STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BANNING HEALTHCARE	3476 W. WILSON ST. BANNING, CA 92220

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a care plan was developed to address gastrointestinal (GI - relating to the stomach and the intestines) bleeding, for one of three residents (Resident 35) reviewed for hospitalization . This failure had the potential to delay the necessary care and services needed for Resident 35's GI bleeding and identify other medical conditions contributing to the episodes of GI bleeding. Findings: On March 3, 2020, at 9:23 a.m., Resident 35 was observed inside his room, lying in bed, awake and alert. During a concurrent interview, Resident 35 stated he was sent to the hospital a few days after being admitted to the facility because he had some episodes of vomiting blood. Resident 35 stated he had a history of [REDACTED]. On March 4, 2020, Resident 35's record was reviewed. Resident 35 was originally admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The history and physical dated, February 1, 2020, indicated Resident 35 could make his needs known but could not make medical decisions. Resident 35's family member was the responsible party. The Nursing Home to Hospital Transfer (INTERACT) form, dated January 26, 2020, was reviewed. The document indicated Resident 35 was transferred to the acute hospital due to two episodes of coffee-ground emesis (vomiting that resembled coffee-ground color and consistency). Resident 35 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. There was no documented evidence a comprehensive care plan was developed to address Resident 35's GI bleeding. On March 5, 2020, at 2:04 p.m., a concurrent interview and record review were conducted with Registered Nurse (RN) 1. RN 1 stated a comprehensive care plan to address the GI bleeding of Resident 35 had not been developed since admission. RN 1 stated a comprehensive care plan should have been developed for Resident 35's GI bleeding. On March 5, 2020, at 3:55 p.m., the Director of Nursing (DON) was interviewed. The DON stated a comprehensive care plan should have been developed for Resident 35's GI bleeding. The facility's policy and procedure titled, Baseline/Comprehensive Care Plan - IDT (Interdisciplinary Team) Conference, dated November 28, 2017, was reviewed. The policy indicated, The facility will .Develop a comprehensive, person-centered care plan for each resident .
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise the comprehensive care plan for one of 22 residents reviewed for comprehensive care plans (Resident 39), when Resident 39 had multiple falls. This failure increased the potential for Resident 39 to experience further falls and possible injury. Findings: On March 3, 2020, at 2:42 p.m., an observation and a concurrent interview were conducted with Resident 39. Resident 39 was alert and awake lying in bed. The bed was observed against the wall at its lowest position with a fall mat on the right side of the bed. Resident 39 stated she fell about a month ago. On March 5, 2020, Resident 39's record was reviewed. Resident 39 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The MDS (Minimum Data Set - an assessment tool) dated December 9, 2019, was reviewed. The MDS indicated Resident 39 had a BIMS (Brief Interview for Mental Status - an assessment for cognitive status) score of three, indicating Resident 39 was cognitively impaired. The physician history and physical dated July 3, 2019, was reviewed. The document indicated Resident 39 did not have the capacity to understand and make decisions. The facility documents titled, FALL RISK ASSESSMENT, were reviewed. The documents indicated Resident 39 was assessed as a high risk for falls (a score of 10 or above) on the following dates: - December 9, 2019, score was 16; - December 23, 2019, score was 10; - January 22, 2020, score was 15; - February 1, 2020, score was 15; and - February 11, 2020, score was 17. The facility documents titled, Incident Notes, were reviewed. The documents indicated the following: - On October 29, 2019, Resident 39 was found in the lobby laying on her right side and complained of generalized body pain. Resident 39 was transferred to the acute hospital; - On January 22, 2020, Resident 39 slid from the wheelchair onto the floor; and - On February 1, 2020, Resident 39 was found on the floor sitting in the front lobby. Resident 39's comprehensive care plan titled Fall, dated November 7, 2014, was reviewed. There was no documentation indicating the care plan was revised with new interventions to reduce Resident 39's risk for falls after Resident 39 had repeated falls on October 29, 2019, January 22, 2020, and February 1, 2020. On March 5, 2020, at 2:46 p.m., Resident 39's record was reviewed with the Director of Nursing (DON). The DON confirmed there were no new interventions added to the comprehensive care plan when Resident 39 had repeated falls on October 29, 2019, January 22, 2020, and February 1, 2020. The DON stated the comprehensive fall care plan for Resident 39 should have been revised with new interventions to reduce Resident 39's risk for falls and injury each time the resident fell . The undated facility's policy and procedure titled, FALL PREVENTION - GENERAL, was reviewed. The policy indicated .additional resident assessment and care related to fall prevention shall be provided according to the Fall Management System .
F 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor each resident's preferences, choices, values and beliefs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident 41) received care and services necessary to maintain the highest level of physical and psychosocial well-being when Resident 41 did not receive incontinent care. This failure increase the potential for Resident 41 to develop a urinary infection, skin breakdown, and cause emotional distress. Findings: On March 2, 2020, at 9:45 a.m., an observation and a concurrent interview were conducted with Resident 41. Resident 41 was observed sitting in a chair, alert, coherent, and conversant. The linen on resident 41's bed was observed discolored with a dark brown ring and there was a strong urine odor. Resident 41's call light was on. Resident 41 stated he was waiting for the nurse to assist him to use the bathroom. On March 2, 2020, at 10:10 a.m., an observation and a concurrent interview with the Director of Nursing (DON) were conducted. The DON entered Resident 41's room and confirmed there was a strong urine odor. The DON stated residents who were incontinent needed to be checked every two hours and changed if the resident was soiled. The DON stated Resident 41's wife (his roommate) became combative when the staff tried to provide incontinent care to Resident 41. On March 2, 2020, at 11:20 a.m., an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated she tried to provide incontinent care to Resident 41 but Resident 41's wife became agitated so she stopped providing incontinent care to Resident 41. On March 3, 2020, at 8:51 a.m., an observation and concurrent interview with Resident 41 was conducted. Resident 41 was lying in bed. The linen on his bed was soiled and there was a strong urine odor. Resident 41 stated he was waiting for the nurse to assist him. On March 4, 2020, at 8:15 a.m., an observation and concurrent interview with Resident 41 was conducted. Resident 41 was lying in bed covered with a blanket. There was a strong urine odor. Resident 41 stated he was waiting to be

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0675 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) changed. On March 5, 2020, Resident 41's record was reviewed. Resident 41 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The undated facility policy and procedure titled, INCONTINENT MANAGEMENT PROGRAM, was reviewed. The policy indicated, .It is the policy of this facility to provide the care and services to keep residents clean and dry and odor free .Check resident for incontinence at minimum of every 2 hours, or more frequently as indicated .
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and treatment according to professional standards of practice when Resident 150 did not receive oxygen therapy upon admission according to the physician's orders [REDACTED]. Findings: On March 2, 2020, at 10:30 a.m., Resident 150 was observed in her room lying in bed asleep with the head of the bed elevated. An oxygen concentrator (electrical machine to provide oxygen to a resident) was observed at bedside. The oxygen concentrator was off and not connected to Resident 150. On March 3, 2020, at 2:30 p.m., Resident 150 was observed inside her room lying in bed awake. The oxygen concentrator was observed to be off and not connected to Resident 150. On March 4, 2020, Resident 150's record was reviewed. Resident 150 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The physician order [REDACTED].@ (at) 2L/min (liter per minutes) via NC (nasal cannula - a tube connected to the nose to deliver oxygen). On March 5, 2020, at 10:04 a.m., the physician's orders [REDACTED]. The QA Nurse confirmed there was a physician's orders [REDACTED]. On March 5, 2020, at 10:20 a.m., the Director of Nursing (DON) was interviewed. The DON stated if Resident 150's oxygen order did not indicate to be administered as needed, then Resident 150 should have been receiving continuous oxygen therapy. The undated facility's policy and procedure titled, OXYGEN THERAPY, was reviewed. The policy indicated, .Oxygen therapy shall be administered as ordered by the physician .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a physician's order was specific for the administration of oxygen and for monitoring oxygen saturation (concentration of oxygen in the blood) for one of four residents reviewed for respiratory care (Resident 100). This failure had the potential for Resident 100 to receive ineffective oxygen therapy. Findings: On March 2, 2020, at 11:45 a.m., Resident 100 was observed inside her room alert and able to respond to questions verbally. Resident 100 was observe receiving oxygen (O2) at 2 Liters per minute via (by way of) nasal cannula (two pronged plastic tubing use to deliver oxygen through the nose). A review of Resident 100's record was conducted on March 3, 2020. Resident 100 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A physician's order dated February 29, 2020, indicated, O2 VIA NASAL CANNULA, KEEP O2 SAT (saturation) > (greater than) 93% (percent). On March 2, 2020, at 4:12 p.m., a concurrent interview and record review with Licensed Vocational Nurse (LVN) 2 were conducted. LVN 2 reviewed Resident 100's Medication Administration Record [REDACTED]. On March 5, 2020, at 9:35 a.m., the Director of Nursing (DON) and the Director of Medical Records (DMR) were interviewed. The DON and the DMR confirmed there was no documentation on the March 2020 MAR for Resident 100 indicating Resident 100's oxygen saturation level was monitored. The DON stated the oxygen saturation level for Resident 100 should have been monitored. The undated facility policy and procedure titled, OXYGEN SATURATION was reviewed. The policy indicated, .Oxygen saturation level should also be monitored .for those residents who are on continuous Oxygen and with [DIAGNOSES REDACTED].
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on interview and record review, the facility failed to ensure sufficient nursing staff was provided, when: 1. During the initial pool process, multiple residents (Residents 7, 15, 32, and 41) stated there was a delay with the staff's response time to call lights, and there was a shortage of nursing staff on various shifts and weekends; 2. During the Resident Council (RC) interview, one of eight residents in attendance stated there was a delay in the staff's response to call lights, and there was a shortage of nursing staff on various shifts; and 3. The facility was staffed below the minimum State requirements on multiple dates. These failures had the potential for the residents not to receive timely and necessary nursing care and related services, to assure the residents' safety, and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in the facility. Findings: On March 2, 2020, an interview was conducted with multiple residents during the initial pool screening process: a. On March 2, 2020, at 11:30 a.m., Resident 7 was interviewed. Resident 7 stated the staff's response to call lights were usually slow during various shifts, and sometimes it took up to one hour for the staff to respond to the call lights. Resident 7 further stated the facility did not have enough nursing staff especially on weekends; b. On March 2, 2020, at 11:05 a.m., Resident 15 was interviewed. Resident 15 stated the call light response were very slow on various shifts. Resident 15 stated it took a long time to receive care from the nursing staff on the weekends; c. On March 2, 2020, at 10:14 a.m., Resident 32 was interviewed. Resident 32 stated the call light response was slow on various shifts. Resident 32 stated the facility needed more staff to respond to call lights in a timely manner; and d. On March 2, 2020, at 9:54 a.m., Resident 41 was interviewed. Resident 41 stated it took a long time for the staff to answer the call lights. Resident 41 stated it took an hour for the staff to answer the call light. 2. On March 3, 2020, at 9:58 a.m., during the RC meeting, one of eight residents in attendance stated the call lights were not answered in a timely manner, and it took up to 30-45 minutes for the staff to respond when the resident called for assistance. The resident further stated the facility was short of staff during various shifts. 3. On March 5, 2020, at 10:19 a.m., an interview and a concurrent record review was conducted with the Payroll Staff (PS). The form titled, Census and Direct Care Service Hours Per Patient Day (DHPPD, a state required form which reflects the facility's total number of nursing hours and nursing hours performed by direct caregivers per patient per day) for the months of December 2019, January 2020, and February 2020, were reviewed. The DHPPD for December 2019, indicated the facility was below the minimum requirement of 3.5 actual DHPPD on 11 of 31 days of the month for all direct caregivers (December 1, 8, 14, 15, 17, 21, 22, 25, 26, 28, and 29), and below the minimum requirement of 2.4 actual DHPPD for CNAs on 15 of the 31 days of the month (December 1, 8, 14, 15, 17, 20, 21, 22, 25, 26, 27, 28, 29, 30, and 31). The DHPPD for January 2020, indicated the facility was below the minimum requirement of 3.5 actual DHPPD on 12 of 31 days of the month for all direct caregivers (January 1, 3, 4, 5, 11, 12, 16, 18, 19, 23, 25, 26), and below the minimum requirement of 2.4 actual DHPPD for CNAs on 18 of the 31 days of the month (January 1, 2, 3, 4, 5, 11, 12, 16, 18, 19, 22, 23, 24, 25, 26, 27, 28, and 29). The DHPPD for February 2020, indicated the facility was below the minimum requirement of 3.5 actual DHPPD on 10 of 29 days of the month for all direct caregivers (February 1, 2, 8, 9, 13, 15, 16, 22, 23, and 29), and below the minimum requirement of 2.4 actual DHPPD for CNAs on 18 of the 29 days of the month (February 1, 2, 3, 4, 5, 8, 9, 10, 12, 13, 14, 15, 16, 17, 22, 23, 24, 26). On March 5, 2020, at 11:40 a.m., the Administrator (ADM) and the Director of Nursing (DON) were interviewed. The ADM stated the facility had identified the insufficient nurse staffing issues for the past several months. The DON stated the facility had a nurse staffing issues and that the facility have been trying to meet the DHPPD nurse staffing requirements. The facility's policy and procedure titled, NURSE STAFFING SUPPORT & STAFF RECALL PROCEDURES, dated July 9, 2015, was reviewed. The policy indicated, The facility shall employ sufficient nursing staff to provide a minimum daily average nursing hours per patient per day staffing ratio . According to Title 22 California Code of Regulations .2(a) Each facility, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall employ sufficient nursing staff to provide a minimum of 3.5 direct care service hours per patient day, except as set forth in Health and Safety Code section 1276.9. Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants to meet the requirements of this subdivision.
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Post nurse staffing information every day.**

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F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Based on observation, interview, and record review, the facility failed to ensure daily nurse staffing information was posted in a prominent place readily available to residents and visitors, and included the total number and the actual hours worked by the licensed and unlicensed nursing staff directly responsible for the resident care per day. This failure had the potential of not having the actual nurse staffing information readily available to the residents and the public to determine if sufficient nurse staffing was available daily to care for the residents. Findings: On March 5, 2020, at 11:07 a.m. an interview and record review were conducted with the Director of Staff Development (DSD). The form titled, Census and Direct Care Service Hours Per Patient Day (DHPPD, a state required form which reflects the facility's total number of nursing hours and nursing hours performed by direct caregivers per patient per day) for the months of December 2019, January 2020, and February 2020, were reviewed. During a concurrent interview, the DSD stated the daily nurse staffing information was posted near the nurse station area. The DSD stated the nurse staffing information data listed was based on the projected DHPPD of the current day. The DSD stated it did not list the actual DHPPD for the licensed and unlicensed nursing staff. On March 6, 2020, at 11:14 a.m., the daily nurse staffing information was observed posted inside a glass cabinet on the wall along the entrance to the nurse station. The daily nurse staffing information data listed the projected DHPPD of the current day, but not the actual DHPPD worked by the licensed and unlicensed nursing staff. During a concurrent interview, Registered Nurse (RN) 1 stated the daily nurse staffing information did not include the actual DHPPD worked by the licensed and unlicensed nursing staff. RN 1 stated the posting placement was not easily visible to the residents, their family, and visitors because it was not in a prominent place. RN 1 stated the daily nurse staffing information should have included the actual DHPPD and should have been posted in a prominent place. The facility's policy and procedure titled, Nurse Staffing, dated September 12, 2019, was reviewed. The policy indicted, .Nurse staffing will be posted on a daily basis at the beginning of each shift. Data must be posted .In a prominent place readily accessible to residents and visitors .Posting will include .the total number and actual hours worked .by nursing staff responsible for the care .
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and services were coordinated with the hospice agency for one resident reviewed for hospice (Resident 27), when the facility staff did not know the hospice plan of care, the hospice schedule, or the care the hospice aide (HA) provided to Resident 27. This failure increased the potential for Resident 27 to not receive the necessary care, services, and treatment for [REDACTED]. Findings: On March 2, 2020, at 9:46 a.m., Resident 27 was observed in his room, lying in bed, awake and confused. There was a strong urine odor inside Resident 27's room. On March 5, 2020, Resident 27's record was reviewed. Resident 27 was admitted to the facility on [DATE], under hospice care, with [DIAGNOSES REDACTED]. On March 5, 2020, at 2:14 p.m., an interview and concurrent review of Resident 21's record were conducted with the Quality Assurance (QA) Nurse and Registered Nurse (RN) 1. The documents titled, Hospice CHHA (Certified Home Health Aide) Note, for the months of November 2019, December 2019, and January 2020, were reviewed. There was no documentation the CHHA reported or communicated to the facility staff the care and services provided for Resident 27. The QA Nurse and RN 1 confirmed there was no documented evidence the hospice agency and the facility coordinated the care and services provided to Resident 27 during the months of November 2019, December 2019, and January 2020. On March 5, 2020, at 2:29 p.m., an interview and concurrent review of Resident 27's record were conducted with the Director of Nursing (DON). There was no documented evidence Resident 27 had a hospice plan of care or a schedule of when the hospice staff would visit Patient 27. The DON stated there should have been a schedule of visits and a hospice plan of care for Resident 27. The undated facility policy and procedure titled, HOSPICE PROGRAM, was reviewed. The policy indicated, .When a resident participates in the hospice program, a coordinated Care Plan between the facility, hospice agency and resident/family will be developed .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, the facility failed to implement infection control precautions to prevent cross contamination and maintain a sanitary environment when: 1. Multiple staff were observed to have long fingernails when serving meals and when providing direct care to one resident (Resident 1); 2. During medication administration observation the licensed nurse did not perform hand hygiene after obtaining medication from the E-kit (Emergency kit) and administering the medication to one resident (Resident 35); 3. The Maintenance Staff (MS) did not wear PPE (personal protective equipment- gloves, mask and gloves) inside an isolation room and did not perform hand hygiene when leaving an isolation room; and 4. The Physical Therapist Assistant (PTA) did not perform hand hygiene after picking up a soiled disinfectant wipe. These failures increased the risk of cross-contamination which could result in the development and transmission of infections to a vulnerable population of 59 residents. Findings: 1. On March 3, 2020, at 9:59 a.m., during the resident council meeting Resident 1 was observed being assisted by Certified Nursing Assistant (CNA) 1 to use the bathroom. CNA 1 was observed with long fingernails. On March 3, 2020, at 12:16 p.m., during lunch observation, CNA 1 and CNA 2 were observed with a long colorful fingernails. During the same observation, the Director of Staff Development (DSD) was observed with long fingernails. The DSD, CNA 1, and CNA 2 were observed assisting residents in the dining room and serving meal trays to the residents. On March 4, 2020, at 11:15 a.m., the DSD was interviewed. The DSD stated the Director of Nursing (DON) told her to cut her fingernails. The DSD stated she did not cut her fingernails because her fingernails were not fake they were polished with gel. On March 4, 2020, at 11:32 a.m., the DON was interviewed. The DON stated fingernails should be short and there should be no hardened gel or artificial fingernails for all facility staff who have direct care contact with the residents. The facility's policy and procedure titled, HAND WASHING, with a hand written date of January 31, 2020, was reviewed. The policy indicated, .Finger nails should not extend beyond the fingertips and no nail polish or artificial nails are allowed . 2. On March 4, 2020, at 8:35 a.m., a medication administration observation was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 was observed to remove medication from the E kit. LVN 1 prepared and administered the medication to Resident 35 without performing hand hygiene. On March 4, 2020, at 9:30 a.m., an interview with LVN 1 was conducted. LVN 1 stated she should have washed her hands after removing medication from the E kit and before administering the medication to Resident 35. The facility's policy and procedure titled, HAND WASHING, with a hand written date of January 31, 2020, was reviewed. The policy indicated, .All staff members will wash their hands before and after direct care and after contact with potentially contaminated substance . 3. On March 4, 2020, a sign was observed on the doorway of Resident 9's room indicating, STOP REPORT TO NURSE BEFORE ENTERING. A hanging rack with personal protective equipment (PPE's - gown's, glove's , mask's, and shoe coverings) was observed stored on the entry door. At 8:06 a.m., Maintenance Staff (MS) 1 was observed exiting Resident 9's room. In a concurrent interview MS 1 stated he did not wear PPE while in Resident 9's room and did not perform hand hygiene. MS 1 stated he should have worn PPE while in Resident 9's room and performed hand hygiene. Resident 9's record was reviewed. Resident 9 was readmitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On March 4, 2020, at 8:48 a.m., an interview with the Director of Nursing (DON) was conducted. The DON stated MS 1 should have worn PPE inside the isolation room and performed hand hygiene. A review of the undated facility's policy titled, INFECTION CONTROL [MEDICAL CONDITION], indicated, . While a resident is in isolation for CDI, ([MEDICAL CONDITION] infection) gloves and gown should be worn when given direct care or having contact with the CDI resident's environment . before exiting the pt's (patient's) room hand washing should be performed immediately. 4. On March 4, 2020, at 10:46 a.m., Physical Therapy Aide (PTA) 1 was observed wearing gloves and wiping down a front wheeled walker with a bleach wipe. The bleach wipe fell on the floor and PTA 1 was observed to pick up the bleach wipe from the floor and continue to wipe the front wheeled walker. In a concurrent interview, PTA 1 confirmed she picked up the bleach wipe and continued to wipe the front wheel walker. PTA 1 stated she should have performed hand hygiene and used a clean bleach wipe from the container before continuing to wipe the front wheeled walker. The undated facility's policy and procedure titled, ISOLATION MEASURES: GENERAL POLICY STATEMENT was reviewed. The policy indicated .If use of common equipment .adequately clean and disinfect them before use for another patient.