STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105335	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ABBEY DELRAY	**2105 SW 11TH COURT DELRAY BEACH, FL 33445**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview and record review, the facility failed to ensure residents are treated in a dignified manner for 1 of 24 sampled resident reviewed for dignity (Resident #35). The findings included: In an observation conducted on 09/21/20 at 12:45 PM, Staff C, a Certified Nursing Assistant, (CNA) was observed in the room assisting Resident #35 with his lunch tray. Closer observation showed that she was feeding Resident #35 while standing over the bed. Record review for Resident #35 showed that his Brief Interview for Mental Status (BIMS) score is 10 which is moderately impaired. In an interview conducted on 09/22/20 at 8:51 AM, with Resident #35's wife, who is also a resident, she reported that he needs assistance with eating otherwise he will not eat. She further stated that she will help him with his tray when she is done eating. In this observation Resident #35 was observed attempting to eat his meal but was not able too. In an observation conducted on 09/22/20 at 9:11 AM, the wife was observed helping the resident eat while sitting in her wheelchair by the bedside. In an observation conducted on 09/23/20 at 9:00 AM, Staff C, was observed in the room assisting Resident #35 with his breakfast tray. Closer observation showed that she was feeding Resident #35 while standing over the bed. In an interview conducted on 09/24/20 at 9:20 AM, with the Director of Nursing, she reported that the facility does not have a specific policy on maintaining dignity during dining. In an interview conducted on 09/24/20 at 10:30 AM, with Staff C, she reported that Resident #35 used to eat on his own and he ate well. According to her, he has not been eating well in the last few weeks and if she does not help him with his meals he will not eat well. She further stated that since there are only two Certified Nursing Assistants on the unit at times she is not able to assist him with his meal so his wife will feed him at the bedside. When asked as to why she was standing over the Resident while feeding him, she reported that she knew that it was wrong, and that you have to sit down while assisting residents to eat.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide restorative nursing services to enhance mobility and prevent further contractures for 2 of 2 sampled residents reviewed for Position/Mobility, as evidenced by failing to initiate active range of motion (AROM) for Resident #92 and failing to provide contracture management with splints for Resident #73. The findings included: 1) Review of the facility policy for Restorative Nursing Services states in part, 'Residents will receive restorative nursing care as needed to help promote optimal safety and independence Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care.' Resident #92 was admitted to the facility on [DATE] with pertinent [DIAGNOSES REDACTED]. On 07/31/20, Resident #92 sustained a right wrist fracture. Review of the clinical record revealed a physician order dated 08/01/20 for non-weight bearing status to her right upper extremity for a [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set ((MDS) dated [DATE], documented Resident #92's Brief Interview for Mental Status was coded as a 2, indicating severe cognitive impairment. On 09/21/20 at 12:30 PM, Resident #92 was observed in the Poinciana unit dining room at the lunch meal. She was observed to be eating her lunch in a slow fashion, picking at it then slowly putting food in her mouth using her right and then left hands. Resident #92 was not interviewable. Review of the clinical record for Resident #92 revealed a Physician Order dated 05/19/20 for 'Restorative Nursing Program for bed mobility and transfers with CNA (Certified Nursing Assistant) 6 days a week'. Further review of the Physician Orders revealed an order dated 08/09/20 for 'AROM to LUE (left upper extremity) shoulder, elbow, wrist, digits, 2 sets of 10 repetitions each site'. Review of the CNA documentation in the Task Section of the clinical record for the past 2 weeks commencing on 09/07/20 forward revealed documentation Resident #92 was coded as participating with encouragement for bed mobility and transfers. There was no evidence of documentation for restorative nursing services being provided for the AROM to the left upper extremities. Review of the CNA Kardex (personalized specific list of needs/capabilities related to Resident #92), revealed documentation of the assist with bed mobility and transfers 6 days a week however there was no documentation of the requirement to perform AROM to the resident's left upper extremities as ordered on [DATE]. Review of the Treatment Administration Records for August and September 2020 revealed no documentation of any AROM of the left upper extremities being provided to Resident #92. Review of the quarterly MDS assessment dated [DATE], under Section O Special Treatments, Procedures and Programs documents Resident #92 is not receiving any Skilled Therapy. Under the Restorative Nursing Programs section the number of days the resident has had Active Range of Motion performed is coded as zero (0). Under the heading Training and Skill Practice documents Resident #92 has received seven (7) days of bed mobility and transfer performed. Under Physician Orders - over the last 14 days on how many days did the physician (or authorized assistant practitioner) change the resident's orders - is documented blank, despite AROM of the left upper extremities was ordered by the physician on 08/09/20, and this quarterly assessment was conducted on 08/23/20, 14 days after the order was placed. On 09/24/20 at 11:10 AM, an interview was conducted with CNA Staff 'S' who assists residents with restorative nursing services. She stated she has a case load of 10-12 residents a week and works throughout the facility. She stated she receives an updated list every week that she gives to the Director of Nursing (DON) and Assistant Director of Nursing (ADON) Staff 'O' who oversee the Restorative Nursing Program. An inquiry was made what restorative nursing services Resident #92 was receiving to which she stated she assists with transfers and bed mobility. A request was made to demonstrate on her electronic documentation what restorative nursing services are being provided to Resident #92. CNA Staff 'S' accessed Resident #92's electronic record which documented the transfers and bed mobility however did not have any documentation of AROM or any place to document AROM. CNA Staff 'S' provided a 4 page document of her current list of residents receiving restorative nursing services to reveal Resident #92 was only listed for Restorative Nursing Program for bed mobility and transfers with a CNA 6 days a week. Resident #92 was not included in this list as receiving AROM to her left upper extremities. CNA Staff 'S' was shown the Physician Order dated 08/09/20 for AROM to the left upper extremities. CNA Staff 'S' confirmed she was not aware of and has not been providing any AROM to Resident #92 per the physician orders of 08/09/20. On 09/24/20 at 11:15 AM, an interview was conducted with the Therapy Program Director. An inquiry was made how residents are referred for restorative nursing services to which she stated they get referrals through the therapists or from nursing. She stated the therapist writes the order on a paper telephone order sheet and the nurse records it and transcribes it into the electronic charting system. A request was made to review the restorative nursing orders for Resident #92. The Therapy Program Director checked her electronic documentation system and the order for AROM was done on 07/31/20 with a revised date of 08/09/20. The Therapy

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 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Program Director confirmed the order was written however it was not documented anywhere. She stated once the referral is made to the restorative nurse, therapy no longer has anything to do with it, it is up to nursing to follow through. On 09/24/20 at 11:20 AM, an interview was conducted with ADON Staff 'O' who stated when they get a restorative nursing referral it is entered into the computer as an order. She stated the aides are then trained by the therapist for the resident's particular requirements and its documented that the training was received. ADON Staff 'O' was apprised Resident #92 was ordered AROM to left upper extremities on 08/09/20, however she has not received any AROM as it was never included in the list of restorative nursing services she was to receive. ADON Staff 'O' was shown the physician order dated 08/09/20 for AROM to her left upper extremities and the current list of residents receiving restorative nursing services provided by CNA Staff 'S' which did not include the AROM. A request was made to review Resident #92's restorative nursing orders. ADON Staff 'O' checked her electronic documentation and confirmed the referral did not make it through the system, further stating maybe there is a 'glitch' in the system. ADON Staff 'O' had no further comment. On 09/24/20 at approximately 3:30 PM, an interview was conducted with the DON who stated she was informed about Resident #92 not receiving AROM as ordered. An inquiry was made how this order could have been missed to which the DON stated it must be a 'glitch' in the system. She had no further comment. Record review of Resident #73 showed that he was admitted on [DATE]. Further review showed an order by the physician dated 09/16/20 for the Resident to have a left-hand digit orthotic donned always except during Activities of Daily Living and skin checks. 2. In an observation conducted on 09/21/20 at 10:45 AM, Resident #73 was observed in his wheelchair in the lounge area by the Garden dining room. Closer observation did not show any left-hand digit orthotic on his hands as ordered. In an observation conducted on 09/21/20 at 12:00 PM, Resident #73 was observed in his wheelchair in the lounge area by the Garden dining room. Closer observation did not show any left-hand digit orthotic on his hands as ordered. In an observation conducted on 09/21/20 at 2:00 PM, Resident #73 was observed in his wheelchair in the lounge area by the Garden dining room. Closer observation did not show any left-hand digit orthotic on his hands as ordered. In an observation conducted on 09/22/20 at 8:30 AM, Resident #73 was observed in his room lying in bed. Closer observation did not show any left-hand digit orthotic on his hands as ordered. In an observation conducted on 09/22/2020 at 11:30 AM, Resident #73 was observed in his wheelchair in the lounge area by the Garden dining room. Closer observation did not show any left-hand digit orthotic on his hands as ordered. In an interview with Staff M, Occupation Therapist, on 09/22/20 at 2:24 PM, she reported that in her assessment which was done on 08/19/20, Resident #73 will benefit from a positioning device that he can get his hand into, to eliminate further contractures and prevent skin breakdown. In this interview she reported that she placed an order for [REDACTED]. Record review of the Occupational Therapy Plan of Care dated 08/19/20, showed that Resident #73 is with left wrist flexion limitation and only able to range to neutral following Passive Range of Motion provided. He left middle, ring and pinky digits flexed in composite fist as well. Further record review of the MAR (Medication Administration Review) and the TAR (Treatment Administration Review) showed that for the month of September, Resident #73's order for the orthotic device was not documented as done daily by nursing staff. In an interview conducted on 09/22/20 at 3:03 PM, with Staff D, Registered Nurse, she reported that if a resident has an order for [REDACTED]. When asked as to why Resident #73 did not have any documentation that the orthotic devices were placed daily, she reported that the order was placed incorrectly which did not required documentation on the MAR and the TAR. She further stated that this can be easily corrected. In an observation conducted on 09/22/20 between 3:00 PM and 4:00 PM, Resident #73 was observed sitting in his wheelchair comfortably with the Left-hand orthotic in place. He did not seem agitated or picking at the orthotic in place. In an observation conducted on 09/23/20 at 2:00 PM, Resident #73 was observed sitting in his wheelchair with the Left-hand orthotic in place, while watching television. Record review conducted on 09/24/20 at 3:00 PM, showed that Resident #73's care plan was updated to reflect Resident #73 resistive to care and will remove the orthotic device, which was initiated on 09/22/20, after surveyor's interventions.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor and re-assess catheter care per physician's orders, for 1 of 2 residents reviewed for Urinary catheter/Urinary tract infection (Resident #51). The findings included: Resident was initially admitted on [DATE] with an indwelling catheter in place related to [MEDICAL CONDITION]. According to the resident's Admission MDS (Minimum Data Set) completed on 03/22/20, Resident #51 had an indwelling catheter; [DIAGNOSES REDACTED]. A Clinical Admission Evaluation documented in progress notes, dated 03/18/20, documents, Urinary catheter intact. Catheter character: Patent, draining, leg band in place. Catheter in place due to [MEDICAL CONDITION] Resident's care plan initiated 03/21/20 and most recently revised on 09/03/20, documents, (Resident) has a urinary catheter. The goal of the care plan is documented as, The resident will be/remain free from catheter-related trauma through review date. with intervention that included Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp. Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. According to Resident #51's most recent MDS, completed on 08/02/20, resident still has an indwelling catheter; [DIAGNOSES REDACTED]. Progress note dated 09/02/20 at 6:00 documents,[MEDICATION NAME] mg x1 dose given [MEDICATION NAME] for UTI/foley change. No adverse reaction noted. No s/s pain/discomfort. Foley draining yellow urine. Safety maintained. Progress note dated 09/22/20 at 00:15 documents, change foley catheter every night shift every 30 days, Catheter care, foley catheter was changed by urologist on 9/1/20. On 09/22/20 at 8:41 AM, Resident #51 was observed in bed with bed in low position and fall mat on floor. It was noted that the urine in the resident's catheter bag was cloudy, which may be a sign of Urinary Tract Infection [MEDICAL CONDITION]. During an interview, on 09/23/20 at approximately 10:00 AM with the two ADONs, Staff O and Staff R, when asked who would observe and document any assessments of the resident's catheter, both replied that the nurse would document in Progress Notes. During an interview, on 09/23/20 at 10:17 AM, with Staff V, LPN, when asked where staff would document signs of UTI (i.e. cloudy urine), she stated that it would have been documented in the resident's Treatment Administration Record (TAR). A review the TAR in Resident #51's electronic health record revealed no documentation of cloudy urine or any signs of UTI, prior to this surveyor's initial observation.
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 observations, interviews and record review, the facility failed to assess the nutritional status of residents in a timely manner, and failed to provide nutritional supplements to prevent further weight loss for 3 of 7 residents reviewed for nutrition (Resident #35, #87, and #85). The findings included: Record review of the Minimum Data Set (MDS) Resident Matrix provided by the facility on 09/21/20 showed that under number 7 which is coded for excessive weight loss, no residents were documented under that section. 1. In an observation conducted on 09/22/20 at 8:50 AM, Resident #35 was observed in bed trying to eat his breakfast meal. Closer observation showed that the tray consisted of: Cereal, Muffin, Milk, and Juice. His wife at the bedside who is also a resident in the facility, reported that he will not be able to eat unless he gets assistance with his meals. She further reported that she will try and help him with his breakfast tray when she is done with hers. In another observation conducted on 09/22/20 at 9:10 AM, Resident #35's wife was observed assisting him with his breakfast tray. Record review of Resident #35 showed that he was admitted on [DATE] with cognitive communication deficit. Review of the weights log for Resident #35 showed that on 08/12/20 he was 143.2 pounds and on 08/26/20 he was 134.6 pounds. That is 6.01 percent significant weight loss in less than a month. Continued review of the weights log showed that on 09/14/20 his weight was 129.8 pounds and on 09/16/20 his weight was at 128.6 pounds. Record review of the Minimum Data Set ((MDS) dated [DATE] showed that Resident #35 needs supervision with set up only for eating. Review of the Care Plan dated 07/22/20 showed that Resident #35 is with nutritional problem and will maintain adequate nutrition status by maintaining weight within 5 percent of monthly weights. Review of the Dietitian follow up note dated 09/04/20, she addressed the significant weight loss which was 9 days later. In this note she reported that Resident #35 is eating independently and is receiving fortified meals and Ensure Plus (nutrition supplement) twice a day. She further stated that Resident #35 will be monitored for meals intake and supplements. Continued review of the physician's orders [REDACTED]. Review of the MAR (Medication Administration Review) and the TAR (Treatment Administration Review) showed that

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Resident #35 was receiving the Ensue Plus supplements twice a day, but no percent consumption was documented. Review of the Registered Dietitian progress note dated 09/16/20 that his total weight loss since 06/01/20 is at 18%. She further noted with the supplements and the diet intake, Resident #35 should be meeting his estimated calories and protein needs. In an interview with the Clinical Dietitian on 09/23/20 at 10:50 AM, she reported that follow up assessments are completed whenever it is warranted. According to her, follow up assessments are done if someone experience a weight loss of 3-4 percent or greater, and she will assess them as soon as possible because she prioritized her assignments accordingly. In this interview the Clinical Dietitian acknowledged that the weight loss experienced by Resident #35 was considered significant. She further acknowledged that an assessment was not completed for Resident #35 until 9 days after the weight loss was noted. Furthermore, her assessment is based on percentage of nutritional supplements consumed by residents. She acknowledged that the percentage of supplements consumed is not always documented in the MAR and the TAR and that staff usually verbalizes the percentage consumed. She ended the interview by reporting discrepancies between assistance for meal setup, independent eater, and surveyors' observations of requiring assistance with meals. In an interview conducted on 09/24/20 at 9:30 AM, with Staff J, Minimum Data Set (MDS) Coordinator, she reported that she bases her assessment from asking nursing staff and sometimes she observes the residents herself. When asked as to why she assessed Resident #35 section G for eating as supervision with set up only, she reported that he can eat on his own. Surveyor voiced concern that Resident #35 was observed all week and was not able to eat on his own unless he was assisted by staff or his wife. 2. In an interview conducted on 09/21/20 at 11:00 AM, Resident #87 reported that she is in pain because of a pressure ulcer on her sacral area and is not eating very well. Review of Section M of the Minimum Data Set ((MDS) dated [DATE] and Care Plan dated 8/27/20 showed that Resident #87 had four pressure ulcers/injuries present upon admission: one stage 2 pressure ulcer/injury, one stage 4 pressure ulcer/injury, two unstageable pressure ulcers/injuries. Review of the weight logs showed that Resident #87 had a weight of 155.4 pounds (lbs.) on 8/28/20, 156 lbs. on 8/29/20, 155.6 lbs. on 8/30/20, 144 lbs. on 9/7/20, 143.6 lbs. on 9/11/20, and 145.2 lbs. on 9/15/20. Resident #87 experienced a 6.56% severe weight loss from 8/28/20 - 9/11/20. Review of the initial Registered Dietitian (RD) assessment dated [DATE] showed that Resident #87 was at nutritional risk and will need increase nutritional needs related to wounds. In this assessment the RD recommended Boost Breeze (nutrition supplement) three times a day, fortified all meals, and monitoring all weights, as well as intake of meals and supplements. Review of the progress note dated 09/14/20 by the RD showed a significant weight loss of 7.7 percent in 2 weeks, and that the weight loss is likely due to varying intake of meals and supplements. This RD note was done 7 days after identifying that Resident #87 lost Significant weight. Review of the physician's orders [REDACTED]. Further review of the Medication Administration Record (MAR) for the month of September 2020 showed that Resident #87 was receiving the Boost Breeze 3 times a day, but percent consumption was not documented. The Care Plan dated 08/27/20 showed that Resident #87 will maintain adequate weight within 5 percent of 163 pounds and consume at least 51-75 percent of meals. During an interview on 9/23/20 at 10:45 AM, the RD stated that Resident #87 experienced a 7.3% weight loss between 8/28/20 - 9/7/20 and acknowledged that this was a severe weight loss. RD acknowledged that it took her seven days to address the 7.3% weight loss. RD further acknowledged that they should have followed-up with Resident #87. When asked about fortified meals, RD stated that one food item per meal is fortified. At breakfast, the oatmeal is fortified, at lunch and dinner, the mashed potatoes are fortified. When asked how staff recognize the difference between fortified and non-fortified oatmeal/mashed potatoes, RD acknowledged that it is difficult to tell the difference between fortified and non-fortified items. RD stated that specific diet orders are not placed on meal tickets as the facility is undergoing changes in the menu cycles. RD also acknowledged that fortified items were not specified on meal tickets and acknowledged the importance of meal tickets. During an interview conducted on 9/23/20 at 12:09 PM, Staff G, Dietary Assistant, stated that she refers to a printout on her wall to identify those in need of fortified meals and diet specifications. An observation was conducted of the printout that was used by Staff G did not show that Resident #87 had fortified meals with her diet order. 3. Review of the facility's policy titled Weight Management revised on 08/16/20, showed that new residents will be weighed by nursing personnel two consecutive days upon admission to establish a baseline weight. If a weight inconsistency occurs with the two admission weights, a request by the Registered Dietitian, Diet Technician, or Certified Dietary Manager will be made for nursing personnel to weigh the resident on the third day following admission. Review of the record showed that Resident #85 was re-admitted to the facility on [DATE]. During an interview conducted on 9/21/20 at 10:10 AM, Resident #85 stated that she had lost a bit of weight but was not sure of how much. Observation of Resident #85 showed that she looked thin with her clavicle bones protruding out. Review of the weight logs showed that Resident #85 had a weight of 103.2 pounds (lbs.) on 8/27/20, 84.6 lbs. on 9/2/20, 84.6 lbs. on 9/4/20, and 86.4 lbs. on 9/11/20. This indicates a 21.99% severe weight loss from 8/27/20 - 9/2/20. A repeated weight was obtained on 9/4/20, which was two days later. Review of the RD progress notes dated 9/7/20, she reported that the resident had a significant weight loss of 18.6 lbs., which is 18% in one week. In this note, she further reported that the resident is receiving fortified foods with all meals and is provided with Resource 2.0 (nutritional supplement) three times per day. RD also recommended Magic Cup (nutritional supplement) daily with the lunch meal. Review of the Medication Administration Review (MAR) for the month of August 2020 showed that Resident #85 was provided with the Resource 2.0, but percentage consumed was not documented. Review of the Care Plan dated 6/20/20 showed that the nutrition goal for Resident #85 was to maintain adequate nutritional status as evidenced by maintaining weight within 5% of 95.6 lbs., with no signs or symptoms of malnutrition, and by consuming at least 75% of meals daily through review date. During an interview on 9/23/20 at 11:13 AM, the RD and Dietetic Technician Registered (DTR) stated that the weight taken on 9/2/20 was 84.6 lbs., indicating an 18% weight loss. RD and DTR stated that they were late in conducting the assessment on Resident #85 because they were waiting on a re-weight to be taken on the resident. When asked as to why the re-weight was taken two days after the initial weight loss, RD and DTR reported that it has been an issue obtaining weights in a timely manner. The DTR further stated that she was not able to conduct the assessment on Resident #85 because the re-weight was conducted by Staff F, Certified Nursing Assistant (CNA), after she left the faciity on Friday (9/4/20). According to DTR, she immediately did the follow-up note on Monday morning (9/7/20). When asked why the re-weights weren't taken during the day, she reported re-weights are only taken by one staff member on the 3:00 PM - 11:00 PM shift and that weights are not taken earlier in the day. During an interview on 9/23/20 at 3:36 PM, the Director of Nursing (DON) stated that weekly weights are conducted by a CNA that works the 3:00 PM - 11:00 PM shift and that monthly weights are conducted by a Restorative CNA that works the 7:00 AM - 3:00 PM shift. DON stated, There is no rule on who does the re-weighs. During an interview conducted on 9/23/20 at 3:38 PM, Staff F stated that she is responsible for conducting the weekly weights. When asked about re-weighs, Staff F stated that she oversees the re-weights only on Wednesdays but that any nursing staff can take the re-weights when needed. In an interview conducted on 9/24/20 at 2:00 PM, the DON acknowledged all findings.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Post nurse staffing information every day.** Based on observation, interview and record review, the facility failed to have accurate nurse staffing hours posted on 1 of 4 nursing units (300 unit). The findings included: During observations on the 300 unit of the facility, on 9/21/20, 9/22/20, 9/23/20 and 9/24/20 it was noted that the Shift Census Reports were not completely filled out. The 7-3 shift was completed each day, however the 3-11 shift and the 11-7 shift were not completed on the forms. During an interview, on 09/23/20 at 3:52 PM, with the Scheduling Coordinator, she stated the shift census report is only filled out for the morning shift by her, the other shifts are filled out by the shift supervisor and they have been doing it that way for about a year. The form is completed by the end of the day, and they keep a copy. The Scheduling Coordinator provided this surveyor with copies of the forms. Review of the documents that were provided revealed one of the forms, dated 9/16/20, was incomplete and missing the 3-11 shift.
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined the medication error rate was 15 percent. Four medication errors were identified while observing a total of 27 opportunities, affecting 3 of 9 residents observed (Residents #27, #87, and #26). The findings included: Review of the facility policy for Medication Administration states in part, 'The administration of medications will be performed only in accordance with written and signed orders from the client's physician. All orders, as appropriate, shall include - Special instructions or precautions, if indicated.' 1) On 09/23/20 at 4:25 PM, a medication pass observation was conducted with Registered Nurse (RN) Staff 'D' for Resident #87 residing on the Cobblestone unit. RN Staff 'D' was observed to dispense a stool softener, a pain medication and one additional medication called Creon. Review of the front of the blister pack revealed a notation 'Take with or after food'.

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) An interview was conducted with RN Staff 'D' inquiring what time dinner was served on this unit to which she stated it comes around 5:30 PM. RN Staff 'D' proceeded to Resident #87 and administered the 3 medications to include [MEDICATION NAME] the resident swallowing all 3 pills at the same time with a quarter glass of water. [MEDICATION NAME] not administered with or after food and the resident had no snacks observed on her table to be taken with the medication. On 09/23/20 at 5:45 PM, the Cobblestone unit and Resident #87 were observed. Dinner had not yet been served. On 09/23/20 at 5:58 PM, the Cobblestone unit and Resident #87 were observed. Resident #87 was observed eating and she stated dinner just arrived. Resident #87 started eating dinner almost an hour and a half after the dose [MEDICATION NAME] administered. Review of a manufacturers prescribing information pamphlet [MEDICATION NAME] a medication used for pancreatitis and is a pancreatic digestive enzyme replacement therapy. Further review of the prescribing information revealed patient directives stating 'Creon and food need to be taken at the same time.' On 09/24/20 at 10:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) Staff 'X' on the Cobblestone unit, and a request made to review [MEDICATION NAME] pack. LPN Staff 'X' retrieved the blister pack from the medication cart. An inquiry was made to LPN Staff 'X' what 'Take with or after food' meant, to which she stated that means the medication can be taken with or without food. LPN Staff 'X' was not aware of the significance of taking the medication with or after food. 2) On 09/23/20 at 4:45 PM, a medication pass observation was conducted with LPN Staff 'Y' for Resident # 27 residing on the Poinciana unit. LPN Staff 'Y' was observed to retrieve 3 blister packs of medications from the medication cart. One medication, an antibiotic, was dispensed into a medication cup. LPN Staff 'Y' reviewed the other 2 blister packs and proceeded to start to place them back into the medication cart. A request was made to observe the 2 blister packs. Upon review, the 2 medications being replaced back into the medication cart were [MEDICATION NAME] (for treatment of [REDACTED]. LPN Staff 'Y' stated these medications are due now, however she is holding them as the resident's vital signs are outside of parameters for administration, further stating the resident's blood pressure is 100/66 and heart rate 60. LPN Staff 'Y' administered 1 of the 3 medications scheduled for 5:00 PM. On 09/24/20 at 10:00 AM, a medication reconciliation with the September 2020 Medication Administration Record (MAR) and Physician Orders was conducted for Resident #27's medications due at 5:00 PM on 09/23/20. Review of the medication order for the [MEDICATION NAME] which was held on the 09/23/20 at the 5:00 PM dose, revealed parameters to hold the medication if the systolic (top number) blood pressure was less than 110 and heart rate less than 60. Review of the medication order for the Valsarten which was held on the 09/23/20 at the 5:00 PM dose, revealed no parameters to hold the medication as a result of the vital signs. Review of the September 2020 MARs revealed LPN Staff 'Y' coded the 5:00 PM Valsarten medication slot with a '4' indicating the vital signs were outside of parameters for administration. There was no parameter for holding the heart failure/blood pressure medication Valsarten. Further, review of the clinical record revealed the Physician was not notified of the resident's blood pressure or that the [MEDICATION NAME] heart failure/blood pressure medication was held. 3) On 09/23/20 at 5:05 PM, a medication pass observation was conducted with LPN Staff 'W' for Resident #26 residing on the Gulfstream unit. LPN Staff 'W' was observed to dispense 7 medications into a medication cup to include Vitamin C, Cranberry supplement, multivitamins with minerals, Eliquis (blood thinner), [MEDICATION NAME] (blood pressure), [MEDICATION NAME] (antidepressant), and [MEDICATION NAME] (diuretic). LPN Staff 'W' stated, 'That's it for now.' Resident #26 was observed to be noncompliant with taking the medications and required encouragement from LPN Staff 'W' to finally do so. On 09/23/20 at 5:55 PM, Resident #26's MARs were briefly reviewed to reveal the medications dispensed for the resident at the medication pass observation conducted at 5:05 PM, had not yet been signed off by LPN Staff 'W' as administered. On 09/24/20 at 10:30 AM, a full medication reconciliation with the September 2020 MAR and Physician orders was conducted for Resident #26's medications due at 5:00 PM on 09/23/20. The 7 medications dispensed and administered on 09/23/20 at the 5:05 PM medication pass observation were included in the medications due at this time and were now signed off as administered. Further review of the MAR revealed 2 medications due twice a day and due at 5:00 PM on 09/23/20 were not included in the medication pass observation conducted on 09/23/20 at 5:05 PM to include [MEDICATION NAME] (stomach medication) and [MEDICATION NAME] (blood pressure medication). These 2 medications that were not included in the 09/23/20 medication pass observation at 5:05 PM, were signed off as administered at the 5:00 PM medication pass with no indication or documentation these 2 medications may have been administered late. On 09/24/20 at 12:20 PM, an interview was conducted with the Director of Nurses (DON) who was apprised of the medication pass observation issues identified on 09/23/20 related to giving [MEDICATION NAME] food as directed for Resident #87; holding a blood pressure medication without parameters and without notifying the physician for Resident #27; and not administering 2 medications at all, during the medication pass observation for Resident #26. On 09/24/20 at 2:28 PM, a telephone interview was conducted with the Pharmacy Consultant who was apprised of the medication pass observations conducted on 09/23/20. An inquiry was made if the [MEDICATION NAME] required to be given with food. The Pharmacy Consultant did his own review of the medications indications and special prescribing information, and [MEDICATION NAME] to be given with food. He inquired about the time between administration and consuming dinner to which he was advised the medication pass observation was conducted at 4:25 PM and Resident #87 did not receive her dinner until 5:58 PM. The Pharmacy Consultant stated if the medication was given 10-15 minutes prior to dinner that would have been satisfactory, however with that much time between dosage and eating, it would affect the medications effectiveness. An inquiry was made if a medication was held without parameters should the nurse notify the Physician to which he stated the Physician should be notified if any medication is held without a parameter. The Consultant Pharmacist could not speak to why the nurse did not include or administer the 2 medications that were due at 5:00 PM for Resident #26. On 09/24/20 at 3:15 PM, during the Quality Assurance interview conducted with the DON, Administrator and Medical Director, the medication pass observation issues were discussed. The Medical Director concurred the [MEDICATION NAME] be given with food. The DON concurred the physician should be notified if a medication is not administered and there are no parameters, and further could not speak to why the nurse did not include the 2 medications during the medication pass observation conducted for Resident #26.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews and record review the facility failed to maintain food safety requirements with storage, preparation, and distribution that is in accordance with professional standards for food service safety that include; equipment in safe working condition, failure to properly cover facial hair, and failure to properly date and label all food items. The findings included: During the kitchen/food service observation tour conducted in the main kitchen on [DATE] at 8:50 AM accompanied with the facility 's Food Service Director the following were noted: 1. Two male diet aides Staff A, Dietary Assistant, and Staff B, Dietary Assistant, were noted to be working in the food preparation and serving area. Further observation of dietary aides revealed that their facial hair was not covered with a hair restraint as per regulatory requirement. 2. The main exhaust hood in the food production area was missing 1 out of 3 light bulbs. 3. The ceiling in the main food production area, had a water leak that was dripping liquid onto the kitchen floor. 4. A private cell phone was stored on a shelf above the food preparation table. Further observation showed that the food preparation table had the following food items that did not have used by/expiration dates, or a label identifying what it is:1 pitcher with a yellow color liquid was missing a label identifying what it was and was missing an expiration/use by date, 1 pitcher with a white color liquid was missing a label identifying what it was and was missing an expiration/use by date, 1 metal pan with brown rice was missing a label identifying what it was and was missing an expiration/use by date, 2 plastic containers with black color liquid were missing a label identifying what they were and were missing an expiration/use by date. When asked what is in the black color liquid, Staff I, Facility Cook, reported that it is dark tea broth that he made for himself. 5. In a continued observation, Staff I was observed handling liquid from a red sanitizing bucket while wearing gloves. Staff I did not change gloves and then proceeded to prepare food without performing hand hygiene. During this observation, Staff I changed the liquid from another red sanitizing bucket and proceeded to handle food again without performing hand hygiene. When asked about the liquid sanitizing solution, Staff I stated that the liquids from the red sanitizing buckets are changed every hour. The facility uses their own test strips to identify the chemical levels of their liquid sanitizing solution, ranging from 50 parts per million (ppm) to 400ppm. Staff I was then asked to test the first red sanitizing bucket for the chemical level in the solution. The first bucket tested showed 50ppm which was below the normal level of 200ppm. The second red sanitizing bucket that was tested showed 100ppm which was below the normal level of 200ppm. Staff I acknowledged that both red buckets were not within the normal level for liquid sanitizing solution that is

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	105335	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ABBEY DELRAY	2105 SW 11TH COURT DELRAY BEACH, FL 33445

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) 200ppm. 6. A bone with meat was rotten and observed on the bottom shelf of a metal table in the equipment storage area. 7. A broken beer cooler was observed in the equipment storage area. A broken ice machine was observed in the hallway near the Disaster Emergency Food Supply closet. The Executive Chef stated that this ice machine had been broken for the past two days. 8. The reach-in cooler next to the three-compartment sink had the following food items that did not have a used by/expiration dates on them, and a label identifying what it is: several mini containers of coleslaw were missing a label identifying what they were and were missing an expiration/use by date, several mini containers of yellow sauces were missing a label identifying what they were and were missing an expiration/use by date, several mini containers of white sauces were missing a label identifying what they were and were missing an expiration/use by date, 1 metal pan with spinach had a label identifying what it was but was missing an expiration/use by date, and 1 metal pan with mixed vegetables had a label identifying what it was but was missing an expiration/use by date. 9. The walk-in refrigerator had the following food items that did not have a used by/expiration dates on them, and did not have a label identifying what it is: 1 block of meat was missing a label identifying what it was and was missing an expiration/use by date, 1 sheet pan with raw chicken wings was missing a label identifying what it was and was missing an expiration/use by date, 1 metal pan with red sauce was missing a label identifying what it was and was missing an expiration/use by date, 2 hotel pans with chopped meat in red sauce were missing a label identifying what they were and were missing an expiration/use by date, 4 white half sheet trays with raw dough were missing a label identifying what they were and were missing an expiration/use by date, 20 pounds of ribs were missing a label identifying what they were and were missing an expiration/use by date, 1 metal pan with diced onions was missing a label identifying what it was and was missing an expiration/use by date, 1 plastic bin of honey mustard had a label identifying what it was but was missing an expiration/use by date, 1 plastic bin with ranch dressing had a label identifying what it was but was missing an expiration/use by date, several packages of tortillas were missing a label identifying what they were and were missing an expiration/use by date, 1 block of ham had a label identifying what it was but was missing an expiration/use by date, 1 plastic bag of cubed beef had a label identifying what it was but was missing an expiration/use by date, 3 bags of Parmesan cheese had a label identifying what they were but were missing an expiration/use by date, 1.5 bags of Swiss cheese cubes had a label identifying what they were but were missing an expiration/use by date, 1 bag of crumbled feta cheese had a label identifying what it was but was missing an expiration/use by date, 1 bag of blue cheese crumbles had a label identifying what it was but was missing an expiration/use by date, 4 packs of natural mild cheddar cheese slices had a label identifying what they were but were missing an expiration/use by date, and 1 pack of provolone cheese slices had a label identifying what it was but was missing an expiration/use by date. 10. The walk-in refrigerator had the following food items that were not covered/sealed: 2 hotel pans with chopped meat in red sauce, 1 sheet pan with raw chicken wings, 1 metal pan with red sauce, 20 pounds of ribs, 1 cardboard box with raw chicken, and 1 individual packet of Grassland unsalted butter. 11. The walk-in freezer had the following food items that were not covered/sealed: 1 cardboard tray of muffins. 12. The walk-in refrigerator had the following food items that were expired: 1 plastic bin of blue cheese dressing with an expiration date of [DATE], 1 plastic bin cocktail sauce with an expiration date of [DATE], and 1 plastic bin of tartar sauce with an expiration date of [DATE]. 13. In the hallway leading to the dry storage area, a scoop was observed inside of a storage bin containing brown rice. In the dry storage area, a plastic container used as a scoop was stored inside a storage bin containing chocolate chips. During an observation conducted on [DATE] at 12:18 PM, the standing freezer in Pantry A was 22 degrees Fahrenheit and not the recommended 0 degrees Fahrenheit and below. A dead insect was also observed in a cabinet. At 12:24 PM in Pantry D, the cabinets were disorganized and the lid to the garbage can was left open. Two open bottles of mustard in a dry storage cabinet had labels that instructed that items must be refrigerated after opening. Staff purse was stored in a dry storage cabinet next to cereal boxes. At 12:40 PM in Pantry B, a bug trap was observed on the bottom shelf of a cabinet and contained dead insects.
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 record review, the facility failed to ensure infection control practices were followed to prevent the potential for cross contamination or potential for development of infection, as evidenced by failing to perform Foley urinary catheter care to prevent the potential for infection and observation of improper hand hygiene for 1 of 2 sampled residents reviewed for Urinary Catheter or UTI (urinary tract infection), Resident #27; failing to perform proper hand hygiene during medication pass observation and improper cleaning of a blood glucometer for Resident #50; staff failed to follow universal infection control measures for COVID-19 precautions; staff failed to follow isolation precautions for Resident #247; and staff failed to handle clean laundered items in the laundry in a manner to prevent the potential for cross contamination or spread of infection. The findings included: 1. Resident #27 was admitted to the facility on [DATE] with pertinent [DIAGNOSES REDACTED]. Review of Physician Orders for [DATE] revealed an order for [REDACTED]. Review of the [DATE] Treatment Administration Records revealed the next Foley catheter change was due on [DATE]. Review the clinical record revealed the latest laboratory result for a urinalysis was collected on [DATE] documenting the sample was cloudy in appearance, showed a few bacteria and contained mixed flora, stating the sample was possibly contaminated. There was no evidence of any repeat urinalysis obtained from the Foley catheter and no evidence of any treatment rendered. On [DATE] at 4:49 PM, a telephone interview was conducted with Resident #27's family member who stated Resident #27 has a chronic Foley catheter and has had several UTIs in the past. A request was made to provide consent to observe Foley catheter care to which the family member consented. On [DATE] at 9:30 AM, a request was made to the Director of Nursing (DON) to observe Foley catheter care for Resident #27 residing on the Poinciana unit. Arrangements were made to observe Licensed Practical Nurse (LPN) Staff 'T' perform Foley catheter care for Resident #27. On [DATE] at 10:45 AM, a Foley catheter care observation was conducted with LPN Staff 'T' assisted by Certified Nursing Assistant (CNA) Staff 'U' and CNA Staff 'S'. CNA Staff 'U' and CNA Staff 'S' were observed to assist LPN Staff 'T' by holding the resident's legs apart and gently holding on to her right arm in the event she might strike out at them. The supplies were readied at the bedside. LPN Staff 'T' was observed to conduct an appropriate cleansing of the perineum and Foley catheter insertion site using soapy water. At 10:55 AM, CNA Staff 'U' stated to LPN Staff 'T' she would get rinse water. CNA Staff 'U' proceeded to remove her gloves and without performing hand hygiene donned new gloves. CNA Staff 'U' proceeded to the bathroom and obtained a basin of rinse water and returned placing the basin on the overbed table for LPN Staff 'T'. LPN Staff 'T' then proceeded to rinse the resident's perineum in an appropriate manner, rinsing from the catheter insertion site upwards. After rinsing the perineum, LPN Staff 'T' retrieved disposable washcloths and proceeded to dry the perineal folds, wiping from the top downwards dirty to clean from the right side to the Foley catheter insertion site and then from the top downwards dirty to clean from the left side to the Foley catheter insertion site. LPN Staff 'T' then removed the towel that was covering the resident's upper half of her body and proceeded to dry the resident's perineal folds with the used towel in the same fashion downwards dirty to clean towards the Foley catheter insertion site on the left side and then the right. LPN Staff 'T' then proceeded to unhook the Foley catheter drainage bag from the side of the bed and proceeded to lift the drainage bag over the height of the bed and placed the bag on the bed next to the resident's right thigh. LPN Staff 'T' and CNA Staff 'U' repositioned the resident up in the bed, LPN Staff 'T' removed the drainage bag off the bed and hooked it back on the side of the bed. At 11:00 AM, CNA Staff 'S' who was standing next to LPN Staff 'T', and after having touched the resident's arms and legs and bed covers, was observed to remove her gloves and don new gloves without performing hand hygiene inbetween. Resident #27 was assisted to a comfortable position by CNA Staff 'S' and Staff 'U'. CNA Staff 'U' was then observed to remove her gloves, don new gloves without performing hand hygiene inbetween, and proceeded to the bathroom to dispose of the rinse water. At 11:20 AM, Resident #27's roommate was observed to be attempting to exit the room however was unable to wheel herself past a chair and Resident #27's gerichair that was obstructing her path. CNA Staff 'S' proceeded to remove her gloves and without performing hand hygiene, pushed the roommate in her wheelchair back and pushed Resident #27's gerichair further into the room to allow the roommate to exit the room. CNA Staff 'S' was not observed to perform hand hygiene after touching Resident #27's and her roommate's belongings. CNA Staff 'S', not wearing gloves, was then observed to retrieve the bag of dirty laundry on Resident #27's bed and placed it on the floor. At no time was CNA Staff 'S' observed to perform hand hygiene during the the Foley catheter care observation or thereafter. Review of the facility policy for Urinary Catheter Care states in part, 'The purpose of this procedure is to prevent catheter associated urinary tract infections . The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.' Review of the facility policy for Hand Hygiene states in part, 'Hand Hygiene is the most effective measure for preventing infections .Indications for hand hygiene - Anytime you remove protective gloves or PPE (personal protective equipment). Wearing gloves

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) does not replace the need for hand hygiene.' On [DATE] at 12:00 PM, an interview was conducted with the DON who was apprised of the Foley catheter care and glove use observations. 2. On [DATE] at 11:50 AM, a medication pass observation was conducted with LPN Staff 'V' for Resident #50 residing on the Garden unit. LPN Staff 'V' removed a glucometer machine from the bottom drawer of her medication cart and placed it on a Styrofoam tray on top of her cart. She placed 2 lancets and alcohol wipes on the tray. She proceeded to the resident's room and placed the tray on the overbed table. She went to the bathroom, washed her hands and donned gloves. After obtaining the resident's blood sugar, she removed and disposed of her gloves in the trash. Without performing hand hygiene after removing her gloves, she proceeded to touch the overbed table and picked up the Styrofoam tray, touched the privacy curtain and touched the door knob to exit the room. Walking to her medication cart, she placed the Styrofoam tray on top of her medication cart. She then took the glucometer machine off the Styrofoam tray and placed it on her mouse pad on top of her medication cart. LPN Staff 'V' then stated she is going to wash her hands. Returning back to her medication cart, she opened the bottom drawer and pulled out another Styrofoam tray and picking up the glucometer machine off the mouse pad with bare hands placed the glucometer machine onto the tray. LPN Staff 'V' then stated she will clean the glucometer machine after she is done. Checking the electronic medication record she determined the amount of insulin Resident #50 required and proceeded to don gloves and drew up the insulin in a syringe and placed it on a Styrofoam tray. LPN Staff 'V' then stated again she will clean the glucometer when she gets back, proceeding to Resident #50's room leaving the glucometer machine sitting on top of her medication cart. In the resident's room, she placed the tray on the resident's overbed table, washed her hands and donned gloves. She administered the insulin to Resident #50, removed her gloves and did not perform hand hygiene after doing so. She then picked up the syringe, disposed of the tray in the trash, opened the privacy curtain and touched the door knob. She walked back to her medication cart and disposed of the syringe in the sharps box then went to wash her hands. Back to her medication cart, she opened the bottom drawer, donned gloves and retrieved 2 disinfecting wipes and proceeded to wrap them around the glucometer however did not wipe the glucometer down. LPN Staff 'V' stated it has to stay wet for 1 minute but she does not clean it by wiping it down, she lets it sit for 2 minutes instead of the required 1 minute, stating it is 12:12 PM and it will be ready for reuse at 12:14 PM. At no point did LPN Staff 'V' wipe the glucometer down to ensure no blood residue remained. On [DATE] at 12:20 PM, an interview was conducted with the DON who was apprised of the medication pass observation conducted with LPN Staff 'V' discussing her glove use, lack of hand hygiene and lack of cleaning of the glucometer. The DON asked 'she did not physically wipe it down?' to which she was again informed the nurse just wrapped the glucometer in the disinfecting wipes however did not physically wipe it down. The DON had nothing further to comment. Review of the facility policy for Procedure for Cleaning and Disinfecting Glucometers states in part, 'Wipe surface of glucometer until completely wet with solution. Let stand for two (2) minutes. Wipe dry or allow to air dry.' 3. Review of the facility's policy titled Handwashing/Hand Hygiene, revised on [DATE], showed that hand hygiene is the final step after removing and disposing of personal protective equipment. Record review for Resident #247 showed that he was admitted to the facility on [DATE]. Further record review showed that he was placed on isolation precaution for 14 days noted on [DATE]. In an observation conducted on [DATE] at 8:10 AM, Staff C, Certified Nursing Assistant, was noted coming out of room [ROOM NUMBER] and walking towards room [ROOM NUMBER] (isolation room). She was observed donning her gown and gloves without washing her hands first. She then proceeded to walk into the isolation room with the front door still opened. She was observed talking to Resident #247 in the bathroom regarding his Breakfast menu. In this observation she took the gloves off, and the gown while in the room, without sanitizing her hands first. Staff C proceeded to open a closet door and took out a new pair of gloves without washing or sanitizing her hands. She then pushed on red garbage bin at the corner, to make room for new garbage space. She disposed of her gloves before leaving the room and did not wash her hands. In an observation conducted on [DATE] at 9:06 AM, Staff E, Registered Nurse, was observed going into the Resident's #247's room without donning gloves or a gown and proceeded to walk into the room with only her face-mask and her surgical mask. She was observed speaking to the Resident in the room by his bedside and opened the curtains around the bed. In this observation she was asked as to what is the protocol for any residents on isolation? She reported that when a resident is placed on isolation the Personal Protective Equipment (PPE) is outside the room. Before going into the room, the staff needs to wear a gown, surgical mask, face-shield and gloves. She further stated that all PPE gear needs to be disposed before leaving the room. Staff E also reported that Resident #247 was placed on 14 days isolation because he was newly admitted to the facility and will need to remain on isolation for the next 14 days. In an interview conducted on [DATE] at 1:08 PM, Staff O, Assistant Director of Nursing, she reported that any new residents admitted to the facility are placed on contact isolation. The staff must use the PPE gear which is placed outside the room. They need to wear the gown, gloves, masks and face-shield. She further stated that they test the residents on isolation once a week for the COVID-19 test. If they test negative they are taken off isolation before the end of the 14 days. 4. In a second tour to the main kitchen which was conducted on [DATE] at 9:29 AM, the following issues were noted: Staff K, Facility Cook, and Staff L, Dietary Assistant, were observed with their face masks below their nose. Staff K and Staff L were observed repositioning their masks with their bare hands and then returning to handling food items without performing hand hygiene. At 9:34 AM, the lid to the garbage can in the kitchen was left open and garbage was overflowing onto the kitchen floor. 5. During an observaton of the laundry, on [DATE] at 1:28 PM accompanied by the Environmental Services Lead, Staff P, Laundry Attendant and Staff Q, Laundry Attendant, while in the drying room, Staff Q was observed holding a piece of linen in her bare hands and against her body, resting on her personal clothing with nothing in between her clothing and the cleaned piece of linen. Staff Q confirmed that the clothing was what she came to work in. The Environmental Services Lead acknowledged that Staff Q should have been wearing a gown over her personal clothing. During the observation, staff confirmed that the linen was cleaned and being folded. Staff were asked about wearing PPE when handling linens, Staff P state that there are plastic aprons for handling the dirty items, neither mentioned any PPE for handling cleaned and dried linens. At the conclusion of the tour, this surveyor requested a copy of the facility's policies and procedures for handling clean linens. On [DATE] at 1:50 PM, the Environmental Services Lead provided this surveyor with a document titled, Environmental Services Department Safety Guidelines Laundry Area. The Environmental Services Lead confirmed that the document was the policy and procedure for the laundry. A review of the policy revealed that there was no guidance for handling clean items. Under the section of the policy titled, Laundry, line 1, it states, Use proper body mechanics and equipment. Always practice universal protection. After reviewing the policy, this surveyor asked the Environmental Services Lead what 'body mechanics' referred to, and she replied, not holding the cleaned items to yourself and holding away from the body. The Environmental Services Lead was asked what 'Universal Protection' referred to, and she replied, PPE (Personal Protective Equipment) in the form of gown, gloves, washing hands and using disinfectant. The Environmental Services Lead acknowledged understanding of the concerns.