STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A206	A. BUILDING _____ B. WING _____	06/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALEM CARE CENTER	1203 N JACKSON, PO BOX 29 SALEM, MO 65560

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, interview and record review, the facility failed to follow infection control protocols for COVID-19 (an infectious disease caused by severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2). Common symptoms include fever, cough, fatigue, shortness of breath, and loss of smell and taste) when facility staff failed to properly wear and store facemasks, and follow social distancing guidelines for staff and residents. Furthermore, staff failed to sanitize a phone before resident use, clean/sanitize multi-use resident equipment before and after use, sanitize handrails/doorknobs after touching, sanitize disposable food containers after sitting it on handrail prior to delivering it to resident, and wash hands before/after going into resident rooms due to the ongoing Coronavirus pandemic. The census was 49. Review of the CDC's recommendation titled Preparing for Covid-19 in Nursing Homes, updated 6/5/20, showed the potential for asymptomatic [DIAGNOSES REDACTED]-CoV-2 transmission underscores the importance of applying prevention practices to all patients, including social distancing, hand hygiene, and surface decontamination. Review of the CDC's recommendation Strategies for Optimizing the Supply of Facemasks, dated 3/17/20, showed facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean, sealable paper bag or breathable container. Review of the facility's, Infection Prevention and Control Manual, dated 2019, showed staff were directed as follows: -Reusable equipment will not be used for the care of another resident until is has been appropriately cleaned and reprocessed and single use items are properly discarded. Review of the facility's, Action Plan - Covid-19, dated 5/29/20, showed staff were directed as follows: -Hand hygiene should be performed before putting on a mask, and after touching, adjusting or removing a mask. Review of the facility's, Universal Mask policy, undated, showed staff were directed as follows: -Allotment Process for Facemasks: With each facemask, staff will be issued a clean brown paper bag that each employee will put their name on. Staff is to date and initial the bag each time the mask is used; -Storage of Facemasks: Employee masks will be stored in each individual brown paper bag within a storage tote. The masks in each brown paper bag will be labeled with the employee name and initials and stored vertically in a storage tote within a designated area in the facility; -To Doff (remove) Facemask with Intent to Reuse: Perform hand hygiene, remove mask carefully, carefully store on a paper towel exterior side down, perform hand hygiene, gently place paper towel with mask on it inside a clean, brown paper bag that can be resealed, perform hand hygiene; -And to leave the community and come back, staff may remove the facemask per the doffing guidelines and store it as noted and then reuse the mask. 1. Observation on 6/5/20 at 11:00 A.M., showed multiple staff stood outside the facility in the staff smoking area. Staff were not six feet from each other, and were not wearing facemasks. Observation on 6/5/20 at 1:30 P.M., showed Licensed Practical Nurse (LPN) D checked a resident's blood pressure. LPN D then checked another resident's blood pressure, using the same blood pressure cuff, without sanitizing it between residents. Additional observation showed he/she then checked a staff member's blood pressure, using the same cuff, without sanitizing the blood pressure cuff. He/She then placed the same blood pressure cuff on a resident's bedside table. LPN D then left the resident's room without washing his/her hands. During an interview on 6/5/20 at 1:35 P.M., Licensed Practical Nurse (LPN) D said staff are expected to wash their hands before and after providing resident care. During an interview on 6/5/20 at 1:50 P.M., the Infection Control Preventionist (ICP) said multi-use resident equipment should be sanitized before and after resident use. Observation on 6/5/20 at 2:00 P.M., showed the facility staff propelled seven residents in wheelchairs to the common area by the front door. The residents sat in the common area, without masks, and were not six feet from each other. Observation on 6/5/20 at 2:42 P.M., showed Certified Nursing Assistant (CNA) A, CNA B, and CNA C removed their facemask and went outside to the smoking area. The CNAs did not place their facemasks in a brown paper bag. Additional observation showed CNA B and CNA C reentered the building after their break, removed their mask from their pocket, and reapplied the masks. During an interview on 6/5/20 at approximately 2:45 P.M., CNA B and CNA C said there were no brown paper bags at the door, so they put their masks in their pocket. CNA B and CNA C said they could have asked the Administrator or the Director of Nursing (DON) for a bag for their mask, but they did not. Observation on 6/5/20 at 2:50 P.M., showed the Social Service Designee (SSD) walked through the service hallway and went into the maintenance room, with his/her facemask on. The SSD exited the building through the maintenance room. Additional observation showed the SSD no longer had his/her facemask on. During an interview on 6/5/20 at approximately 3:00 P.M., the SSD said he/she hung his/her facemask on a hook in the maintenance office. He/She said the facility policy was to place facemasks in a brown paper bag when not in use. He/She said he/she should have placed his/her facemask in a brown paper bag when he/she went outside. Observation on 6/5/20 at 4:00 P.M., showed the facility identified part of a hallway into a Transition hallway, which was utilized for residents who had returned from or been admitted from the hospital. Further observation showed each room required staff to apply full PPE (gown, gloves, masks, and shoe covers) before entering. The Director of Nursing (DON) walked down the Transition hallway while he/she talked on the facility phone. Observation showed the phone rested on the DON's face and facemask. The DON stopped at Resident #1's doorway, and handed the resident the phone he/she was using. The DON did not clean/sanitize the phone before he/she gave it to the resident. Observation on 6/5/20 at 4:05 P.M., showed CNA A went into a resident room on the Transition hallway and propelled a resident out of the room. CNA A did not wash or sanitize his/her hands when he/she entered or exited the resident's room. Observation on 6/5/20 at 4:15 P.M., showed CNA A donned (put on) shoe coverings, gloves, and a gown before he/she entered resident #2's room on the transition hallway. CNA B exited the resident's room and touched the handrail in the hallway and the resident's doorknob while he/she removed his/her PPE. Additional observation showed CNA A did not sanitize the handrail or doorknob after he/she touched it. Observation on 6/5/20 at 4:21 P.M., showed CNA B responded to Resident #1's call light. CNA B entered the room, turned off the call light, and exited the room with the facility phone. Additional observation showed CNA B did not wash or sanitize his/her hands or apply gloves before or when he/she entered the resident's room, or before he/she touched the call light. Observation on 6/5/20 at 4:25 P.M., showed the SSD gave the facility phone and a disposable food container to CNA A. The CNA placed the phone and the container on the handrail outside Resident #2's room while he/she donned PPE. Additional observation showed CNA A picked up the phone and container and gave them to Resident #2. CNA A did not sanitize the phone or the container before he/she handed them to the resident. Observation on 6/5/20 at 5:00 P.M., showed two residents sat in the hallway. The two residents sat within six feet of each other, and were without masks. During an interview on 6/5/20 at 4:45 P.M., the Infection Control Preventionist (ICP) said staff should wear full PPE when entering resident rooms on the Transition hallway. He/She said signs are posted to let each staff member know what to wear inside the room, and these items are located at each resident's door. He/She said staff should not touch handrails and doorknobs when donning and doffing PPE, and if they do touch them, then it is expected that the staff sanitize them. He/She said staff should place their facemask in a brown paper bag when they go outside to smoke, and facemasks should not be stored in pockets or on hooks. He/She said

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) staff and residents are expected to maintain a distance of at least six feet from each other while they smoke. Additionally, he/she said the facility phone should be sanitized before and after each resident uses it. During an interview on 6/5/20 at 5:51 P.M., the Administrator said staff are expected to place their facemasks in a brown paper bag when they go outside to smoke, and at the end of their shift. Additionally, he/she said staff and residents should maintain a distance of six feet from each other when care is not being given.