STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045168	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JOHNSON COUNTY HEALTH AND REHAB, LLC	1451 EAST POPLAR STREET CLARKSVILLE, AR 72830

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 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure a comprehensive assessment was completed within 14 days after a significant change of status to determine if any changes in care were necessary for 1 (Resident #51) of 25 Residents #51, #46, #66, #10, #56, #105, #5, #29, #7, #22, #256, #61, #71, #92, #31, #18, #98, #59, #50, #38, #34, #2, #11, #96, and #42) sampled residents whose MDS Assessments were reviewed. The findings are: 1. Resident #51 had a [DIAGNOSES REDACTED]. a. The Quarterly Minimum Data Set with an Assessment Reference Date of 5/11/2020 documented the resident scored 9 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status; was totally dependent with one person assistance with locomotion on and off the unit and eating; and was totally dependent with one person assistance with eating. This indicated the resident had a decline in transfers, locomotion on and off the unit and eating, with the resident becoming totally dependent in these areas of activities of daily living. b. On 7/8/2020 at 11:27 a.m., the Minimum Data Set Coordinator was asked, Has there been a decline in activities of daily for (Resident #51)? She stated, Yes, there are changes in there. She was asked, Should a Significant Change of Condition have been completed? She stated, Yes, it was a decline in ADLs (activities of daily living). c. On 7/9/2020 at 10:30 a.m., the Restorative Nurse was asked if Resident #51 had received any Restorative Treatment. She stated, When she first got here, we noticed she was having trouble transferring. We decided it may have been positioning in the room on the side she was on. So, therapy looked at her. She was moved to another room and a raised toilet seat was tried. It was determined that she couldn't follow instructions, so we started using the lift. 2. The Centers for Medicare and Medicaid Services Resident Assessment Instrument Version 3.0 Manual, Chapter 2, Section 03, Page 2 documented, .A 'Significant Change' is a major decline or improvement in a resident's status that . a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting' . b. Impacts more than one area of the residents' health status . and c. Requires Interdisciplinary Review and / or revision of the Care Plan .
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the resident's current status to provide accurate information with which to develop a Care Plan to meet the resident's needs for 1 (Resident #105) of 1 sampled resident who had a [MEDICAL CONDITION] and required suctioning. The findings are: Resident #105 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set with an Assessment Reference Date of 1/2/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ADR) of 6/17/2020 documented the resident was totally dependent with two-person assistance with transfer, bed mobility, and personal hygiene; had limitation in range of motion on both sides of the upper and lower extremities; had no shortness of breath; required oxygen therapy; did not require suctioning; and required [MEDICAL CONDITION] care. a. A physician's orders [REDACTED].Change O2 (oxygen) canister / tubing on Sunday on 11-7 (11:00 p.m. to 7:00 a.m.) shift weekly . Every night shift . Every Sun (Sunday) for maintenance . b. A physician's orders [REDACTED].Deep Suction PRN (as needed) to keep airway patent, prevent choking, gagging and vomiting . c. A physician's orders [REDACTED].O2 (oxygen) (at) 2 l/min (liters per minute) [MEDICAL CONDITION] mask . May remove for ADLs (activities of daily living) . d. The Care Plan with a revised date of 6/30/2020 contained no documentation related to the resident's [MEDICAL CONDITION] care, suctioning, or oxygen therapy. e. On 7/6/2020 at 12:10 p.m., the resident was lying in bed and was receiving oxygen at 2 liters per minute via a [MEDICAL CONDITION] collar. The [MEDICAL CONDITION] collar was dated 6/29/2020. f. On 7/7/2020 at 10:38 a.m., the resident was lying in bed and was receiving oxygen at 2 liters per minute via a [MEDICAL CONDITION] collar. The [MEDICAL CONDITION] collar was dated 7/6/2020. g. On 7/8/2020 at 9:45 a.m., Licensed Practical Nurse (LPN) #2 was asked, Have you received any training for specific respiratory interventions or care, including oxygen and nebulizer treatment? She stated, No, not really. She was asked, You have an order to deep suction. Did you have any special instruction for that? She stated, No. I just suction what he coughs up. She was asked, Who is responsible to assure that machines or equipment used are working properly? She stated, I'm not sure. She was asked, What procedures are in place for power outages? She stated, The generator kicks in. She was asked, Will you describe infection control practices for respiratory care? She stated, We use clean gloves. h. On 7/9/2020 at 9:06 a.m., the Assistant Director of Nursing was asked, Who provides suctioning and emergency care? She stated, The nurses on the hall, and I do. She was asked, When and what type of training do you provide? She stated, The DON (Director of Nursing) checks them off. She was asked, How often are competencies assessed? She stated, Yearly. She was asked, Who is responsible to assure that machines or equipment used for respiratory care are properly working and maintained? She stated, I check them weekly.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Enteral Feeding bags / containers were labeled and dated when initiated, to prevent potential illness by facilitating staff's ability to promptly dispose of any remaining formula if the formula manufacturer's recommended hang time was exceeded for 3 (Residents #105, #7, and #5) of 3 sampled residents who had Physicians Orders for Enteral Feeding. This failed practice had the potential to affect 3 residents who required nutrition via an enteral feeding tube. The facility also failed to ensure enteral feedings were administered according to physician's orders [REDACTED].#105) of 3 (Residents #105, #7, and #5) sampled residents who had physician's orders [REDACTED]. Resident #105 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set with an Assessment Reference Date of 1/2/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ADR) of 6/17/2020 documented the resident had a percutaneous endoscopic gastrostomy tube; received 51% or more of total calories via tube feeding; and received 501 cubic centimeters (cc's) of total fluid intake via tube feeding. a. A physician's orders [REDACTED].[MEDICATION NAME] 1.5 calories via (by) pump at 52 ml/hr (milliliter every hour) . b. The Plan of Care with a revised date of 1/28/19 documented, .[MEDICATION NAME] as ordered for Dysphagia . may remove for shower and reattach as ordered . Intake amount of PEG (Percutaneous Endoscopic Gastrostomy) Intake Amount of PEG Tube Feeding as ordered . Change Tubing Feeding, bag, bottle . Syringe as ordered . c. On 7/6/2020 at 11:10 a.m., the resident was receiving an enteral feeding of [MEDICATION NAME] 1.5 calories via pump at 55 cubic centimeters per hour (cc/hr). The enteral feeding formula bottle was not labeled or dated. The enteral feeding formula contained 600 cubic centimeters (cc's) of formula remaining in the bottle. d. On 7/6/2020 at 11:30 a.m., the Assistant Director of Nursing (ADON) was asked, Should tube feeding 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 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) labeled and dated? She stated, Yes. e. On 7/6/2020 at 1:30 p.m., the enteral tube feeding was hanging and contained no label or date. f. A physician's orders [REDACTED].[MEDICATION NAME] at 52 ml/hr (milliliters per hour) . g. A physician's orders [REDACTED].[MEDICATION NAME] at 55 ml/hr (milliliters per hour) . every shift for Dysphagia . h. A facility policy titled Enteral Feeding provided by the Director of Nursing on 7/6/2020 documented, .Label, date, time and initial . 2. Resident #5 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ADR) of 6/29/2020 documented the resident scored 14 (13 to 15 indicates cognitively intact); on a Brief Interview for Mental Status, was totally dependent for eating; received Nothing By Mouth (NPO); received 51% or more of total calories daily via tube feeding; and received 501c cc's or more of fluid intake via tube feeding. a. The Comprehensive Care Plan with a revision dated of 9/30/19 documented, .Tube feeding as ordered . b. A Physicians Order dated 4/11/20 documented, .Two-Cal HN (High nitrogen) at 44 cc/hr (cubic centimeters) via (by) pump . c. On 7/6/2020 at 10:53 a.m., the resident was receiving a tube feeding of Two Cal (calorie) HN infusing at 44 cc/hr via pump. There were 750 cc's remaining in the enteral formula container. The enteral feeding container of formula was not labeled or dated, and the resident's container of water was not dated. The head of the resident's bed was up, but the resident was slid down in the center of the bed. d. On 7/6/2020 at 10:54 a.m., the Assistant Director of Nursing (ADON) was in the resident's room looking at the resident's oxygen. The ADON was asked, Should the tube feeding be labeled and dated? After looking at the tube feeding, she stated, It should be. I will take care of it e. On 7/6/2020 at 12:53 p.m., the resident's tube feeding was not labeled or dated. f. On 7/7/2020 at 10:00 a.m., the resident's tube feeding was labeled and dated. 3. Resident #7 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ADR) of 4/2/2020 documented the resident was moderately impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; was totally dependent for nutrition; received 51% or more of total calories per tube feeding; and received 501 cubic centimeters (cc's) or more of total fluid intake per tube feeding. a. The Comprehensive Care Plan dated 1/3/2020 documented, .Tube Feeding (and) Flushes as ordered . b. A physician's orders [REDACTED].[MEDICATION NAME] 1.2 at 55 cc/hr (cubic centimeters per hour) via (by) Kangaroo pump . c. On 7/6/2020 at 10:42 a.m., the resident was receiving [MEDICATION NAME] 1.2 calories 55 cc/hr via feeding pump. The of the resident's water flush was hanging and was dated 7/6/2020. The tube feeding syringe was dated 7/6/2020. The resident's container of enteral formula of [MEDICATION NAME] 1.2 was not labeled or dated.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure medication carts were kept locked while unattended for 1 (600 Hall) of 4 medication carts, and failed to ensure expired medications were removed from the Medication Cart and placed into an area for destruction to prevent potential administration to 1 (Resident #63) of 1 sampled resident who had physician's orders [REDACTED].#69) of 1 sampled resident who had physician's orders [REDACTED]. On 7/8/2020 at 9:39 a.m., an unlocked Medication Cart was in the 600 Hall hallway in front of room [ROOM NUMBER]. (The Surveyor took a photograph of the Medication Cart at this time.) At 9:43 a.m., Registered Nurse (RN) #1 was asked if the Medication Cart was unlocked. She stated, Yes. I just locked it. She was asked, Where is the nurse who left the Medication Cart unlocked? She stated, She is in his room. She pointed to Resident #617's room. The door to the resident's room was partially closed. a. On 7/8/2020 at 9:47 a.m., Licensed Practical Nurse (LPN) #1 exited the resident's room with the Therapist. LPN #1 was asked where she was when she left her medication cart unlocked. She stated, I was in room [ROOM NUMBER]. I went in there and forgot my stuff, so came back to get a breathing treatment. I removed my PPE and unlocked the Medication Cart to get the breathing treatment and forgot to lock it back up when I went back in the room. She was asked, Should the Medication Cart have been left unlocked? She stated, No. b. On 7/8/2020 at 10:00 a.m., the Director of Nursing (DON) was asked if the Medication Carts should be left unlocked. She stated, No, not when they are outside of the line of site of the Medication Cart. She was asked, If the Nurse is inside a Resident's room and the Medication Cart is out in the hallway against the wall outside of his room, should the Medication Cart be unlocked? She stated, No, it should have been locked. 2. On 7/7/2020 at 10:25 a.m., the following observations were made in the Medication Cart on the 200 Hall with LPN #1: a. On 7/7/2020 at 10:26 a.m., one vial of Insulin [MEDICATION NAME] R (Regular) was stored in a drawer in the 200 Hall Medication Cart. The opened vial of insulin documented an opened date of 6/3/2020. LPN #1 was asked, Is this the insulin that you used for this resident? She stated, Yes. She was asked, Is the insulin in date? She stated, No. It should be replaced. It is only good for 28 days after it is opened. b. On 7/7/2020 at 10:27 a.m., one Medication Card containing [MEDICATION NAME] HCL ([MEDICATION NAME]) 4 milligrams (mg) was stored in the bottom drawer of the 200 Hall Medication Cart. The Medication Card of [MEDICATION NAME] HCL pharmacy label documented an expiration date of 5/25/2020. LPN #1 was asked, Is this medication expired? She stated, Yes. She was asked, Should it be on the Medication Cart? She stated, No.
F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide or obtain dental services for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide documentation of interventions implemented to ensure the resident could maintain adequate nutritional status while awaiting dental services for 1 (Resident #66) of 2 (Residents #21 and #66) sampled residents who had dentures. The findings are: 1. Resident #66 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of 5/21/2020 documented the resident scored 8 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status; required limited assistance with meals; and had no natural teeth or teeth fragments. a. On 7/6/2020 at 9:31 a.m., the resident stated she had been without dentures for about 3 weeks and the facility had been giving her the same meals without changing her diet to soft foods. She stated she was having trouble chewing her food and she was eating a lot of soup. b. On 7/6/2020 at 12:40 p.m., the resident was eating lunch in her room. Her meal consisted of soft vegetables and an intact pork chop. The resident consumed approximately 2% of the pork chop and approximately 25% of the soft vegetables. c. On 7/9/2020 at 11:21 a.m., the Administrator was asked, Can you provide the facility's policy regarding when the facility will replace lost / damaged dentures? She stated, It talks about that in the Admission Packet, but I can tell you what the process is. When we are told that the dentures are lost or damaged, we look for them very thoroughly, and if we can't find them, then we immediately contact our dental provider. For (Resident #66), when we called the Mobile Dental Services, they were not able to come right away as they normally would due to COVID. She was asked, Can you tell me what the facility did to ensure the resident was able to continue to eat while awaiting dental services? She stated, I think the Dietary Manager spoke with the resident and she (the resident) didn't want to change anything. She was asked, Where is that conversation documented? She stated, I am not sure she did document that. She was asked, Where should it be documented? She stated, In the Progress Notes. d. On 7/9/2020 at 11:23 a.m., the Director of Nursing (DON) was asked, Can you provide documentation with the interventions initiated to ensure the resident was able to continue to eat while awaiting dental services for replacement dentures? She stated, I believe the Dietary Manager spoke with the resident around the time her dentures were lost, and the resident did not voice any difficulty with chewing her food. She was asked, Do you know when this conversation took place? She stated, No, but it was close to the time the dentures went missing. e. On 7/9/2020 at 12:02 p.m., the Dietary Manager was asked, Did you speak with the resident regarding her dentures being lost? She stated, Yes, and she told me she did not want to make any changes to her diet. f. On 7/9/2020 at 12:50 a.m., the Social Director was asked, When did the resident's dentures go missing? She stated, On May 19, 2020. She was asked to explain what actions were taken after the dentures were known to be lost. She stated, I get notified immediately and make the referral. I called the Mobile Dental company the same day (May 19, 2020) but they (Mobile Dental) were not able to come into the building due to COVID. She was asked if she knew the date the company planned to come to the facility. She stated, I believe it is going to be this week, but we had a positive (COVID-positive) resident in the facility for 3 weeks and that resident has had one negative test. g. As of 7/9/2020 at 12:55 a.m., the Medication Review Report with the date range of 6/1/2020 through 7/8/2020 documented, .Dietary Order Summary . Regular, NAS (no added sodium) diet . Regular texture . Regular consistency . Low fiber . No milk products . 2000 ml (milliliters) fluid restriction every 24 hours . Can have Regular fish . Fortified juice TID (three times a day) with meals . Order Date 9/23/2019 . Regular, NAS (no added sodium) Diet . Regular texture . Regular consistency . Low fiber . No

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F 0791 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) milk products . 2000 ml (milliliters) fluid restriction every 24 hours . Can have Regular fish . Fortified juice TID (three times a day) with meals . Ground meat with meals . Order Date 7/9/2020 . h. On 7/10/2020 at 8:04 a.m., the Registered Dietician was asked, How are you made aware of issues regarding residents' nutritional status? She stated, I am reviewing the records off-site during COVID. She was asked, Were you aware (Resident #66) had lost her dentures on 5/19/2020? She stated, No. I was not informed. She was asked, Can you look at the documentation and tell me if it had been documented? She stated, It was not documented in any of the documents I review for off-site review. She was asked, Did anybody from the facility notify you that she had lost her dentures on 5/19/2020? She stated, No, not until yesterday. I spoke with (Dietary Manager) yesterday and she stated that when she spoke with the resident at the time the resident lost the dentures, the resident told her that she did not want to make any changes to her diet. She was asked, Do you know if anyone readdressed the issue at any time other than on 5/19/2020? She stated, She (Dietary Manager) did yesterday I believe. i. On 7/10/2020 at 10:00 a.m., the Dietary Manager was asked if she spoke with the resident again yesterday. She stated, Yes and she told me she has been having trouble chewing and wants a Mechanical Diet. j. The facility policy titled Dental Services provided by the Administrator on 7/9/2020 at 11:38 a.m., documented, .The facility will promptly refer a resident with lost or damaged dentures to a dentist . ' Prompt referral ' means, within reason, that an appointment will be made as soon as the dentures are lost or damaged. In the interim, the facility will document efforts to ensure the resident is able to adequately eat and drink while awaiting dental services and any extenuating circumstances leading to a delay in treatment .
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure 2 of 2 ice machines and dietary equipment were maintained in a clean and sanitary manner and failed to ensure food was properly stored in a sanitary manner to prevent the potential of food borne illness. The failed practices had the potential to affect 100 residents who received ice and meals from the kitchen, and 100 residents who received ice from the ice machines, according to the list provided by the Dietary Manager on 7/6/2020. The findings are: 1. On 7/6/2020 at 11:20 a.m., an ice machine located in front of the kitchen was checked for cleanliness. The Dietary Manager used a white napkin and wiped the inside shield and the surrounding area of the ice machine. After wiping the ice machine, there was an unidentified black substance on the napkin. The Dietary Manager was asked what she saw. She stated, Black stuff. She was asked what she thought the substance could be. She stated, Sedimentation from the water. 2. On 7/6/2020 at 11:30 a.m., two opened 32-ounce cartons of tomato juice were on a shelf in the refrigerator. One carton had a received date of 6/18/2020 and the second carton had a received date of 6/4/2020. The cartons of tomato juice had no opened date. The Dietary Manager was asked what the shelf life of the tomato juice was once opened. She stated, 10 days. She was asked, Can the safety of the juice be determined without an opened date? She stated, No. 3. On 7/6/2020 at 11:35 a.m., the stand mixer had an unidentified dried substance on the underside where the beaters fit. The Dietary Manager was asked, What do you see? She stated, Dry splatter. They used it yesterday to mix a cake. 4. On 7/6/2020 at 11:38 a.m., an opened bottle of lemon juice was on a pantry shelf. The label on the bottle of lemon juice documented Refrigerate After Opening on the side of the bottle. The Dietary Manager was asked to look at the bottle. She stated, Oh, it says to refrigerate after opening. 5. On 7/6/2020 at 12:10 p.m., the ice machine on the 200 Hall was checked for cleanliness. The Dietary Manager took a white napkin and wiped the inside ice dispensing spout. When the napkin was removed from the dispensing spout, the napkin contained an unidentified black residue. The Dietary Manager was asked to describe what she saw. She stated, Blackish stuff.
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, record review, and interview, the facility failed to ensure staff followed isolation precautions, including the consistent appropriate disposal and handling of contaminated / soiled Personal Protective Equipment (PPE) and supplies, to prevent potential cross-contamination which could result in infection or other complications for 1 (Resident #256) of 1 sampled resident who had physician's orders [REDACTED]. These failed practices had the potential to affect 5 residents who required isolation, and 103 residents who resided in the facility, according to a list provided by the Administrator on 7/ at 8:35 a.m. The findings are: 1. Resident #256 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of 7/2/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status; required extensive two person assistance with transfers; required extensive one person assistance with personal hygiene; experienced shortness of breath with exertion and when lying flat; required oxygen therapy; and did not require isolation. a. On 7/6/2020 at 11:35 a.m., the resident was lying in bed and was receiving oxygen via a nasal cannula. Two isolation disposal barrels were in the resident's room. One isolation barrel was over-flowing and contaminated / soiled PPE was protruding from under the lid on top of the barrel. b. On 7/8/2020 at 9:47 a.m., Licensed Practical Nurse (LPN) #1 and the Therapist were in the resident's room. The resident was lying in bed. Both isolation barrels in the resident's room containing contaminated / soiled PPE which was over-flowing from under the closed lids on the barrels. c. On 7/8/2020 at 9:53 a.m., the Therapist exited the resident's room after disposing of her PPE in one of the overflowing barrels. LPN #1 also disposed of her PPE in the overflowing barrels. LPN #1 was asked if the isolation barrels had contaminated / soiled PPE overflowing from them. She stated, Oh, yes they do! (She looked at the barrels.) She was asked if they should have contaminated / soiled PPE overflowing. She stated, No, they shouldn't! She was asked, Who is responsible for making sure the barrels are emptied and disposed of properly? She stated, I think it is the aides (Certified Nursing Assistants) responsibility. d. On 7/8/2020 at 9:54 a.m., the Therapist, was replenishing the Isolation Three-Drawer Supply plastic bins outside of the resident's and other isolation rooms down the hallway. She stated, Those barrels are supposed to pulled by the CNAs (Certified Nursing Assistants) if full at the end of each shift and put it in the isolation barrel hopper rooms. She turned and instructed LPN #2, Make sure the resident's isolation barrels are taken care of immediately.! e. On 7/8/2020 at 10:00 a.m., the Director of Nursing (DON) was asked, Whose responsibility is it to ensure the isolation barrels are emptied and disposed of properly? She stated, They are pulled at the end of shift if full by the CNAs and put in the isolation barrel hopper rooms. 2. On 7/7/2020 at 10:10 a.m., Laundry Employee #1 was asked, How is clean linen transferred to the residents? She stated, Personal clothing is transferred in covered carts. We handle it so it doesn't touch our clothing. She was asked, How about linens, blankets, sheets, et cetera? She stated, It is put in a bin and taken to resident rooms or storage closets on the hall. She was asked, Is it covered? She stated, No. a. On 7/7/2020 at 10:15 a.m., the Housekeeping and Laundry Supervisor, was asked, How is the linen transferred to the halls? He stated, It is put in a bin and rolled down the halls. He was asked, Is it covered? He stated, No, should it be? b. On 7/8/2020 at 9:42 a.m., a bin containing linens, such as sheets, towels, and blankets, was being pushed down the 600 Hall, and was not covered.