STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE CREEK VILLAGE	**2530 NORTH MONROE STREET DECATUR, IL 62526**

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 0564 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to allow visitors during end of life care for one of three residents (R2) reviewed for end of life care in the sample of 40 residents. Findings include: V31's (Dietitian) Note dated [DATE] documents (R2) Due to significant wt (weight) decline since previous admit and diet downgrade recently, requesting to evaluate for feeding tube placement. Noted PU (pressure ulcer) on sacrum stage 4. The Progress Note dated [DATE] at 2:40 am documents (R2) frequent checks revealed resident to have . increased episode of slow response, decreased fluid intake- non verbal, Lower extremities cool to touch but not discolored, bilateral lung congestion 02 sat (oxygen saturation)- 83% placed on o2 (oxygen) per nursing measure. The Progress note dated [DATE] at 2:53 am documents R2 was transferred to the hospital at that time. The Progress Note dated [DATE] at 3:22 PM documents Resident (R2) returned to facility per (ambulance). Resident does not verbalize anything except ouch with movement of extremities or body. Noted per skin assessment left heel dime size red/purple discoloration, rt (right) heel red with slight [MEDICAL CONDITION], rt side of buttocks red/purple in color, no drng (drainage) or foul odor present, left hand areas of discoloration with intact skin. PEARl (pupils equal, round and reactive to light and accommodation), grips weak, Bilateral lungs clear at this time. Abdomen soft with hypoactive bowel sounds. Body remains very rigid and stiff. Oral cavity moist and pink in color. Cap (capillary) refill less 3 sec. Pedal pulses weak. The Progress Note dated [DATE] at 9:56 PM documents Resident evaluated and admitted to (hospice care). Hospice Nurse here and orders for [MEDICATION NAME] 0.25 ML (Milliliters) every ,[DATE] hours PRN (as needed) and [MEDICATION NAME] 0.25 ml every 4 hours received staff continues to monitor. The Progress Note dated [DATE] at 3:50 AM documents CNA (Certified Nurses Aide) called writer to room. Resident without respirations, pulse, or blood pressure at 0215. Hospice nurse aware at 0220. On [DATE] at 10:30 am V36 Family Member stated R2 returned to the facility on a Monday ([DATE]) and V1 Administrator and V37 Previous Director of Nurses told the family R2 could have one visitor at a time. V36 stated they were able to visit R2 on Tuesday ([DATE]) and were then told R2 could not have visitors unless R2 was actively dying. V36 stated V36 asked V1 how to define actively dying and V1 stated that's the rules. V36 stated V36 called the facility to check on R2 on [DATE] and R2's nurse was not aware R2 was on hospice. V36 stated R2 died on [DATE]. On [DATE] at 10:40 am V1 Administrator was asked if V1 consulted with R2's Physician or the Local Public Health Department to determine R2's status when R2's family was requesting to visit and V1 stated that R2 was the facility's first hospice resident during the emergence of COVID 19. V1 stated they were developing their policy and stressing only essential visits. The COVID 19 Facility Response Policies Current Through [DATE] document states All visits will be restricted to essential visits only. An essential visit is an end of life situation and decisions about visitation during an end of life situation should be made on a case by case basis.
F 0573 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Let each resident or the resident's legal representative access or purchase copies of all the resident's records.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide personal and medical records within two working days for four of four residents (R5, R28, R29 and R30) reviewed for medical records requests in the sample of list of 40 residents. The findings include: 1. V10 stated during telephone interview on 7/27/20 at 9:00 am that V10 is the Power of Attorney (POA) for R5. V10 stated that V10 requested a copy of R5's medical records to clear up insurance issues related to the facility reporting to V10 on 4/20/20 that R5 had passed away when in fact it was another resident (R1). V10 stated V10 received an ambulance bill for that date with R5's name on it. V10 stated V10 requested R5's medical records verbally and in writing the beginning of May 2020 and did not receive the copies until the beginning of June 2020. V10 stated V10 also hand delivered a request for medical records from R5's attorney to the facility. V10 stated V10 spoke with two different (unknown names) staff in the Medical Records Department who told V10 that due to the Covid-19 restriction the Medical Records Staff were only working every other day and it was taking longer. Medical Record V17 stated during interview on 7/29/20 that R5's name was not on her list of Medical Record Requests. 2. The Authorization for Release of Health Information form dated 6/4/20 documents a request from V39 (R28's Family) for R28's medical records. The letter dated 6/10/20 documents a request from a Legal Firm for R28's Medical Records. On 8/4/20 at 7:30 am V17 Medical Records stated V17 received the requests for R28's medical records on 6/17/20 and sent the requests to the facility's legal department. V17 stated V17 sent a flash drive of R28's medical records to R28's legal representative on 7/29/20. 3. The Authorization for Release of Medical Information/Records form dated 5/4/20 documents R29 requested R29's medical records on that date. On 8/4/20 at 7:30 am V17 stated R29 came to the facility on [DATE] and completed the paperwork to request R29's medical records. V17 stated R29's medical records were sent to R29 on a flash drive on 7/17/20. 4. The Letter dated 7/6/20 documents a request for medical records for R30 from V38 (Family Member). On 8/4/20 at 7:30 am V17 stated V17 received the letter from V38 requesting R30's medical records in the mail around 7/13/20 and V17 sent the letter to the facility's legal department that day. V17 stated the records have not been sent to V38. V17 stated V17 is getting ready to send them. The Release of Information policy dated 2/2016 states Residents may initiate a request to release such information contained in their medical records and charts to anyone they wish. Such requests will be honored only upon receipt of a written, signed and dated request from the resident or legal representative. The policy also states At least forty-eight hours advanced notice must be provided to the facility when photo copies of the resident's record are requested.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow a physician order [REDACTED]. R5's Physician order [REDACTED]. The undated Resident Census documents R1 was admitted to room [ROOM NUMBER]-B on [DATE]. R1's Hospital After Visit Summary dated [DATE] documents Discharge Instructions Code Status: No Code. R5's Progress Note dated [DATE] at 1:10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE CREEK VILLAGE	**2530 NORTH MONROE STREET DECATUR, IL 62526**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) am documents CNA (Certified Nurses Aide) doing routine rounds called for help. Writer (V26 Licensed Practical Nurse) rushed to the room and found res (resident) to have no heart beat and no pulse. Writer called for nursing staff to assist in CPR (Cardiopulmonary Resuscitation) and began @ (at) this time. 911 called @ this time d/t (due to) full code status. The addendum to the note dated [DATE] at 5:36 am documents Reason for Invalidation: Wrong resident. R1's Progress Note dated [DATE] at 1:22 am, created on [DATE] at 6:17 am states Staff doing rounds yelled for writer to come to room [ROOM NUMBER]-A. Writer rushed to the room and found res no heart beat an no pulse. Verified TOD (time of death) via 2nd nurse. On [DATE] at 2:30 PM V26 stated on [DATE] V26 notified the wrong family of a resident death because R1 and R5's were listed in the computer system in the wrong beds. On [DATE] at 10:40 am V1 Administrator stated V26 had R1 and R5 confused because V26 was not familiar with R5 and R1. V1 confirmed R1 and R5 were listed in the computer system in the wrong beds. V1 confirmed that R5's Progress note documents R5 was found with out a pulse and CPR was started, but the resident found without a pulse was R1.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to monitor meal intake and implement dietitian recommendations for three of three residents (R2, R12 and R13) reviewed for weight loss in the sample of 40 residents. Findings include: The undated Significant Weight Loss Procedure states Nursing will contact the attending physician with dietary recommendations promptly, within 72 hours and Meal intake records will be started and completed on all residents with significant weight loss. 1. The Physician order [REDACTED]. The Minimum (MDS) data set [DATE] documents R13 is severely cognitively impaired. R13's Nutritional Status Care Plan dated 7/29/20 documents Monitor amount of food consumed at each meal. The Vitals Results sheet dated 12/1/19 to 7/30/20 documents the following weights for R13: 1/9/20 148 pounds, 2/9/20 142.2 pounds, 4/3/20 134.2 pounds, 5/7/20 129 pounds, 6/9/20 121.9 pounds and 7/9/20 119.6 pounds. R13's Meal Intake documentation for July 2020 includes no documentation for 7/2/20 - 7/4/20, 7/6/20 - 7/15/20, 7/17/20-7/22/20, 7/24/20, 7/26/20, 7/27/20 or 7/28/20. V31's (Dietitian) Note dated 4/19/20 documents (R13) Reviewed for wt (weight) loss of 12% past 3 months. V31's Note dated 5/22/20 documents (R13) Reviewed for wt (weight) loss at 3,6 months with net loss of 11% past 6 (months). The Note documents R13 is at increased nutrition risk related to Dementia and advanced age. V31's Note dated 6/17/20 documents (R13) Reviewed for further wt (weight) loss past month, -5.5% H/O (history of) [MEDICAL CONDITION] and remains on [MEDICATION NAME]; all of which can affect wt/appetite. Appetite is fair and is at nutritional risk related to progressing dementia and multiple other comorbidities. Will request to increase 2.0 (supplement) to 180 cc(cubic centimeters) x 4 (four times a day). The Dietary Recommendations/Follow Up dated 6/17/20 documents V31 recommended that R13's 2.0 supplement be increased to 180 cc four times daily. The Medication Administration Records dated 6/1/20 through 7/29/20 document R13's 2.0 supplement has not been increased to 180 cc four times a day. On 7/30/20 at 9:15 am V32 Dietary Manager stated V31's recommendations are sent to nursing and the nurses are responsible for sending the recommendations to the physician for signature. On 7/30/20 at 9:15 am V1 Administrator stated V31's recommendation should have been processed by V2 Director of Nurses (DON) and V2 should have followed up to ensure the recommendation was implemented. On 8/4/20 at 10:15 am V31 Dietitian stated a significant weight loss would be considered a 5% or greater weight loss in one month, a 7.5% or greater weight loss in three months or a 10% or greater weight loss in six months. V31 stated R13's weight loss of 12% in three months, 11% in six months and 5.5% in one month would be considered significant weight loss. 2. R12's Care Plan dated 5/5/20 documents R12 has [DIAGNOSES REDACTED]. The Care Plan documents an intervention of monitor amount of food consumed at meals. The Minimum (MDS) data set [DATE] documents R12 has severe cognitive impairment and requires extensive assistance with eating. The Vitals Results sheet dated 12/1/19 to 7/30/20 documents the following weights for R12: 12/9/19 118.2 pounds, 12/23/19 112.4 pounds, 1/28/20 107.4 pounds, 4/7/20 106.4 pounds and 5/12/20 104.4 pounds. The Dietary Recommendations/Follow Up dated 12/21/19 documents V31 requested R12's 2.0 supplement to be increased to 120 cc four times a day. The Medication Administration Records dated 12/1/19 through 1/31/19 document R12's 2.0 supplement was not increased to 120 cc four times a day until 1/10/20. On 7/30/20 at 10:00 am V1 Administrator stated V1 would have expected V31's recommendation to be implemented sooner. 3. R2's Care Plan dated 1/1/19 though 7/29/20 documents R2 has [DIAGNOSES REDACTED]. The Care Plan documents an intervention of Monitor amount of food consumed at meals. V31's Note dated 11/26/2019 documents (R2) Reviewed for wt loss of 17.4 % past 6 months with low BMI (body mass index) at 18. Goal BMI(Body Mass Index) is 19 and is at increased nutrition risk per Dementia DX (diagnosis) Diet is pureed with double gravy on meats and 2.0 supplement 180 CC x4 (four times a day.) Appetite varies and is assisted with meals. Will request to add fortifieds x3 daily for more calorie dense foods. R2's Meal Intake Documentation dated December 2019 January 2020 includes no documentation of meal intake for 12/22/20 - 12/24/20, 12/26/19, 12/31/19, 1/3/20, 1/5/20, 1/7/20-1/9/20, 1/12/20, or 1/20/20. On 8/4/20 at 7:35 am V1 Administrator was asked if V1 had any additional documentation of meal intake for R13 or R2 and V1 stated unfortunately no. On 8/4/20 at 10:15 am V31 Dietitian stated If residents are not eating or have weight loss V31 would encourage the staff to monitor meal intake.

F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately document bed assignments, weight and physician orders [REDACTED]. Findings Include: 1. The undated Resident Census documents R5 was admitted to the facility on [DATE] to room [ROOM NUMBER]-A and then transferred to room [ROOM NUMBER]-A on [DATE]. The undated Resident Census documents R1 was admitted to room [ROOM NUMBER]-B on [DATE]. R5's Progress Note dated [DATE] at 1:10 am documents CNA (Certified Nurses Aide) doing routine rounds called for help. Writer (V26 Licensed Practical Nurse) rushed to the room and found res (resident) to have no heart beat and no pulse. Writer called for nursing staff to assist in CPR (Cardiopulmonary Resuscitation) and began @ (at) this time. 911 called @ this time d/t (due to) full code status. The addendum to the note dated [DATE] at 5:36 am documents Reason for Invalidation: Wrong resident. R5's Progress Note dated [DATE] at 1:15 am documents POA (Power of Attorney) (V10) called and informed of res condition at this time and (ambulance service) being called to facility d/t to res having no pulse and no heartbeat. The addendum to the note dated [DATE] at 5:37 am documents Reason for Invalidation: wrong resident. R5's Progress Note dated [DATE] at 2:13 AM documents (ambulance) at facility @ this time an called TOD (time of death) @ 1:22 am. POA (V10) and (V28 Physician) aware. The addendum to the note dated [DATE] at 5:37 am documents Reason for Invalidation: wrong resident. R5's Progress Note dated [DATE] at 1:59 am documents Family stated they will be here in the AM to pick up res belongings. Macon County Corners office called and given TOD of 1:22 am by writer and given clearance to release body to the funeral home. The addendum to the note dated [DATE] at 1:55 PM documents Reason for Invalidation: wrong resident Invalidation. R1's Progress Note dated [DATE] at 1:22 am, created on [DATE] at 6:17 am states Staff doing rounds yelled for writer to come to room [ROOM NUMBER]-A. Writer rushed to the room and found res no heart beat an no pulse. Verified TOD via 2nd nurse. R1's Progress Note dated [DATE] at 4:00 am, created on [DATE] at 6:23 am states POA (V15) and (V29 Physician) aware of TOD of 1:22 am. On [DATE] at 2:30 PM V26 stated V26 notified the wrong family of a resident death because R1 and R5's were listed in the computer system in the wrong beds. On [DATE] at 10:40 am V1 Administrator confirmed R5's family was notified R5 was dead when R5 was still living and R1's family's notification of R1's death was delayed because R5 and R1 were listed in the computer system in the wrong beds. V1 also stated V26 had not worked on the floor before and was not familiar with the residents. 2. The Progress Note dated [DATE] documents R2 was admitted to the hospital on [DATE]. The Progress Note dated [DATE] documents R2 returned to the facility on [DATE]. The Vitals Search Results sheet dated [DATE] through [DATE] documents R2 was weighed on [DATE] at 3:41 PM by V17 (Medical Records) and that R2's weight was 83.7 pounds. On [DATE] at 10:40 am V1 Administrator confirmed R2 was not residing at the facility on [DATE] when V17 documented V17 weighed R2. 3. The Wound Evaluation and Management Summaries dated [DATE] and [DATE] document an order from V30 Wound Physician for R4 to have a treatment of [REDACTED]. The Wound Evaluation and Management Summary dated [DATE] documents V30 Wound Physician assessed R4's right heel diabetic wound and documented that the wound had deteriorated. The Wound Evaluation and Management Summary dated [DATE] documents V30 changed R4's right heel wound treatment to Alginate calcium apply once daily and Foam without border once daily. R4's Treatment Administration Records (TAR) dated [DATE] through [DATE], [DATE] through [DATE] and [DATE] through [DATE] document Cleanse (R) heel with NS (normal saline) then apply Calcium Alginate cover with non border foam Q (every three days) at bedtime give 3 days hold 1 day. The TARS document staff were completing R4's right heel wound treatment three days in a row and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146003	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE CREEK VILLAGE	**2530 NORTH MONROE STREET DECATUR, IL 62526**

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 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) then holding the treatment on the fourth day. On [DATE] at 9:55 am V2 Director of Nurses stated the orders were probably entered into the computer incorrectly. V2 confirmed V30 wanted R4's treatment completed daily starting on [DATE] and staff were holding the treatment on the fourth day. The Wound Dressing policy dated ,[DATE] states Frequency of wound dressing changes and the type of wound dressing will be specified in the physician orders.
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 observations, record review and interviews the facility failed to ensure that infection control precautions for prevention of Covid-19 were being provided including social distancing of residents during staff supervised activities and dining. Staff also failed to wear personal protective equipment (PPE) when cleaning an isolation room. These failure have the potential to affect 14 of 15 residents (R4, R8, R20, R15, R16, R17, R18, R19, R21, R22, R24, R25, R26 and R27) reviewed for infection control in the sample list of 40 residents. The findings include: The Facility Covid-19 Testing and Response Plan dated 7/17/20 documents This Facility will work to guard against the introduction and spread of [DIAGNOSES REDACTED]-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus 2) within its community. The Facility uses available current guidance from the Centers for Disease Control and Prevention (CDC) , the Center for Medicare and Medicaid Services (CMS) , the Illinois Department of Public Health (IDPH), and Local Health Department (LHD) officials to develop and implement policies and procedures that, in addition to pre-existing Infection Control Protocols, make up its plan to prevent, respond to and mitigate the presence of [DIAGNOSES REDACTED]-CoV-2 infection the Facility. The policy also states E. Infection Prevention and Control interventions-In response to the COVID-19 pandemic, the Facility implemented comprehensive policies as per CDC, CMS, and IDPH. Additional COVID specific policies remain in effect including the following: 2. Cessation of communal dining and large group activities-The Facility has discontinued normal communal dining and large group congregate activities. The Facility as provided alternatives that maintain social distancing such as arranging in room dining or allowing for us of the dining room with limited capacities and properly distant tables. 1. On 7/23/20 at residents and staff were not social distancing on the 2nd floor during activities and meals at 10:30 am, 11:00 am, 12:30 pm. On 7/23/20 at 10:30 am four residents (R15, R16, R17, R19) were seated around two square tables pushed together playing a dice game with two activity staff (V18, V19). Residents were wearing masks and were sitting side by side at the tables playing dice game. On 7/23/20 at the lunch meal on second floor at 12:30 pm three residents (R15, R16, R20) were seated at a square table eating lunch and three residents (R18 R21, R22) were at another square dining table. The residents seated at the tables together were not six feet apart from each other. The dining room tables were spaced apart. There was only one table that had a single occupant. Nursing staff were passing food trays and were supervising did not cue or attempt to social distance residents. Activity Director V27 stated on 7/30/20 at 9:45 am that for activities and dining there is only supposed to be one resident per table and the tables are not to be pushed together. V27 stated the staff are to wear personal protective equipment (PPE) masks, face shields and also gloves if handling dice or cards. Residents are to wear masks and use gloves also. There are gloves and hand sanitizer on the utility carts. 2. On 7/23/20 at 12:15 pm R4 was seated in the dining room at a 36 inch square table without a mask on eating lunch and R24 was propelled by a staff member to R4's table and positioned next to R4. On 7/23/20 at 12:21 pm V33 Certified Nurses Aide propelled R25 to R4's table and positioned R25 next to R4 and R25 was not wearing a mask. On 7/23/20 at 12:40 pm V34 Registered Nurse was seated at the table feeding R25. On 7/23/20 at 1:05 pm R4, R24 and R25 were seated at the table next to each other and R4, R24 and R25 were not wearing masks. On 7/23/20 at 12:15 pm R26 and R27 were seated at a 36 inch square table next to each other eating lunch. On 7/23/20 at 1:10 pm V35 Licensed Practical Nurse stated they try to keep the residents six feet apart. V35 confirmed the residents should not be seated next to each other at the dining tables. 3. On 7/23/20 at 12:20 V17, Medical Records staff was in R8's bedroom spraying cleaner on the floor and was mopping around the bed. R8 was in the bed. There was an isolation cabinet outside of R8's bedroom and a placard on the door frame to check with nursing staff before entering. V17 was wearing a mask but was not wearing eye protection as her safety goggles were up on forehead above V17's glasses. V17 was not wearing a gown or gloves. V17 picked up R8's remote for the television (TV) with her bare hands to assist the resident with a channel change. V17 placed the remote back on the over bed table when she was finished with out disinfecting the remote control. When questioned why R17 was not wearing appropriate personal protective equipment for the isolation room, V17 stated she had not noticed that it was an isolation room. V17 stated she was just helping out. V17 brought the housekeeping cart to the utility room. The water in the mop bucket that V17 had used on R8's floor was dark gray in color. V17 stated she had not gotten fresh mop water but had pulled the housekeeping cart from the utility room and used the water and mop that was there. V17 stated she should have gotten fresh water and mop, worn gloves, gown, and safety goggles and should have sanitized the TV remote. Per record review and interview with V5 Licensed Practical Nurse on 7/23/20 at 12:30 pm, R8 is under Contact Isolation precautions for [MEDICAL CONDITION] Resistant [DIAGNOSES REDACTED] aureus (MRSA) of foot wounds. V5 stated they currently do not have any residents who are suspected of or are positive for Covid-19. The Infection Control Logs reviewed for May 2020 and June 2020 documented one resident (R11) who had been positive for Covid-19 on 5/29/20 and was under Transmission Based Precautions until 6/13/20. The Facility Covid-19 Testing and Response Plan dated 7/17/20 policy also states D. Appropriate Personal Protective Equipment (PPE) is a critical component of the Facility's Infection Control Policy. PPE is necessary to both protect staff and reduce transmission within the Facility.