STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265580	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROLLA PRESBYTERIAN MANOR	1200 HOMELIFE PLAZA ROLLA, MO 65401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to implement appropriate infection control measures related to COVID-19 (an infectious disease caused by severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2)). Staff failed to follow Center for Disease Control & Prevention (CDC) guidelines for facemask use. In addition, staff failed to prevent the spread of bacteria and other infection causing contaminants during the provision of care for one resident (Resident #1) when staff failed to complete thorough incontinence care and by not disinfecting multi-resident use equipment. Facility census was 25. Review of the facility's in-service summary, dated 5/29/2020, showed staff were instructed to sanitize all equipment, such as vital sign equipment and lifts, between each use. Further review of the in-service summary showed it did not identify who was responsible to clean the equipment or instruct staff how to sanitize the equipment. Review of the facility's policy Lifting and Transferring Residents, revised 5/2/2019, directed staff as follows: -Handle grips that come in contact with resident's hands, will be covered in plastic or cleaned with a sanitizing wipe and allowed to dry prior to the resident grasping the handle. Review of the facility's Perineal Care Procedure, undated, showed staff were directed as follows: -After washing, rinsing, and drying the perineal area and genitalia, staff are to: -Wash and rinse other skin areas between the legs; -Wash and rinse the anal area; -And then pat the perineal area dry. 1. Observation on 6/3/2020 at 11:10 A.M., showed Resident #1 in his/her bed wearing a wet brief. Certified Nursing Assistant (CNA) A & CNA B pulled the resident's brief down, in the front, while CNA A used disposable wipes to clean the resident's groin creases, and then placed a clean brief under the resident without washing the resident's buttocks or thighs. Upon being positioned to his/her back the resident was incontinent of urine a second time. CNA B used disposable wipes to clean the resident's groin creases, removed his/her gloves, and threw them across the resident's bed to the trash can, where one glove landed on the floor. CNA A placed a clean brief under the resident without washing the resident's buttocks or thighs. Further observation showed CNA A and CNA B used a mechanical lift (device used to lift and move residents who are unable to do so on their own) to transfer the resident, and then placed the lift in the hallway, without being sanitized. Observation on 6/3/2020 at 11:27 A.M., showed housekeeping staff passed the lift in the hallway without disinfecting it. Observation on 6/3/2020 at 11:35 A.M., showed the mechanical lift still in the hallway without being disinfected. Observation on 6/3/2020 at 11:45 A.M., showed the mechanical lift still in the hallway without being disinfected. During an interview on 6/3/2020 at 11:20 A.M., CNA B said the facility had three residents who used the lift. He/She said staff usually store the lift in the shower room, but if they were going to be using it quickly, they left it in the hallway. He/She said housekeeping comes by and disinfects the lift with wipes. He/She said CNAs do not disinfect the lift. During at interview on 6/3/2020 at 12:10 P.M., CNA A said staff should wash hands, apply gloves, clean the resident from front and back, change gloves and put a new brief on the resident when performing perineal care. He/She said they did not wash Resident #1's bottom when performing perineal care, but did not say why. He/She went on to say CNAs are supposed to wipe down the mechanical lift with bleach wipes right after use, and he/she sometimes goes back to do it before using the lift on someone else. During an interview on 6/3/2020 at 12:00 P.M., the Director of Nursing (DON) said lifts should be disinfected between residents. He/She said ideally staff should wipe lifts down after use, but staff do not know if the person who used the lift before them wiped it down, so the lift should be wiped down before it's used. He/She said CNAs should use sani-cloths to wipe the lifts down, and they had been trained to wipe them down after use. Furthermore, he/she said if a resident is incontinent of urine, he/she expected staff to wash the resident's creases, groin, genitalia, gluteal crease (where the buttocks meets the thighs), and buttocks. During an interview on 6/3/2020 at 12:30 P.M., the Executive Director (ED) said multi-use equipment should be sanitized after every use with sani-wipes or bleach wipes. 2. Review of the CDC's, Sequence for Removing Personal Protective Equipment, showed: -The front of the mask/respirator is contaminated-DO NOT TOUCH; -If your hands get contaminated during mask/respirator removal, immediately wash your hands or use alcohol based hand rub; -And grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front. Observation on 6/3/2020 at 10:50 A.M., showed dining service assistant C wearing a cloth facemask. He/she touched the middle of his/her facemask with his/her fingers, and took food trays from the hot cart and placed them on the steam table. Dining service assistant C did not perform hand hygiene after touching his/her contaminated mask, and before touching trays that held resident food. Additional observation showed dining service assistant C touched his/her mask two more times, and then adjusted the lids on the steam table. He/She did not perform hand hygiene, after touching his/her contaminated mask and before touching the steam table that held resident food. During an interview on 6/3/2020 at 10:55 A.M., dining service assistant C said the facility provided an in-service on how to properly wear a facemask. He/She said staff are not supposed to touch the front, or inside of the mask. He/She did not say why he/she touched his/her mask during the dining service. During an interview on 6/3/2020 at 12:00 P.M., the DON said staff training for mask use included covering their mouth and nose, wearing masks at all times, and not touching the mask with their fingers. He/She said staff were instructed to use the mask's ear loops for adjustment. He/She said if staff touch their mask they are expected to perform hand hygiene after doing so.

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