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For-Profit Nursing Homes Received Hundreds Of Millions From Trump's Provider Relief Fund, Despite Infection Control Deficiencies

KEY POINTS:

- Since November 2017, the Trump administration has consistently deregulated and lessened fines for the nursing home industry—including its most recent push to weaken rules that required nursing homes to employ infection prevention specialists.

- Even as COVID-19 ravages nursing homes, killing at least 32,000 nursing home residents, the Trump administration has been indiscriminately sending money to nursing homes and other health care facilities with “no strings attached."

- As of June 2020, the Trump administration has allocated at least $665.37 million to nursing facilities from the provider relief fund. **At least** 18 of these nursing homes that received over $24.83 million combined were cited for multiple deficiencies by CMS over the past two years, with most of the facilities specifically having infection control deficiencies. The Trump administration's terms and conditions for the provider relief funds do not appear to mention any remedial requirements ahead of receiving funds.

The Trump Administration Deregulated The Multi-Billion Dollar Nursing Home Industry, Failed To Send Proper PPE, And Oversaw Record Deaths Then Sent Hundreds Of Millions Of Dollars To Deficient For-Profit Nursing Homes With "No Strings Attached"

Between 2017 And 2020, The Trump Administration Deregulated And Lessened Fines For The Nursing Home Industry—Including Its Most Recent Push To Weaken Rules That Required Nursing Homes To Employ Infection Prevention Specialists

November 2017: The Trump Administration Exempted Any Nursing Homes That Violated A Set Of Eight Safety Rules From Penalties For 18 Months

November 2017: New York Times: "The Trump Administration Exempted Nursing Homes That Violate Eight New Safety Rules From Penalties For 18 Months." "In November, the Trump administration exempted nursing homes that violate eight new safety rules from penalties for 18 months. Homes must still follow the rules, which are intended, among other things, to reduce the overuse of psychotropic drugs and to ensure that every home has adequate resources to assist residents with major psychological problems." [New York Times, 12/24/17]

March 2019: The Trump Administration Scaled Back The Use Of "Fines Against Nursing Homes That Harm Residents"

March 2019: The Trump Administration Scaled Back The Use Of "Fines Against Nursing Homes That Harm Residents Or Place Them In Grave Risk Of Injury." "The Trump administration is scaling back the use of fines against nursing homes that harm residents or place them in grave risk of injury, part of a broader relaxation of regulations under the president. The shift in the Medicare program's penalty protocols was requested by the nursing home industry. The American Health Care Association, the industry's main trade group, has complained that under President Barack Obama, federal inspectors focused excessively on catching wrongdoing rather than helping nursing homes improve." [New York Times, 12/24/17]

July 2019: Following A Lobbying Push, CMS Set Out To Weaken Rules That Required That Nursing Homes Employ Infection Prevention Specialists

July 2019: CMS Set In Motion A Plan To Weaken Rules Imposed By The Obama Administration That Required Every Nursing Home To Employ At Least One Specialist In Preventing Infections. "Last July, the federal Centers for Medicare and Medicaid Services, or C.M.S., set in motion a plan to weaken rules imposed by the Obama administration that required every nursing home to employ at least one specialist in preventing infections. The proposed rules — which the agency is completing and has the power to enact — eliminate the requirement to have even a part-time infection specialist on staff. Instead, the Trump administration would require that anti-infection specialists spend 'sufficient time at the facility.'" [New York Times, 03/14/20]

- **New York Times: "Infection-Prevention Specialists Are Supposed To Ensure That Employees At Nursing Homes Properly Wash Their Hands And Follow Other Safety Protocols. They Are Widely Considered The Front Line For Stopping Infections, Among The Leading Causes Of Deaths In Nursing Homes."** "Infection-prevention specialists are supposed to ensure that employees at nursing homes properly wash their hands and follow other safety protocols. They are widely considered the front line for stopping infections, among the leading causes of deaths in nursing homes. Each year, about 380,000 residents are killed by infections, according to the Medicare agency. Failure to prevent them is also the leading cause of citations that state inspectors bring against nursing homes." [New York Times, 03/14/20]

2019: CMS Weakened A Rule That "Would Have Made It Easier For Nursing Home Residents And Their Families To Sue Over Claims Of Elder Abuse, Sexual Harassment And Wrongful Death." "The agency also weakened a rule that would have made it easier for nursing home residents and their families to sue over claims of elder abuse, sexual harassment and wrongful death. 'Together these changes gut enforcement,' said Toby Edelman, a senior lawyer at the Center for Medicare Advocacy, a nonprofit legal assistance group for the elderly. 'They are a gift to the industry.'" [New York Times, 03/14/20]

New York Times: "The Administration's Moves Came After Intense Lobbying By The Nursing Home Industry, Including By The Firm Run By Brian Ballard, Mr. Trump's Friend And A Fund-Raiser." "The administration's moves came after intense lobbying by the nursing home industry, including by the firm run by Brian Ballard, Mr. Trump's friend and a fund-raiser. Parlaying his personal connections to Mr. Trump, Mr. Ballard has become one of the most powerful lobbyists in Washington, with the most clients of any registered lobbyist last year, according to an analysis by the Center for Responsive Politics. His firm has lobbied on behalf of nursing homes in his home state, Florida, for years, according to public records. (He was also a lobbyist for Mr. Trump's Florida golf course, the Doral.)" [New York Times, 03/14/20]

Between January And March 2020, Ballard Partners Spent $80,000 Lobbying, Including Long-Term Care Reform, Medicare And Medicaid Funding, And Discussions Impacting Skilled Nursing Facilities. [Ballard Partners, Q1 Lobbying Report, 04/20/20]

The Trump Administration's Deregulation Of Nursing Homes Stood To Financially Benefit The Multibillion Dollar Elder Care Industry, Especially Large Chains

Critics Claim That The Shift From Fining Nursing Homes For Each Day They Were Out Of Compliance To One Single Fine Would Give Nursing Homes Less Incentive To Fix Faulty And Dangerous Practices. "Encouraged by the nursing home industry, the Trump administration switched from fining nursing homes for each day they were out of compliance — as the Obama administration typically did — to issuing a single fine for two-thirds of infractions, the records show. That reduces the impact of the penalty, critics say, giving nursing homes less incentive to fix faulty and dangerous practices before someone gets hurt." [NPR, 03/15/19]

Washington Post: "Elder Care Is A Multibillion-Dollar Field, And Nursing Homes — Especially Large Chain Operations." "This is important because elder care is a multibillion-dollar field, and nursing homes — especially large chain operations — have revenue in the millions of dollars. Small, one-off fines barely register in this context. The daily fines the Obama administration levied could rack up quickly, resulting in higher average fines. The lower average

under Trump suggests that offenders are being spared the harshest penalties." [Washington Post, 03/25/19]

April 2020: The Trump Administration Announced Billions Of Dollars In Provider Relief Funds, Including Nursing Homes With "No Strings Attached."

APRIL 2020: CMS ADMINISTRATOR SEEMA VERMA ON THE PROVIDER RELIEF FUND: "THERE ARE NO STRINGS ATTACHED."

April 2020: CMS Administrator Seema Verma On The Provider Relief Fund: "There Are No Strings Attached." "Without much fanfare, the Centers for Medicare & Medicaid Services (CMS) has begun doling out the first $30 billion chunk of approximately $100 billion set aside for health care providers in the coronavirus stimulus package passed last month. CMS administrator Seema Verma touted the flexibility that operators would be given once they received their shares of the COVID-19 stimulus cash. 'There are no strings attached, so the health care providers that are receiving these dollars can essentially spend that in any way that they see fit,' Verma said during a White House press conference last week." [Skilled Nursing News, 04/13/20;White House Press Briefing, 04/07/20]

As Of June 2020, Nearly 32,000 American Nursing Home Residents Died From The Coronavirus

As Of June 2020, Nearly 32,000 American Nursing Home Residents Died From The Coronavirus, While The Federal Government Continues To Leave Nursing Homes Without PPE

As Of June 5, 2020, Nearly 32,000 American Nursing Home Residents Died From The Coronavirus. "Data updated yesterday by the federal government now show that nearly 32,000 American nursing home residents have died of the virus — a figure certain to grow, with 12 percent of all facilities yet to report their totals. Nearly 700 nursing home employees have also died. As of Thursday, more than 106,000 Americans overall had died of the disease." [Washington Post, 06/05/20]

Washington Post: "It May Turn Out That As Many As 4 In 10 Covid-19 Deaths Occurred Among Nursing Home Residents." "It may turn out that as many as 4 in 10 covid-19 deaths occurred among nursing home residents. 'We have failed the residents and we have failed the staff as a society,' Michael Wasserman, president of the California Association of Long Term Care Medicine, told The Post's Peter Whoriskey, Debbie Cenziper and Will Englund." [Washington Post, 06/05/20]

JUNE 2020: NPR: THE FEDERAL GOVERNMENT IS FAILING TO ENSURE THESE [NURSING HOME] FACILITIES HAVE ALL THE PERSONAL PROTECTIVE EQUIPMENT, OR PPE NEEDED TO PREVENT THE SPREAD OF THE VIRUS

NPR: "As Nursing Homes Remain The Pandemic's Epicenter, The Federal Government Is Failing To Ensure These Facilities Have All The Personal Protective Equipment, Or PPE, Needed To Prevent The Spread Of The Virus." "As nursing homes remain the pandemic's epicenter, the federal government is failing to ensure these facilities have all the personal

protective equipment, or PPE, needed to prevent the spread of the virus, according to interviews with administrators and federal data." [NPR, 06/11/20]

At Least 18 For-Profit Nursing Homes Received Over $1 Million From Trump's Provider Relief Funds Despite Having Multiple Deficiencies Within. The Past Two Years, Most With Infection Control Deficiencies

Allied Services Skilled Nursing Center

2020: ALLIED SERVICES SKILLED NURSING CENTER RECEIVED OVER $1.7 MILLION FROM TRUMP'S PROVIDER RELIEF FUND

Allied Services Skilled Nursing Center Received $1,740,095 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

NOVEMBER 2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT ALLIED SERVICES NURSING CENTER—INCLUDING ITS FAILURE TO MAINTAIN CLEAN AND SANITARY ENVIRONMENT

November 2019: CMS Regulators Reported That Allied Services Skilled Nursing Center Failed To Provide Housekeeping Services Necessary To Maintain A Clean And Sanitary Environment. "Based on observations and staff interview, it was determined that the facility failed to provide housekeeping services necessary to maintain a clean and sanitary environment and resident care equipment for five of 35 residents (Residents 181, 83, 40, 291 and 285) on three of six nursing units." [Allied Services Skilled Nursing Home, CMS Inspection Report, 11/08/19]

November 2019: CMS Regulators Reported That Allied Services Skilled Nursing Center "Failed To Implement Transmission-Based Precautions When Entering Rooms Of Residents Identified As Requiring Staffs' Use Of Personal Protective Equipment To Prevent The Spread Of Infection." "Based on a review of the facility's infection control policy and clinical records, observations and staff interview, it was determined that the facility failed to implement transmission-based precautions when entering rooms of residents identified as requiring staffs' use of personal protective equipment to prevent the spread of infection for two residents out of seven sampled" [Allied Services Skilled Nursing Home, CMS Inspection Report, 11/08/19]

The Board Of Appleton Municipal Hospital And Nursing Home

2020: THE BOARD OF APPLETON MUNICIPAL HOSPITAL AND NURSING HOME RECEIVED NEARLY $4 MILLION FROM TRUMP'S PROVIDER RELIEF FUND

The Board Of Appleton Municipal Hospital And Nursing Home Received $3,807,718 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT APPLETON MUNICIPAL HOSPITAL, INCLUDING A FAILURE TO REPORT A SUSPECTED INFLUENZA OUTBREAK TO THE STATE AGENCY

March 2019: Appleton Municipal Hospital And Nursing Home Failed To Report A Suspected Influenza Outbreak At Its Facility To The State Agency. "Based on observation, interview and document review, the facility failed to conduct an annual review of it's infection prevention and control program. In addition, the facility failed to report a suspected influenza outbreak for 4 residents (R14, R29, R12, R37) to the state agency (SA)." [The Board Of Appleton Municipal Hospital And Nursing Home, CMS Inspection Report, 03/21/19]

Glenview Terrace Nursing Center

2020: GLENVIEW TERRACE NURSING CENTER RECEIVED OVER $1.44 MILLION FROM TRUMP'S PROVIDER RELIEF FUND

Glenview Terrace Nursing Center Received $1,445,883 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

February 2020: CMS Inspectors Found That Glenview Terrace Nursing Center Facility "Failed To Ensure That Resident's Indwelling Urinary Catheter Drainage Bag Was Not Touching The Floor, According To The Standards Of Practice For Infection Prevention." "Based on observation, interview, and record review, the facility failed to ensure that resident's indwelling urinary catheter drainage bag was not touching the floor, according to the standards of practice for infection prevention. This affects one resident (R60) of two residents, reviewed for indwelling urinary catheter maintenance, in a sample of 83 residents." [Glenview Terrace Nursing Center, CMS Inspection Report, 02/13/20]

BETWEEN 2019 AND 2020, CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT GLENVIEW TERRACE NURSING CENTER, INCLUDING A FAILURE TO PREVENT CROSS CONTAMINATION OF EQUIPMENT

February 2020: CMS Inspectors Found That Glenview Terrace Nursing Center Facility "Failed To Implement Safeguards And Systems, To Ensure That Accountability Records Are Accurately Maintained … For Controlled Medications Stored In 2 Of 9 Medication Carts." "Based on observation, interview and record review, the facility failed to implement safeguards and systems, to ensure that accountability records are accurately maintained for periodic reconciliation's, for controlled medications stored in 2 of 9 medication carts observed. This has the potential to affect all 46 residents on the east wing of the second floor." [Glenview Terrace Nursing Center, CMS Inspection Report, 02/13/20]

January 2019: CMS Inspectors Found That Glenview Terrace Nursing Center Facility "Failed To Prevent Cross Contamination Of Equipment By Failing To Disinfect A Stethoscope Between Resident Uses." This "Based on observation, interview, and record review, the facility failed to prevent cross contamination of equipment by failing to disinfect a stethoscope between resident uses. This affected two (R168 and R379) of two residents reviewed for infection control." [Glenview Terrace Nursing Center, CMS Inspection Report, 01/18/19]

Concourse Rehabilitation And Nursing Center Inc

2020: CONCOURSE REHABILITATION AND NURSING CENTER INC RECEIVED OVER $1.38 MILLION FROM TRUMP'S PROVIDER RELIEF FUND

Concourse Rehabilitation And Nursing Center Inc Received $1,386,867 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT CONCOURSE REHABILITATION AND NURSING CENTER, INCLUDING A FAILURE TO ENSURE THAT INFECTION CONTROL PRACTICES WERE MAINTAINED.

August 2019: CMS Inspectors Found Concourse Rehabilitation And Nursing Center Did Not Ensure That Infection Control Practices Were Maintained. "Based on observations and interviews conducted during the recertification survey, the facility did not ensure that infection control practices were maintained. Specifically, a resident who continuously used oxygen was observed on multiple occasions to have oxygen tubing on the floor." [Concourse Rehabilitation And Nursing Center, CMS Inspection Report, 08/05/19]

Victoria Nursing & Rehabilitation Center, Inc.

2020: VICTORIA NURSING & REHABILITATION CENTER RECEIVED $1,386,867 FROM TRUMP'S PROVIDER RELIEF FUND

Victoria Nursing & Rehabilitation Center, Inc. Received $1,314,876 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2020: CMS REGULATORS REPORTED AN INFECTION CONTROL DEFICIENCY AT VICTORIA NURSING & REHABILITATION CENTER

January 2020: CMS Inspectors Found That Victoria Nursing & Rehabilitation Center Failed To Implement An Effective System Of Identification For Multidrug Resistant Organisms." "Based on record review and interviews, the facility failed to implement an effective system of identification for Multidrug Resistant Organisms (MDRO) such as [MEDICAL CONDITION] for one resident (R#232) out of four residents sampled for infection control. There were 250 residents residing in the facility at the time of this survey." [Victoria Nursing & Rehabilitation Center, Inc., CMS Inspection, 01/16/20]

Bon Secours Maria Manor Nursing Care Center, Inc.

2020: BON SECOURS MARIA MANOR NURSING CARE CENTER FROM TRUMP'S PROVIDER RELIEF FUND

Bon Secours Maria Manor Nursing Care Center, Inc. Received $1,274,717 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT BON SECOURS MARIA MANOR NURSING CARE CENTER, INCLUDING A FAILURE TO IMPLEMENT INFECTION CONTROL PRACTICES DURING WOUND CARE

May 2019: CMS Inspectors Found That Bon Secours Maria Manor Nursing Care Center "Failed To Ensure A Safe And Sanitary Environment For Residents Residing On One Of Four Units." "Based on observation and staff interview, the facility failed to ensure a safe and sanitary environment for residents residing on one of four units (secured unit)." [Bon Secours Maria Manor Nursing Care Center, CMS Inspection, 05/24/19]

May 2019: CMS Inspectors Found That Bon Secours Maria Manor Nursing Care Center "Failed To Implement Infection Control Practices During Wound Care For One Worsening Wound, And Two Facility Acquired Pressure Ulcers For One Resident." "Based on observation, interview, and record review the facility failed to implement infection control practices during wound care for one worsening wound, and two facility acquired pressure ulcers for one resident (#131) out of two residents reviewed for wound care." [Bon Secours Maria Manor Nursing Care Center, CMS Inspection, 05/24/19]

Sheepshead Nursing And Rehabilitation Center LLC

2020: SHEEPSHEAD NURSING AND REHABILITATION CENTER RECEIVED OVER $1.2 MILLION FROM TRUMP'S PROVIDER RELIEF FUND

Sheepshead Nursing And Rehabilitation Center LLC Received $1,260,898 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT SHEEPSHEAD NURSING AND REHABILITATION CENTER, INCLUDING A FAILURE TO ENSURE THAT STAFF MAINTAINED AN INFECTION PREVENTION AND CONTROL PROGRAM

October 2019: CMS Inspectors Found That Sheepshead Nursing And Rehabilitation Center "Did Not Ensure That Staff Maintained An Infection Prevention And Control Program Designed To Provide A Safe, Sanitary And Comfortable Environment, And To Help The Development And Transmission Of Communicable Diseases And Infections." "Based on observation and interview conducted during the recertification survey, the facility did not ensure that staff maintained an infection prevention and control program designed to provide a safe, sanitary and comfortable environment, and to help the development and transmission of communicable diseases and infections. Specifically, staff was observed entering a resident's room who was maintained on contact precautions without wearing appropriate Personal Protective Equipment (PPE). This was evident for 1 of 1 resident reviewed for Infections (#18) out of a total sample of 49 residents." [Sheepshead Nursing And Rehabilitation Center, CMS Inspection, 10/10/19]

Mountain City Nursing & Rehabilitation Center, LLC

2020: MOUNTAIN CITY NURSING & REHABILITATION CENTER, LLC RECEIVED $1,254,052 FROM TRUMP'S PROVIDER RELIEF FUND

Mountain City Nursing & Rehabilitation Center, LLC Received $1,254,052 Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT MOUNTAIN CITY NURSING & REHABILITATION CENTER, INCLUDING A FAILURE TO MAINTAIN A SANITARY ENVIRONMENT IN ONE OF TWO FACILITY BUILDINGS

May 2019: CMS Inspectors Found That That Mountain City Nursing & Rehabilitation Center Failed To Provide Housekeeping Services To Maintain A Sanitary Environment In One Of Two Facility Buildings." "Based on observation and staff interview it was determined that the facility failed to provide housekeeping services to maintain a sanitary environment in one of two facility buildings (the Blue Building)." [Mountain City Nursing & Rehabilitation Center, CMS Inspection, 05/31/19]

April 2019: CMS Inspectors Found That Mountain City Nursing & Rehabilitation Center "Failed To Ensure That Two Residents, Were Free From Physical Abuse And Failed To Timely And Consistently Implement Measures To Protect These Residents From Abusive Behavior." "Based on observation, a review of clinical records and facility investigation and staff interview, it was determined that the facility failed to ensure that two residents, were free from physical abuse and failed to timely and consistently implement measures to protect these residents from abusive behavior resulting in minor physical injury to two (Resident 46 and 103) out of two sampled residents." [Mountain City Nursing & Rehabilitation Center, CMS Inspection, 04/03/19]

St. Petersburg Nursing Home, LLC

2020: ST. PETERSBURG NURSING HOME, LLC RECEIVED $1,253,134 FROM TRUMP'S PROVIDER RELIEF FUND

St. Petersburg Nursing Home, LLC Received $1,253,134 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT ST. PETERSBURG NURSING HOME, INCLUDING A FAILURE TO ENSURE PROPER STORAGE OF RESPIRATORY EQUIPMENT

September 2019: CMS Inspectors Found That St. Petersburg Nursing Home "Failed To Ensure Proper Storage Of Respiratory Equipment." "Based on observation, clinical record review, and interview, the facility failed to ensure proper storage of respiratory equipment, of a facemask for one (Resident #51) of twenty-five residents sampled." [St. Petersburg Nursing Home, CMS Inspection, 09/06/19]

September 2019: CMS Inspectors Found That St. Petersburg Nursing Home "Failed To Ensure That One (Resident #51) Of Twenty-Five Residents Sampled, Was Assessed And Properly Monitored To Self-Administer A Respiratory Treatment." "Based on observation, interview and record review, the facility failed to ensure that one (Resident #51) of twenty-five residents sampled, was assessed and properly monitored to self-administer a respiratory treatment." [St. Petersburg Nursing Home, CMS Inspection, 09/06/19]

January 2019: CMS Inspectors Found That St. Petersburg Nursing Home "Personnel Neglected A Resident By Failing To Provide The Structures And Processes To Honor The Advance Directives For … [CPR] Administration"—"The Facility's Failure To Implement Their Own Policies And Procedures Resulted In Findings Of Immediate Jeopardy…" "Based on interviews with the facility's nursing and administrative staff, clinical record review, internal facility documentation, physician interview, the Nurse Practice Act, and review of the facility's policies and procedures, it was determined that facility personnel neglected a resident by failing to provide the structures and processes to honor the Advance Directives for Cardiopulmonary Resuscitation (CPR) administration, for one resident (#3) of six sampled residents. The resident's assigned nurse did not initiate CPR or call Emergency Medical Services (EMS) upon finding the resident without a pulse or respirations. The facility neglected to provide basic life support to Resident #3, a [AGE] year-old female, who had a physician's orders [REDACTED]. As a result of the neglect, Resident #3 did not have her wishes upheld to remain a Full Code and receive basic life support when she was found by staff without a pulse or respirations. Furthermore, the facility failed to follow their own policy and procedure related to the initiation of Cardiopulmonary Resuscitation (CPR) for Resident #3 who had Full Code orders and whose expressed wishes were to remain a Full Code. The facility's failure to implement their own policies and procedures resulted in findings of Immediate Jeopardy, past noncompliance on [DATE]. The Immediate Jeopardy was determined to be removed on [DATE], prior to the survey." [St. Petersburg Nursing Home, 01/04/19]

Wayne Center For Nursing And Rehabilitation

2020: WAYNE CENTER FOR NURSING AND REHABILITATION RECEIVED $1,237,001 FROM TRUMP'S PROVIDER RELIEF FUND

Wayne Center For Nursing And Rehabilitation Received $1,237,001 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2020: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT WAYNE CENTER FOR NURSING AND REHABILITATION, INCLUDING A FAILURE TO ENSURE THAT INFECTION CONTROL PRACTICES WERE MAINTAINED

January 2020: CMS Inspectors Found That Wayne Center For Nursing And Rehabilitation "Did Not Ensure That Infection Control Practices Were Maintained. Specifically, A Resident's Oxygen Tubing Was Observed To Be Laying On The Floor In The Resident's Room." "Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure that infection control practices were maintained. Specifically, a resident's oxygen tubing was observed to be laying on the floor in the resident's room. This was evident for 1 of 3 residents reviewed for Respiratory Care (Resident #187)." [Wayne Center For Nursing And Rehabilitation, 01/13/20]

Samaritan Keep Nursing Home Inc

2020: SAMARITAN KEEP NURSING HOME INC RECEIVED $1,215,901FROM TRUMP'S PROVIDER RELIEF FUND

Samaritan Keep Nursing Home Inc Received $1,215,901 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT SAMARITAN KEEP NURSING HOME, INCLUDING A FAILURE TO PROVIDE A SAFE, SANITARY AND COMFORTABLE ENVIRONMENT TO HELP PREVENT THE DEVELOPMENT AND TRANSMISSION OF COMMUNICABLE DISEASES

April 2019: CMS Inspection Found That Samaritan Keep Nursing Home "Did Not Ensure It Established And Maintained An Infection Prevention And Control Program Designed To Provide A Safe, Sanitary And Comfortable Environment To Help Prevent The Development And Transmission Of Communicable Diseases And Infections For 1 Of 1 Resident (Residents #61) Reviewed For Urinary Catheters." "Based on observation, record review, and interview during the recertification survey, the facility did not ensure it established and maintained an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident (Residents #61) reviewed for urinary catheters. Specifically, Resident #61 was observed multiple times with his urinary catheter drainage bag resting directly on the floor." [Samaritan Keep Nursing Home, CMS Inspection, 04/26/19]

Carillon Nursing And Rehabilitation Center, LLC

2020: CARILLON NURSING AND REHABILITATION CENTER RECEIVED $1,199,572 FROM TRUMP'S PROVIDER RELIEF FUND

Carillon Nursing And Rehabilitation Center, LLC Received $1,199,572 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT CARILLON NURSING AND REHABILITATION CENTER INCLUDING A FAILURE TO IMPLEMENT AN ONGOING INFECTION PREVENTION AND CONTROL PROGRAM

May 2019: A CMS Inspection Report Found That Carillon Nursing And Rehabilitation Center "Did Not Ensure There Was Sufficient Nursing Staff To Care For Each Residents Needs." "Based on observations, record review and interviews during the Recertification survey, the facility did not ensure there was sufficient nursing staff to care for each residents needs as identified through resident assessments and plans of care on 1 of 7 nursing units (Unit 7) in a timely manner. Specifically, Resident # 136, who required assistance with transfers and toileting did not have staff provide care in a timely manner." [Carillon Nursing And Rehabilitation Center, LLC, CMS Inspection, 05/21/19]

May 2019: A CMS Inspection Report Found That Carillon Nursing And Rehabilitation Center "Did Not Implement An Ongoing Infection Prevention And Control Program (IPCP) To Prevent, Recognize, And Control The Onset And Spread Of Infection." "Based on observation, record review and staff interviews during the Recertification survey, the facility did not implement an ongoing Infection Prevention and Control Program (IPCP) to prevent, recognize, and control the onset and spread of infection. This was identified for one (Resident

#92) of one resident reviewed for Infection control. Specifically Resident #92's, Suprapubic drainage bag was observed laying directly on the floor without a barrier." [Carillon Nursing And Rehabilitation Center, LLC, CMS Inspection, 05/21/19]

August 2019: A CMS Inspection Report Found That Carillon Nursing And Rehabilitation Center "Did Not Ensure Resident Rights To Be Free From Abuse For One (Resident #1) Of Three Residents Reviewed For Abuse." "Based on interviews and record review during an abbreviated survey (Complaint # NY 507), the facility did not ensure resident rights to be free from abuse for one (Resident #1) of three residents reviewed for Abuse. Specifically, a Certified Nurse's Aide (CNA) pushed Resident #1 in her bed using his hand over her head/face three times when the resident was trying to get out of bed. Resident #1 was cognitively intact and provided a consistent account of the incident." [Carillon Nursing And Rehabilitation Center, LLC, CMS Inspection, 08/28/19]

Marwood Manor Nursing Home

2020: MARWOOD MANOR NURSING HOME RECEIVED $1,144,162 FROM TRUMP'S PROVIDER RELIEF FUND

Marwood Manor Nursing Home Received $1,144,162 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

MARWOOD MANOR NURSING HOME RECEIVED 8 DEFICIENCIES IN ITS TWO MOST RECENT CMS INSPECTION REPORTS, INCLUDING MULTIPLE INFECTION-RELATED DEFICIENCIES

May 2019: A CMS Inspection Report Found That Marwood Manor Nursing Home "Facility Failed To Safely Transport A Resident (R42) By Not Placing The Foot-Rests On The Wheelchair." "Based on observation, interview, and record review, the facility failed to safely transport a resident (R42) by not placing the foot-rests on the wheelchair, resulting in R42's right foot being caught underneath the wheelchair and suffering a right leg fracture and pain" [Marwood Manor Nursing Home, CMS Inspection, 06/12/19]

May 2019: A CMS Inspection Report Found That Marwood Manor Nursing Home "Failed To Ensure Assessment, Care And Documentation Of Indwelling Urinary Catheters Per Professional Standards…" "Based on observation, interview and record review, the facility failed to ensure assessment, care and documentation of indwelling urinary catheters per professional standards of practice for two (#'s 192 and 581) of two Residents reviewed for catheters, resulting in unsanitary placement of urinary drainage bags, inappropriately placed catheter tubing securement device, lack of assessment and timely intervention, increased risk of infection, and a Resident experiencing a skin ulceration at the catheter insertion site and unnecessary pain." [Marwood Manor Nursing Home, CMS Inspection, 06/12/19]

June 2019: A CMS Inspection Report Found That Marwood Manor Nursing Home "Failed To Properly Label Medications And Biologicals, And Store Drinks And Medications Separately Affecting All Residents That Receive Medications From The Med Room And Or Medication Cart." "Based on observation, interview, and record review the facility failed to properly label medications and biologicals, and store drinks and medications separately affecting all residents that receive medications from the med room and or medication cart,

resulting in the likelihood of residents receiving outdated and less effective medications, unauthorized access to the medication cart and improper medication storage or contamination." [Marwood Manor Nursing Home, CMS Inspection, 06/12/19]

April 2018: A CMS Inspection Report Found That Marwood Manor Nursing Home "Failed To Perform Adequate Hand Hygiene During A Dining Observation Effecting All Residents That Dine In The Rehab Dining Room Resulting In The Potential For The Preventable Spread Of Infections." "Based on observation, interview, and record review, the facility failed to perform adequate hand hygiene during a dining observation effecting all residents that dine in the Rehab Dining room resulting in the potential for the preventable spread of infections." [Marwood Manor Nursing Home, CMS Inspection, 04/06/18]

April 2018: A CMS Inspection Report Found That Marwood Manor Nursing Home Failed To Properly Label Medications And Biologicals With The Resident's Names And/Or The Date Opened. "Based on observation, interview, and record review the facility failed to properly label medications and biologicals with the resident's names and/or the date opened, for 1 (# 328) sampled resident and six(#'s 174, 304, 317, 319, 323, and 325) supplemental residents, from a total sample of 35 residents, resulting in the potential for residents receiving other resident's medications or receiving out dated medications and biologicals." [Marwood Manor Nursing Home, CMS Inspection, 04/06/18]

April 2018: A CMS Inspection Report Found That Marwood Manor Nursing Home Failed To Operationalize Policies And Procedures To Ensure Temperature Monitoring For Medication Refrigerator Containing Vaccines Per Centers For Disease Control (CDC) Recommendations And Standards Of Practice In One (Lighthouse Unit) Medication Storage Refrigerators. "Based on observation, interview and record review, the facility failed operationalize policies and procedures to ensure temperature monitoring for medication refrigerator containing vaccines per Centers for Disease Control (CDC) recommendations and standards of practice in one (Lighthouse Unit) medication storage refrigerators, resulting in the potential for residents residing the facility to receive vaccines with altered potency and efficacy." [Marwood Manor Nursing Home, CMS Inspection, 04/06/18]

April 2018: A CMS Inspection Report Found That Marwood Manor Nursing Home Failed To Document New Interventions To Prevent Further Weight Loss For Two (#'S 104 And 120) Of Eight Residents Reviewed For Weight Loss. "Based on observation, interview and record review, the facility failed to document new interventions to prevent further weight loss for two (#'s 104 and 120) of eight residents reviewed for weight loss, from a total sample of 35, resulting in the potential for further weight loss, malnutrition, and continued decline." [Marwood Manor Nursing Home, CMS Inspection, 04/06/18]

April 2018: A CMS Inspection Report Found That Marwood Manor Nursing Home Failed To "Monitor/Supervise, Document Failed Interventions And Implement New And Previous Fall Interventions, And Failed To Initiate Specific Fall Care Plans With Interventions To Prevent Falls And Injuries." "Based on observation, interview and record review, the facility failed to monitor/supervise, document failed interventions and implement new and previous fall interventions, and failed to initiate specific fall care plans with interventions to prevent falls and injuries, for 3 (#'s 30, 120 and 160) of 6 residents reviewed for falls, from a total sample of 35, resulting in repeated falls, injuries and a potential for continued major injuries related to falls." [Marwood Manor Nursing Home, CMS Inspection, 04/06/18]

April 2018: A CMS Inspection Report Found That Marwood Manor Nursing Home Failed To "Ensure Assessment, Monitoring, And Care Per Professional Standards Of Practice For A Change In Condition For One (#116) Of Four Residents Reviewed For A Change In Condition." "Based on observation, interview and record review, the facility failed to ensure assessment, monitoring, and care per professional standards of practice for a change in condition for one (#116) of four Residents reviewed for a change in condition, from a total sample of 38, resulting in a Resident with identified respiratory compromise experiencing respiratory distress, not receiving continued assessment, monitoring, and supportive oxygen therapy, and the potential contribution to [MEDICAL CONDITION] and death." [Marwood Manor Nursing Home, CMS Inspection, 04/06/18]

Landmark Of Louisville Rehabilitation And Nursing

2020: LANDMARK OF LOUISVILLE REHABILITATION AND NURSING RECEIVED $1,100,826 FROM TRUMP'S PROVIDER RELIEF FUND

Landmark Of Louisville Rehabilitation And Nursing Received $1,100,826 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED SEVERAL DEFICIENCIES AT LANDMARK OF LOUISVILLE REHABILITATION AND NURSING, INCLUDING A FAILURE TO MAINTAIN AN INFECTION PREVENTION AND CONTROL PROGRAM

August 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing "Failed To 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." "Based on observation, interview, record review, and review of facility Policy, it was determined the facility failed to 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. This affected one (1) of one (1) sampled resident observed for a dressing change out of a total of ten (10) sampled residents (Resident #9) and affected four (4) employees." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 08/16/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing Failed To Have "An Effective System In Place To Ensure The Facility Was Administered Effectively Has Caused Or Is Likely To Cause Serious Injury, Harm, Impairment, Or Death To A Resident." "Based on interview, record review, review of facility Job Descriptions, and review of the facility's policy, it was determined the facility failed to be administered in a manner to use its resources effectively and efficiently to ensure residents attained and/or maintained their highest practicable physical, mental, and psychosocial well-being for thirteen (13) of sixty-four (64) sampled residents, Residents #12, #13, #14, #15, #16, #17, #18, #19, #20, #25, #27, #37, and #58. (Refer to F656, F689, F692, and F725) Observation, interview, and record review revealed staff was unable to provide assistance at meals and monitoring residents assessed at choking risk, weigh residents per the facility's policy and/or physician order, and provide restorative services due to insufficient staff. The facility's failure to have an effective system in place to ensure the facility was administered effectively

has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE], and was determined to exist on [DATE]." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing "Failed To Ensure Adequate Staffing Was Provided To Meet The Needs Of Thirteen (13) Of Sixty-Four (64) Sampled Residents." "Based on observation, interview, record review, and review of the facility's assessment, it was determined the facility failed to ensure adequate staffing was provided to meet the needs of thirteen (13) of sixty-four (64) sampled residents, Residents #12, #13, #14, #15, #16, #17, #18, #19, #20, #25, #27, #37, and #58. Observation, interview, and record review revealed staff was unable to provide assistance at meals and monitoring residents assessed at choking risk, weigh residents per the facility's policy and/or physician order, and provide restorative services due to insufficient staff." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing "Failed To Ensure Residents Individualized Dementia Care Needs Were Met For One (1) Of Sixty-Four (64) Sampled Resident." "Based on observation, interview, record review, and review of the facility's Dementia Unit packet, it was determined the facility failed to ensure residents individualized dementia care needs were met for one (1) of sixty-four (64) sampled residents, Resident #16. Resident #16 resided on the Dementia Care Unit and observations from 7:19 AM to 10:36 AM, on 02/14/19, revealed Resident #16 yelled for help, stated he/she was cold, made statements regarding pooping and his/her pants were soaked, with minimal staff assistance to address his/her distress. In addition, the resident wandered into several resident rooms while continuing to holler in distress without staff intervention." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing Failed To Provide "Pain Management For One (1) Of Sixty-Four (64) Sampled Residents, Resident #21." "Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide pain management for one (1) of sixty-four (64) sampled residents, Resident #21. Interview with Resident #21 on 02/13/19, revealed the resident was in pain due to the facility did not have his/her medication available for administration. Documentation revealed staff did not administer prescribed pain medication on 02/12/19 or 02/13/19, in addition to three (3) other days, 02/05/19, 02/07/19, and 02/08/19. Record review also revealed staff failed to assess the resident's pain characteristics such as intensity, location, and precipitating factors prior to administering pain medication and failed to assess for relief after administration according to the facility's Pain Flow Sheet." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing "Failed To Ensure Residents At Risk For Weight Loss Did Not Lose Weight For Three (3) Of Sixty-Four (64) Sampled Residents." "Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure residents at risk for weight loss did not lose weight for three (3) of sixty-four (64) sampled residents, Resident #13, #16, and #25." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing Failed To Ensure Residents At Risk For Choking Were Monitored During

Meals To Prevent Accidents For Nine (9) Of Sixty-Four (64) Sampled Residents." "Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure residents at risk for choking were monitored during meals to prevent accidents for nine (9) of sixty-four (64) sampled residents, Resident #12, #14, #15, #16, #17, #18, #19, #20, and #25." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing "Failed To Implement Care Plan Interventions For Seventeen (17) Of Sixty-Four (64) Sampled Residents." "Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to implement care plan interventions for seventeen (17) of sixty-four (64) sampled residents, Residents #7, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #25, #27, #37, #55 and #58." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

March 2019: A CMS Inspection Report Found That Landmark Of Louisville Rehabilitation And Nursing "Failed To Thoroughly Investigate Allegations Of Abuse For Five (5) Of Sixty-Four (64) Sampled Residents." "Based on observation, interview, record review, and facility policy review, it was determined the facility failed to thoroughly investigate allegations of abuse for five (5) of sixty-four (64) sampled residents, Residents #5, #6, #7, #8, and #26." [Landmark Of Louisville Rehabilitation And Nursing, CMS Inspection, 03/08/19]

Douglasville Nursing And Rehabilitation Center

2020: DOUGLASVILLE NURSING AND REHABILITATION CENTER RECEIVED $1,089,831 FROM TRUMP'S PROVIDER RELIEF FUND

Douglasville Nursing And Rehabilitation Center Received $1,089,831 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT DOUGLASVILLE NURSING AND REHABILITATION CENTER, INCLUDING A FAILURE TO DON APPROPRIATE PERSONAL PROTECTIVE EQUIPMENT (PPE) WHEN ENTERING A RESIDENT'S ROOM ON TRANSMISSION-BASED PRECAUTIONS

January 2019: A CMS Inspection Report Found That Douglasville Nursing And Rehabilitation Center Failed To "Conduct Annual Review And Update Their Policies And Infection Prevention Control Program; Don Appropriate Personal Protective Equipment (PPE) When Entering A Resident's Room On Transmission-Based Precautions; Failed To Use Hand Hygiene Prior To Donning PPE And During Medication Administration." "Based on observation, interviews, record review, and policy reviews the facility failed to provide evidence that infection control surveillance data was collected in (MONTH) of (YEAR). Failed to provide documentation that infection control data collected in (MONTH) of (YEAR) was analyzed for trends and appropriate actions taken in response. In addition, the facility failed to do the following; conduct annual review and update their policies and infection prevention control program (IPCP); failed to don appropriate personal protective equipment (PPE) when entering a resident's room on transmission-based precautions; failed to use hand hygiene prior

to donning PPE and during medication administration." [Douglasville Nursing And Rehabilitation Center, CMS Inspection, 01/11/19]

May 2019: A CMS Inspection Report Found That Douglasville Nursing And Rehabilitation Center Failed To Ensure The Medication Error Rate Was Less Than Five Percent (5%). "Based on observation, record review, and staff interviews, the facility failed to ensure the medication error rate was less than five percent (5%). A total number of 26 medication opportunities were observed, and there were two errors for one of three residents ® (R#9) by one of three nurses observed giving medications, for an error rate of 7.69%." [Douglasville Nursing And Rehabilitation Center, CMS Inspection, 05/23/19]

Mi Nursing Restorative Center Inc

2020: MI NURSING RESTORATIVE CENTER RECEIVED $1,065,187 FROM TRUMP'S PROVIDER RELIEF FUND

MI Nursing Restorative Center Inc. Received $1,065,187 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT MI NURSING RESTORATIVE CENTER, INCLUDING A FAILURE TO ENSURE THAT MEDICATIONS WERE ADMINISTERED IN A MANNER TO PREVENT THE SPREAD OF INFECTION DURING MEDICATION PASS

November 2019: A CMS Inspection Report Found That MI Nursing Restorative Center Inc. Failed To "Ensure That Medications Were Administered In A Manner To Prevent The Spread Of Infection During Medication Pass." "Based on record review, interview and observation, the facility failed to: 1) ensure its hot water was kept within an acceptable temperature range to inhibit the growth of Legionella bacteria (a serious type of pneumonia); 2) ensure that medications were administered in a manner to prevent the spread of infection during medication pass. Findings include:" [MI Nursing Restorative Center, CMS Inspection, 11/15/19]

White Oaks Rehabilitation And Nursing Center

2020: WHITE OAKS REHABILITATION AND NURSING CENTER RECEIVED $1,027,481 FROM TRUMP'S PROVIDER RELIEF FUND

White Oaks Rehabilitation And Nursing Center Received $1,027,481 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT WHITE OAKS REHABILITATION AND NURSING CENTER, INCLUDING A FAILURE TO PROVIDE AND IMPLEMENT AN INFECTION PREVENTION AND CONTROL PROGRAM

September 2019: A CMS Inspection Report Found That White Oaks Rehabilitation And Nursing Center "Did Not Ensure That An Infection Prevention And Control Program To Help Prevent The Development And Transmission Of Communicable Diseases And Infections Was Implemented For One Resident." "Based on observation, record review, and

interviews during the Recertification Survey the facility did not ensure that an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections was implemented for one (Resident #13) five residents observed during the medication pass and one (Resident #13) five residents reviewed for Pressure Ulcers. Specifically, 1a) during the medication pass observation for Resident #13, the Licensed Practical Nurse (LPN) medication nurse popped medications from the blister-pack directly into her ungloved hand, put the medications into a souffle cup, and administered them to the resident; and 1b) During wound care observation for Resident #13, the LPN treatment nurse was observed to first cleanse the periwound (around the outside the wound) using gauze in a circular motion, and then in a continuous motion cleansed the inner part of the wound with the same gauze." [White Oaks Rehabilitation And Nursing Center, CMS Inspection, 09/20/19]

Landmark Of Richton Park Rehabilitation And Nursing Center

2020: LANDMARK OF RICHTON PARK REHABILITATION AND NURSING CENTER RECEIVED $1,022,555 FROM TRUMP'S PROVIDER RELIEF FUND

Landmark Of Richton Park Rehabilitation And Nursing Center Received $1,022,555 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT RICHTON PARK REHABILITATION AND NURSING CENTER, INCLUDING A FAILURE TO TO DOCUMENT IF INFLUENZA IMMUNIZATIONS WERE OFFERED

November 2019: A CMS Inspection Found That Landmark Of Richton Park Rehabilitation And Nursing Center "Failed To Document [MEDICATION NAME] And Influenza Immunizations Were Offered, Received And/Or Refused For Four Of Five Residents." "Based upon record review, and interview, the facility failed to document [MEDICATION NAME] and influenza immunizations were offered, received and/or refused for four of five residents (R2, R49, R89, R119) reviewed." [Landmark Of Richton Park Rehabilitation And Nursing Center, CMS Inspection, 11/07/19]

November 2019: A CMS Inspection Found That Landmark Of Richton Park Rehabilitation And Nursing Center "Failed To Ensure That Staff Were Aware Of Resident Infections And/Or Type Of Isolation Precautions For Six Of Six Residents Reviewed." "Based upon observation, interview, and record review the facility failed to ensure that staff were aware of resident infections and/or type of isolation precautions for six of six residents reviewed (R49, R56, R86, R89, R112, R119) for infection prevention and failed to post an isolation sign on R86's door." [Landmark Of Richton Park Rehabilitation And Nursing Center, CMS Inspection, 11/07/19]

November 2019: A CMS Inspection Found That Landmark Of Richton Park Rehabilitation And Nursing Center "Based upon observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%. This affects one resident (R38) of six residents, (in a sample of 50 residents), observed for medication administration. There were 25 opportunities and 2 errors, resulting in an 8% medication error rate." [Landmark Of Richton Park Rehabilitation And Nursing Center, CMS Inspection, 11/07/19]

Maywood Skilled Nursing & Wellness Centre

2020: MAYWOOD SKILLED NURSING & WELLNESS CENTRE RECEIVED $1,016,280 FROM TRUMP'S PROVIDER RELIEF FUND

Maywood Skilled Nursing & Wellness Centre Received $1,016,280 From The Provider Relief Fund. [HHS Provider Relief Fund, General Distribution, HHS ASPA Data, accessed, 06/09/20]

2019: CMS REGULATORS REPORTED MULTIPLE DEFICIENCIES AT MAYWOOD SKILLED NURSING & WELLNESS CENTRE, INCLUDING A FAILURE TO PRACTICE PROPER HAND HYGIENE DURING A BED BATH

March 2019: A CMS Inspection Found That Maywood Skilled Nursing & Wellness Centre Failed To Practice Proper Hand Hygiene During A Bed Bath. "Based on observation, interview, and record review, the facility failed to practice proper hand hygiene (a general term that applies to routine hand washing, antiseptic hand wash, antiseptic hand rub) during a bed bath, and a stain free privacy curtain for one of 25 sampled residents (226)." [Maywood Skilled Nursing & Wellness Centre, CMS Inspection, 03/13/19]

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