviewed all testing procedures and the results of the test that had been completed. The facility started in-service training with all employees of the facility that were currently working on January 21, 2021 at 2:00 PM. The training was initiated by the Interim Administrator, Licensed Practical Nurse (LPN) #4, RN #4, and LPN #5. The working staff members were in-serviced on the following: hand hygiene, soiled linen handling, storage of soiled linen, cleaning and disinfecting of resident care equipment and the donning and doffing of Personal Protective Equipment (PPE). A total of 22 employees were in-serviced: two (2) RN's, six (6) LPN's, eight (8) Certified Nursing Assistants (CNA), one (1) maintenance, four (4) housekeeping/laundry agency staff members, and one (1) administrative staff were completed at 3:20 PM. The facility will not allow any employee to work until they have completed all the in-services on the CDC Guidelines of appropriately donning and doffing PPE when entering and exiting isolation and observation rooms, appropriate hand hygiene, appropriate disinfection of medical equipment, and appropriate handling of laundry in the facility to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	01/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(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 882	Continued From page 36	F 882		

prevent the spread of COVID-19 and other potential infectious diseases.

4. The facility on January 21, 2021 at 12:45 PM, held a QAPI committee meeting. The interim Administrator, RN #1, RN #4, LPN #1, LPN #4, LPN #5 Housekeeping Contractor #3, Dietary #1 and Maintenance #4 were all in attendance. The Medical Director and Administrator attended via telephone conference. The committee discussed the deficient performance in the facility which are the following: failure to provide a certified Infection Preventionist, failure to don PPE before entering COVID-19 positive rooms and observation resident rooms, performing hand hygiene following resident care, disinfection of medical equipment upon exiting a COVID-19 positive room, and by causing contamination of laundry by allowing it to come in contact with the floor. After the information provided by the State Agency was discussed and reviewed, it was determined that the root cause of the facility's deficient practice stemmed from the facility's failure to follow the policies regarding the surveillance and tracking and trending of COVID-19 and other infectious diseases. The QAPI Committee discussed and developed a plan to correct and monitor all deficient practices. Recommendations were made for Quality Assurance (QA) to monitor and implement all CDC approved training to bring into compliance all facility staff and contracted services. It is the responsibility of the QA nurse, administrative nurses, charge nurses, interim DON/ Infection Preventionist and interim Administrator to visually monitor and audit staff every shift daily for three weeks on the following: hand hygiene, soiled linen handling, storage of soiled linen, cleaning and disinfecting of resident care equipment,

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F 882	Continued From page 37 donning and doffing of personal protective equipment. The QAPI committee will reconvene on January 26, 2021 at 9:30 AM, to further develop the facility's long term plan to improve infection prevention through auditing, staff education, and modifications of policies and procedures to ensure evidence-based practice are followed within the facility. 5. The facility alleges that all corrective actions are completed on 1-21-21 and the IJ was removed on 1-22-21.	F 882		