STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465094	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOODLAND PARK REHABILITATION AND CARE CENTER	**3855 SOUTH 700 EAST SALT LAKE CITY, UT 84106**

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** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to establish an infection prevention and control program designed to prevent the development and transmission of COVID-19. Specifically, observations were made of staff not performing hand hygiene during the lunch meal tray delivery, and a resident on droplet precautions was observed seated in the open doorway to their room. Resident identifier 5. Findings include: 1. On 8/11/2020 at approximately 12:10 PM, an observation was made of Certified Nurse Assistant (CNA) 1 delivering lunch meal trays to resident rooms. CNA 1 was observed to donn a gown and gloves prior to delivery. No hand hygiene was observed prior to donning of gloves. CNA 1 was observed to deliver coffee to room [ROOM NUMBER]A and place on the bedside table. Hand hygiene was not performed upon exiting the resident room. On 8/11/2020 at 12:13 PM, CNA 1 delivered a meal tray to room [ROOM NUMBER]B. The tray was placed on the bedside table, and items on bedside table were pushed to the side to clear room for the meal tray. Hand hygiene was not performed upon exiting the resident room. CNA 1 then removed a tray from the meal cart and delivered it to bed 120A. Hand hygiene was not performed upon exiting the resident room. CNA 1 was then observed to deliver a meal tray to room [ROOM NUMBER]A. CNA 1 asked the resident if he would like more water and the resident replied yes. CNA 1 removed the resident's water mug and placed it on top of meal cart. Hand hygiene was not performed upon exiting the resident room nor after touching the resident mug. CNA 1 was then observed to deliver a meal tray to room [ROOM NUMBER]. Hand hygiene was not performed upon exiting the resident room. On 8/11/2020 at 12:15 PM, CNA 1 was observed to deliver meal trays to room [ROOM NUMBER]B and 118A. Hand hygiene was not performed upon exiting either resident room. On 8/11/2020 at 12:17 PM, an interview was conducted with CNA 1. CNA 1 was asked when she should perform hand hygiene during the meal tray delivery. CNA 1 stated that her hands were clean and she had gloves on so no contamination. On 8/11/2020 at 12:21 PM, an interview was conducted with Registered Nurse (RN) 5. RN 5 stated that hand sanitizer was located inside each resident room by the door and that staff also had a bottle of hand sanitizer provided to them by the facility. On 8/11/2020 at approximately 12:22 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the CNAs should perform hand hygiene after each meal tray delivery. The DON stated that the staff had access to either a room dispenser of alcohol-based hand rub (ABHR), a bottle of ABHR or a sink to wash their hands. The DON instructed all CNAs to remove their gown and gloves for meal tray delivery. On 8/11/2020 at 12:31 PM, CNA 1 was observed to deliver a meal tray to room [ROOM NUMBER]A. Hand hygiene was not performed upon exiting the resident room. CNA 1 was then observed to deliver a meal tray to room [ROOM NUMBER]B. CNA 1 was observed to take 106B water mug to the meal service cart, remove the lid and fill it with lemonade that was located in a pitcher on top of the meal cart. The resident's mug was returned to the resident room. CNA 1 was observed to perform hand hygiene with ABHR afterwards. Review of the Centers for Disease Control and Prevention guidance on Hand Hygiene in Healthcare Settings under When to Perform Hand Hygiene stated, after touching a patient or the patient's immediate environment. The recommendation was reviewed on January 31, 2020. Review of the Centers for Disease Control and Prevention guidance on Preparing for COVID-19 in Nursing Homes under Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices stated, Unless hands are visibly soiled, an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations. The recommendation was updated on June 25, 2020. 2. Resident 5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 8/13/2020 at approximately 11:15 AM, the North unit was observed. This unit consisted of the rooms numbered in the 200's. One room had a droplet precautions sign on the door and personal protective equipment (PPE) in a cart outside the door. The door to the room was observed to be open and resident 5 was in the room. On 8/13//2020 at 11:18 AM, the nurse for the North Unit was interviewed (RN 7). RN 7 stated that resident 5 was on droplet precautions and must remain six feet away from other residents due to his refusal to have a second COVID-19 test after other residents recently tested positive. On 8/13/2020 at 11:20 AM, resident 5 was observed in the droplet precaution isolation room. Resident 5 was observed sitting in the doorway to the room, facing the hallway. Resident 5 was observed to not wear a mask. Resident 5 stated that he had refused a COVID-19 test recently, so he was on precautions for COVID-19. On 8/13/2020 between 11:30 AM and 1:12 PM, resident 5's door remained propped open, and resident 5 was observed sitting in his doorway without wearing a mask. Resident 5 was observed to talk to four staff members and one resident who were in the hallway. Staff members included one nurse, two certified nursing assistant (CNAs) and one housekeeper. Staff members did not ask resident 5 to put on a mask, close his door, or remain six feet from other residents. Staff were observed to talk to resident 5 about lunch and organizing his room. Resident 5 was offered water and other drinks for lunch while resident 5 was sitting in his doorway. On 8/13/2020 at approximately 1:30 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that all residents were tested for COVID-19 on 8/8/2020, with the exception of resident 5, who refused. The DON stated that several residents had tested positive, and a COVID-19 unit was created in the facility. The DON stated that all residents in the facility had the potential of being exposed to COVID-19. The DON stated that resident 5 was on precautions to protect the other residents in the facility.

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