STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OLIVIA REHABILITATION & HEALTHCARE CENTER	1003 WEST MAPLE OLIVIA, MN 56277

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 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident's (R4) care plan was followed when staff failed to implement the intervention of use of body pillows beside R4 prior to her fall. This caused actual harm when R4 sustained a nasal fracture and facial sutures. Findings include: R4's 2/26/20, quarterly Minimum Data Set (MDS) identified R4 had severe cognitive impairment. R4 required extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. R4's [DIAGNOSES REDACTED]. R2 had 1 fall with major injury on 2/18/20 since the last assessment and was at risk for falls. R4's 6/5/19, Care Area Assessment (CAA) identified R4 was at risk for falls. R4's 2/19/20, report filed to the State Agency (SA) identified R2 was found in her room on the floor next to her bed on 2/18/20. R4 was bleeding from her nose. R4 was transported to the emergency department (ED) for evaluation. R4 was in bed sleeping prior to being found. R4's 2/18/20, ED note identified R2 had a small contusion to the left forehead above the eyebrow, and a small 0.5 centimeter (cm) V-shaped laceration to the bridge of the nose with mild swelling and bruising. A CT scan of her facial bones identified bilateral nasal bone fractures and a non-displaced nasal fracture. R4's laceration on her nose was cleansed and sutured closed. R4's 2/19/20, incident report identified nursing assistant (NA)-A walked past R4's room at 10:30 p.m. on 2/18/20, and found R4 lying on floor next to the bed. R4 was bleeding profusely from her nose, and her nose was turning purple and was swollen. R4 also had a quarter-sized raised area above her left eye. R4's neurological status was assessed. R4 was transferred to the ED for evaluation. There were no witnesses identified. R4's bed was higher then it usually was. A request was made for the facility's investigation notes but no facilty investigation reports were available. R4's 2/24/20, 5-day investigation report submitted to the SA identified R4's care plan and the facilty abuse and neglect policy were reviewed. Interviews with staff identified R4 was assisted to bed at 8:30 p.m. Staff last observed R4 sleeping in bed at 10:10 p.m. At 10:30 p.m., NA-A found R4 on the floor next to her bed. R4 sustained a nasal fracture as a result of the fall. NA-A had not placed R4's body pillows next to the resident in the bed as R4's care plan directed. NA-A was suspended on 2/20/20, until completion of assigned training and education. R4's care plan was updated to increase R4's safety, and the staff education occurred on 2/21/20, regarding R4's care plan. Staff were to keep R4's bed placed next to the wall. Staff were to ensure R4's bed was locked in the lowest position when in bed. Staff also were to place a floor mat next to the bed. Review of R4's 2/24/20, Fall Risk assessment identified R4 was found to be at high risk for falls Review of R4's 2/18/20, incident report identified the interdisciplinary team (IDT) reviewed R4's fall. R4 was found on the floor next to her bed on 2/18/20, at 11:30 p.m. R4's 3/4/20, current care plan identified R4 required total assistance of 2 staff for bed mobility. R4 had fluctuating cognition. R4 required staff to use 2 body pillows to position her body in bed. R4 was at moderate risk for falls. Staff were to ensure the call light was within reach and the bed was to be locked and in lowest position and placed against the wall. Staff were to ensure the body pillows were placed and a floor mat lying on the floor next to the bed. R4 was to use a hip plate call light when in bed. R4's use of body pillows while in bed for movement and positioning had a created on date of 5/16/19 and was a current intervention at the time R4 fell on [DATE]. Review of the undated, nursing assistant care plan included R4 staff were to ensure use of a body pillow, floor mat and were to check R4 every 2 hours. Interview on 3/4/20, at 2:00 p.m. with NA-A identified she was one of the NAs on duty when R4 was found on the floor. R4 fell during change of shift rounding. NA-C was the staff who found R20 lying on the floor when responding to call lights. R4 was not aware of any recent falls out of bed prior to her most recent fall. R4 was not mobile and required assistance of 2 staff to position her in bed. Prior to her fall, staff were required to place pillows on her side to prevent her from rolling out of bed. R4 tended to roll out of bed. NA-A confirmed R4 did not have body pillows placed on her side at the time of fall. Review of the 2/26/20, nurse meeting notes identified staff education was provided regarding R4's fall out of bed. A power point slide was provided and included the fall investigation found R4's pillows were not placed next to her in bed. The pillows could have prevented R4's fall had that intervention been followed. All staff were expected to follow resident care plans. Additionally, the facilty abuse prevention policy was reviewed. Review of the 2/26/20, staff meeting attendance roster identified 12 of 33 staff were not in attendance at the meeting. Interview on 3/5/20, with the director of nursing (DON) identified R4's care plan was not followed at the time R4 fell out of bed. R4 was to have had body pillows on both sides while in bed. After her fall on 2/18/20, her care plan was changed to have the bed placed with one side against the wall. The DON expected staff to follow the care plan. The DON verified 12 staff had not completed the education as described in the nurses meeting note from 2/26/20. 5 of the 12 remaining staff had worked since 2/26/20, who were not present at the meeting and had not been educated prior to thier next shift. Review of the undated, Assessing Falls and Their Causes policy identified the purpose of the policy was to provide guidelines for assessing resident falls to assist staff in identifying causes of falls. Equipment and environmental factors that may have contributed to falls were to be addressed promptly. NA-C was unavailable for interview at the time of the survey.
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 document review, the facility failed to assess and notify the registered dietitian (RD) of changes in 1 of 2 resident (R13) nutritional status who had pressure ulcers, loss of lower dentures, and history of weight loss to ensure nutritional interventions were appropriate. Findings include: Interview on 3/3/20, at 7:30 p.m. with R13 identified her lower dentures were missing for over 2 weeks. R13 had a sore lower jaw from her dentures not fitting correctly. She removed her dentures and wrapped them in tissues. Later, staff had thrown out tissues containing her dentures. R13 notified management her dentures when they were thrown out. R13 had a history of [REDACTED]. R13 stated it was hard to eat foods, and was not able to eat foods like salsa and chips, and she chewed other foods to the best of her ability. No changes were made to her diet after her dentures were lost. R13's 12/20/19, admission Minimum Data Set (MDS) identified R13's cognition was intact. R13 required limited assistance of 2 staff for dressing and personal hygiene. R13 ate independently after set up assistance from staff. R13 was able to move through out the facilty independently in her wheelchair. R13's [DIAGNOSES REDACTED]. R13's admission weight was 84 pounds. R13 had unplanned weight loss and was not on a prescribed weight-gain regimen. R13 had no natural teeth. R13 had two stage 2 pressure ulcers and one stage 1 pressure ulcer upon admission to the facility. R13 received nutritional supplements 2-Cal 120 milliliters (ml), and [MEDICATION NAME] packets twice daily related to pressure ulcers. R13's 3/4/20, care plan identified R13 had nutritional problems. R13 had dentures and was able to perform oral cares independently. R13 ate independently after staff set up her tray. Staff were to provide R13's diet as ordered, and monitor for signs of malnutrition, significant weight loss. R13 received nutritional supplements 2-Cal 120 milliliters (ml), and received [MEDICATION NAME] packets twice daily. R13's diet was regular texture and consistency. R13

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 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) was provided education regarding alternative foods when a meal is not desired. R13 received snacks twice daily between meals and offered additional fluids. R13's 12/27/19, admission Nutritional Assessment identified R13 wore upper and lower dentures. R13 ate 80 percent (%) of meals. R13 [DIAGNOSES REDACTED]. R13's current weight was 90.5 pounds. R13 received a regular diet with regular texture and regular consistency. R13 had upper and lower dentures and had no issues chewing or swallowing. R13 ate all meals in center dining area and ate independently after staff assisted with meal set-up. R13 was educated on alternative menus available. Resident had pressure ulcers to her left buttocks and sacral areas. Snacks were provided twice daily between meals and additional fluids were provided twice daily by water pitcher at bedside. There was no mention the RD had identified the need for increased caloric intake or to have fortified foods. No additional assessments were included in R13's medical records. R13's weight record identified R13's weight was 104 pounds on 3/2/20. R13's weight had slowly increased since admission to the facilty, but was still below normal. An interview on 3/05/20, at 12:02 p.m. with registered dietitian (RD)-A identified she completed routine nutritional assessments, and also reviewed residents identified at nutritional risk on a monthly basis. RD-A expected to be notified whenever a resident was found to have weight loss, weight gain, pressure ulcers, or any health status changes. RD-A identified facility's communication with her was not consistent. RD-A was working with the facility to ensure she received current resident information and was kept updated consistently about resident status changes. RD-A met with dietary manager (DM)-A and the director of nursing (DON) on a monthly basis to gather resident information to assess residents' nutritional needs. In January 2020, RD-A provided DM-A and the director of nursing (DON) a protocol outlining expectations for the facilty regarding resident nutritional management. She expected DM-A and the DON to follow the procedures. RD-A emailed the protocol to the DON and DM-A and continued to work with the facility to establish use of protocols to address nutritional needs in a timely manner. RD-A verified she had not assessed R13 since her admission. She expected DM-A to have R13 be on the at risk list for monthly review until her pressure ulcers were resolved. RD-A expected to be updated regarding R13's weight, pressure ulcer status, and contributing issues such as noncompliance of treatment, changes in woud care, and loss of lower dentures to ensure R13 was properly assessed and provided appropriate interventions to promote wound healing and maintenance or gain of weight. An interview on 3/06/20, at 9:06 a.m. with DM-A identified she was responsible for quarterly nutritional assessments and to notify RD-A of resident identified at nutritional risks. DM-A received updates regarding resident's status at daily stand up meetings, and wrote down resident notes. Staff were also expected to provide her with updates regarding changes in resident status, and wound care needs. DM-A had access to the weekly wound care assessments in the electronic medical records. She kept a list of residents at nutritional risk for RD-A to assess when she came to the facility for monthly visits. DM-A also communicated changes in resident status to RD-A through email. DM-A verified R13 was not included on the resident's nutritional risk list because she had some weight gain. DM-A confirmed R13 had pressure ulcers, but was unsure of R13's wound status. DM-A identified she could review R13's wound assessments and visit with the nurse who monitors pressure ulcers to identify if R13 should be monitored monthly by RD-A. Additionally, DM-A confirmed she had not notified RD-A R13's had lost dentures, and confirmed no documentation was available as evidence R13 was assessed for potential increased dietary needs following the loss of her dentures. An interview on 3/6/20, at 1:30 p.m. with the DON identified DM-A attended daily stand up meetings and was provided information at the stand up meetings regarding residents at nutritional risk. The undated RD Needs for Assessments and Protocols policy identified the faciltiy interdisciplinary team (IDT) meetings were to work with the DM to identify residents at nutritional risk and develop a list of at -risk residnets for RD-A to assess monthly. Nutritional risk criteria included the following: (1) new admissions; (2) any residnets with weight loss or gain; (3) anyone resident with a pressure or diabetic wound; (4) any resident on [MEDICAL TREATMENT]; (5) any resident with significant changes, including reasons for significant changes; (6) any resident on hospice (Hospice requires a monthly RD review); (7) any resident with a swallowing or chewing issue. Speech Therapy was also to be contacted to assess residents with chewing or swallowing issues. Additionally, staff were to always notify the RD-A of residents admitted to the facility with pressure ulcers or wounds, admission to hospice care, [MEDICAL TREATMENT], and significant weight loss. Protocols included to contact the physician to request wound supplements, protein additives, vitamin supplementation, and addition of extra protein at meals according to protocol guidelines.
F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident's (R20) central venous catheter (CVC) was covered with the appropriate transparent dressing for licensed staff to monitor daily for signs and symptoms of infections. Findings include: R20's admission Minimum Data Set ((MDS) dated [DATE], indicate R20 was admitted to the facility from a community setting and had intact cognition. R20's [DIAGNOSES REDACTED]. Medication list Remodulin (medication for [MEDICAL CONDITION] arterial hypertension) solution intravenous therapy (IV). R20 required extensive assistance of 1 staff for bed mobility, transfers, toileting, and dressing. A motorized scooter is used for mobility both in her room and throughout the facility. admitted to the facility with a CVC line located in her upper right chest. R20's significant change Minimum Data Set ((MDS) dated [DATE], identified R20 was cognitively intact and continued use the CVC line for medication. R20's [DATE], care plan identified R20 received intravenous (IV) medication. Staff were to observed the CVC dressing every shift and change the dressing and record observations of the site weekly. Staff were to monitor, document, and reported signs and symptoms of drainage, inflammation, swelling, redness, and warmth. R20's 3/4/20, current physician orders [REDACTED]. Observation and interview on 3/4/20 at 3:50, with licensed practical nurse (LPN)-A of R20's CVC dressing identified the dressing was a non-transparent (non-see through) [MEDICATION NAME] dressing. There was no date written on the dressing to identify when it was last changed. The CVC site is checked daily for signs of infection or concerns. . LPN-A agreed the dressing used was a non-transparent dressing. The area around the dressing was monitored daily but not the actual catheter site. R20's dressing was to be changed on shower days and as needed (PRN). Interview and document review on 3/05/20 at 12:11 p.m., with director of nursing (DON), identified R20's dressing was changed weekly on their bath day and PRN. DON reviewed R20's current physician orders [REDACTED]. The area around the [MEDICATION NAME] was checked each day by nursing staff. Staff were to monitor around the dressing for signs or symptoms of infection. R20 stated to nursing staff at the facility she was allergic to adhesive tape and this was the only type of dressing she had found to work to prevent R20's skin breakdown. The DON was aware of the policy related to CVC dressing changes which directed staff to use transparent semi permeable dressing. R20 directed how she wants the site covered and R20 managed her own site previous to her admission to the facility. The DON confirmed the allergy to adhesive tape was not listed in the resident care plan (CP) or on the MAR. The DON had not researched transparent dressing that may be used in lieu of traditional transparent dressings for residents who have allergies [REDACTED]. She used a [MEDICATION NAME] dressing pervious to her admission. R20' s' physician was aware of choice of dressing but has never written an order. Reported the allergic reaction she experienced with the [MEDICATION NAME] dressing was inflammation to dressing area and burning sensation. R20's [MEDICATION NAME] was changed twice per week by nursing on her bath days. Interview on 3/06/20 at 10:13 a.m., with nurse aid (NA)-C, identified R20 was scheduled for a shower twice a week. Scheduled shower days are Tuesday and Friday's. After shower, aide staff were to notify the the nurse on duty know to perform a skin check and dressing change. Review of the 3/12/18, Central Venous Catheter Dressing Changes policy identified catheter site care was to allow for the observation and evaluation of the catheter-skin junction and surrounding tissue. Documentation of the dressing change was to be recorded along with signature and title of person recording the data.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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, interview, and document review, the facility failed to appropriately secure, discard, and destroy [MEDICATION NAME]es (narcotic medication) for 3 of 3 residents (R8, R14, and R32). Findings include: Observation and interview on 3/5/20 at 12:27 p.m., with licensed practical nurse (LPN)-A in the medication room identified [MEDICATION NAME]es were destroyed by 2 nurses and placed in the RX Destroyer (a chemical destruction system used to breakdown medication). Inside the RX Destroyer , there was a [MEDICATION NAME] floating on top of the liquid and would be accessible to any licensed staff for retrieval. Interview on 3/6/20 at 8:16 a.m., with LPN-B identified [MEDICATION NAME]es were

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) discarded into the RX Destroyer stored in the locked medication room in the presence of 2 licensed staff. The director of nursing (DON), nurses and trained medication aids (TMA)s had access the medication room. Interview and document review on 3/6/20 at 10:24 a.m., with the DON identified RX Destroyer was used to improve medication destruction compliance and improve ease of medication destruction of [MEDICATION NAME]es. On 1/16/18, the city of Olivia provided a letter to instruct the facility to not dispose of any type of medication via the city sewer system, including [MEDICATION NAME]es. The DON had not looked into other type medication destruction processes or receptacles to prevent potential medication diversion. 3 residents were prescribed [MEDICATION NAME]es. Review of the manufacturer recommendations for RX destroyer identified the chemical used in the RX Destroyer container broke down the chemicals in medications to render medications unusable. The DON identified full drug buster containers were stored in the bio hazard bin in soiled utility room. The DON stated only nurses and housekeepers accessed to the biohazard room. The full containers were removed from the facility either on monthly or quarterly basis. Review of the undated, Discarding and Destroying Medications policy identified the process to destroy controlled substances must render it non-retrievable and permanently alter the physical or chemical properties of the substance to make the medication unusable and prevent diversion. The November, 2009, [MEDICATION NAME] Pharmaceuticals manufacturer recommendations to destroy [MEDICATION NAME] identified patches were to be disposed by immediately folding the adhesive side of patch onto itself, then immediately flush down the toilet.
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R13) received dental services following the loss of her lower denture plate. Findings include: R13's 12/20/19, admission Minimum Data Set (MDS) identified R13's cognition was intact. R13 required limited assistance of 2 staff for dressing and personal hygiene. R13 ate independently after set up assistance from staff. R13 was able to move through out the facilty independently in her wheelchair. R13's [DIAGNOSES REDACTED]. R13 had unplanned weight loss and was not on a prescribed weight-gain regimen prior to her admission. R13 had no natural teeth. R13 had 2 stage 2 pressure ulcers and 1 stage 1 pressure ulcer upon admission to the facility. Interview on 3/03/20 at 7:46 p.m., with R13 identified her bottom dentures were thrown away when the nursing assistants (NA)s threw away a bunch of tissues containing her lower denture approximately 2 weeks ago. R13 told management her denture was thrown away. The faciilty offered to compensate or make arrangements to replace the denture. R13 stated the dentures were hurting her gums, so she removed them and wrapped them in a Kleenex and placed them in her pocket. Her clothing went to the laundry. The denture was not recovered. It was hard to eat foods but she chewed to the best of her ability. R13's 3/4/20, care plan identified R13 had nutritional problems. R13 had dentures and was able to perform oral cares independently. R13 ate independently after staff set up her tray. Staff were to provide R13's diet as ordered, and monitor for signs of malnutrition, significant weight loss. R13 received nutritional supplements 2-Cal 120 milliliters (ml), and [MEDICATION NAME] packets twice daily. R13's diet was regular texture and consistency. R13 was provided education regarding alternative foods when a meal is not desired. R2 received snacks twice daily between meals and offered additional fluids. There was no mention R13 had lost her dentures which impacted her ability to eat or her foods were altered to be easier to chew. An interview on 3/05/20 at 7:51 a.m with social worker (SW)-A identified she was aware of the missing dentures. R13 told BO-A the NAs had thrown her dentures away when they emptied napkins from her coat pocket about 2 weeks ago When R13 checked her pocket they were not there. When dentures and personal items go missing, the facility tries to resolve the issue. Staff had looked in the dumpster, looked in R13's room, and they were not found. SW-A verified there was not documentation of missing dentures in nurse progress notes. No appointment was made to replace the dentures because the facilty wanted to make sure the dentures were not misplaced before replacing them. An interview on 3/05/20, at 8:20 a.m. with BO-A identified R13 had told her her dentures were tossed into the trash by the NAs. R13 wanted to keep the napkins, but the NAs convinced her to allow them to throw out the napkins. She was not able to recall if she had documented R13's report, but had reported her dentures missing at daily stand-up, and the facility had searched for the dentures. An interview on 3/05/20, at 8:46 a.m. with the dietary manager (DM)-A identified R13 had no troubles with eating. DM-A confirmed R13 was not assessed for proper diet and textures after her dentures were lost. The registered dietitian (RD) was not notified R13's dentures were missing. The RD would not typically assessed R13 unless she had changes in weight or if R13 refused meals. DM-A planned to observe and follow R13 to identify any concerns planned to follow-up with the RD as needed. An interview on 3/5/20, at 10:38 a.m. with RD-A stated she provided monthly visits. RD-A expected DM-A to notify her of changes, including missing dentures to assess if any additional interventions were required to ensure R13's nutritional needs were met. The undated Dental Services policy identified the routine and emergency dental services were available to meet the resident's oral health according to individual resident assessments and plans of care. Nursing services was responsible to report resident needs for dental services to social services. The social services personnel was responsible to assist residents to make dental appointments and arrange transportation as necessary. The policy made no mention of the facility's responsibilities of denture care or replacement.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to implement appropriate infection control (IC) technique related to supplies and disinfection methods while caring for 1 of 1 resident (R33) with a highly infectious disease ([MEDICAL CONDITION] aka [MEDICAL CONDITION]). The facility also failed to ensure all [MEDICAL CONDITION] activity was included in the facility surveillance program. This had has the potential affected all 33 residents in the facility. Findings include: R33's 2/13/20, admission Minimum Data Set (MDS) identified she had intact cognition and required 2 staff assist for most Activities of Daily Living (ADL's) but was able to eat and drink independently. Observation and interview on 3/3/20 at 3:41 p.m. with R33's identified she was recently diagnosed with [REDACTED]. R33 was currently taking antibiotics to treat her [MEDICAL CONDITION] infection. Staff gloved and gowned (PPE) when providing cares for R33. In the back of R33's room were 2 large bins on wheels. 1 bin was used for garbage when staff took off PPE. The other bin was located between R33'c chair and her bed. That bin was used for soiled linen. R33 had limited space on her bedside table and had placed her water glass on top of the lid of the bin. R33 continued to have 3 to 4 loose stools per day. Interview on 3/4/20 at 1:56 p.m. with housekeeper (H)-A identified the facility had 2 housekeeping carts used to clean residents' rooms. H-A's cart had multiple cleaning bottles, stored next to one another. These cleaners were used from room to room. 1 cleaner, the Clorox Fuzion disinfectant was used to disinfect R33's room. Staff would spritz the disinfectant on all surfaces of R33's room, including her floor. R33 was unaware if Clorox Fusion was to be used on floors specifically in that manner. H-A identified in order to remove her PPE, she would have to discard her PPE in the large bin at the far side of R33's room. She would then walk towards the entrance, where R33's sink was located and wash her hands. H-A would then have to go back to the large bin, touch the large lid handle with her bare hand, and place her used paper towels inside. H-A had never disinfected that lid as part of her cleaning duties. H-A would then collect her supplies and return them to her cart, including the Clorox Fuzion disinfectant spray bottle and place on the top with other cleaners where it co-mingled with other cleaners in direct contact. There was no designated mop, broom, or disinfectants dedicated to R33's room. The mop handle and broom would then be used on each resident's room as she completed her duties. H-A had never disinfected her mop handle or broom before returning it to R33's cart. H-A agreed cleaning and disinfecting R33's room was a potential source of contamination to other residents. Review of the Clorox Fusion: Directions for Use, located on the bottle from the manufacturer identified the product was to be used to clean and disinfect hard, non-porous surfaces until the surfaces was thoroughly wet. The product was to remain wet for 2 minutes, A pre-cleaning step was required to kill [MEDICAL CONDITION]. All matter and waste must be thoroughly cleaned from surfaces or objects before disinfection by application with a clean cloth, mop, or sponge saturated with the product. Special attention was needed for high-touch surfaces. To disinfect surfaces, staff were to spray the product 6-8 inches from the surface until the surfaces was thoroughly wet and remain wet for 2 minutes. Interview and Clorox Fuzion bottle review on 3/4/20 at 2:00 p.m. with housekeeping supervisor (HS)-B identified staff were to clean all residents' rooms daily. There was no designated cleaning supplies for R33. Those supplies were kept on the cart and used for approximately half of the 33 residents in the facility. HS-B agreed it would be impossible to use this spray in the manner described on floors, both room and bathroom. HS-B would call the contracted Eco-lab company for guidance on getting an appropriate product designed for floors. HS-B identified all surfaces were to be cleaned, including bedside tables. Observation and interview on 3/4/20 at 2:45 p.m. with R33 identified her bedside table remained in the same manner from the day before. No items had been moved. Staff had never cleaned or disinfected her bedside table she observed while being isolated inside her room when daily cleaning had occurred. Staff had never

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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 -** Many	(continued... from page 3) disinfected the lid and would have to touch the lid with their contaminated gloves after providing cares and before discarding PPE. After staff removed their PPE and washed their hands, they had to walk back to the far side of her room, lift the lid to the waste bin with their bare hand, and place the used paper towel inside the bin. R33 had no room on her beside table to place her water glass and would place that glass on top of the bin between her chair and bed. She observed staff with their contaminated gloved hands when placing dirty linen inside. That lid was not cleaned or disinfected any way. Interview on 3/4/20 with H-C identified she also cleaned resident rooms. H-C would disinfect the floors by spritzing the Clorox Fuzion on the floor and was unaware the surface needed to be thoroughly wet for the product to appropriately disinfect. Interview on 3/6/20 at 11:11 a.m., with the infection preventionist (IP) identified she was aware of the large bins used in R33's room. IP had not performed any audits on staff to ensure appropriate IC was used to disinfect R33's room or when staff removed PPE. The IP agreed use of the large bins was not an effective way to manage infection control technique when discarding PPE inside the room, away from the entrance. The IP agreed there was no way for staff to open the lid without using their bare hands after performing handwashing. Those concerns were brought forward by housekeeping yesterday. The IP then removed the large bins and placed smaller waste receptacles in side R33's room without lids. The IP also gave R33 an additional bedside table to place her glass on. The IP agreed the above concerns with IC were a potential source of transmission to any resident in the facility. There were no other residents with loose stools at that time. Further interview and document review on 3/4/20 at 11:11 a.m., with the IP identified her surveillance was only tracking bacterial infections and had not tracked potential [MEDICAL CONDITION] activity in the facility. If any resident showed signs or symptoms of an infection, staff were to email her at the time of discovery. Only infections which were treated with antibiotics were included in her surveillance. The IP agreed if staff failed to identify any signs or symptoms of [MEDICAL CONDITION] illness in report or stand up meeting minutes, she would be unaware of any emerging infectious disease. There was no formal process to ensure the IP had incorporated [MEDICAL CONDITION] activity in her IC surveillance she was aware of. The IP began her position in the facility in January, 2020. Interview on 3/6/20 at 1:06 p.m., with the director of nursing (DON) and consultant identified their expectation was for staff were to follow appropriate infection control policies and procedures. They agreed with IC concerns related to the proper use of disinfectants, comingled and multi-resident room use housekeeping supplies, and lack of up to date IC surveillance which should have included potential [MEDICAL CONDITION] activity. Review of the undated, [MEDICAL CONDITIONS] policy identified the primary reservoirs for [MEDICAL CONDITION] were infected people and surfaces. Spores can persist on resident care items and surfaces for several months and are resistant to common cleaning and disinfection methods. Steps towards prevention included frequent handwashing with soap and water by staff and residents and disinfection of items with potential contamination. Staff were to remove environmental sources of [MEDICAL CONDITION] and perform enhanced environmental cleaning, reduce sharing or use dedicated equipment. There was no specific guidelines on setting up resident rooms with appropriate equipment nor mention of any auditing of staff practices and techniques by the IP to ensure compliance. No policy related to infection surveillance was provided by the end of the survey.