STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A378	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYLVIA G THOMPSON RESIDENCE CENTER, INC	3333 W TENTH STREET SEDALIA, MO 65301

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	**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, facility staff failed to actively screen all employees and visitors for sign and symptoms of COVID-19 upon entrance to the facility. Facility staff failed to restrict the entrance of non-essential healthcare personnel when the facility continued to allow a contracted licensed beautician to enter the facility and perform services for residents. Facility staff failed to promote social distancing and ensure residents wore facemasks when out of their rooms in accordance with the Centers for Disease Control (CDC) guidelines. Facility staff failed to discontinue communal dining and group activities. Facility staff failed to wash their hands as often a necessary using approved techniques before, during and after resident care to prevent the spread of infection. Facility staff failed to provide the opportunity for residents to perform hand hygiene before meals to prevent the spread of infection. Facility staff also failed to disinfect multi-use gait belts between residents. The facility census was 112. 1. Review of the CDC's guidance for United States Nursing Homes and Long-term Care Facilities about COVID-19, updated 05/19/20, showed the following: -Restrict all visitors except for [MEDICATION NAME] care situations (e.g., end-of- life). -Restrict all volunteers and non-essential healthcare personnel (HCP), including consultant services (e.g., barber, hairdresser). -Implement universal use of source control for everyone in the facility. -Actively screen anyone entering the building (HCP, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift; send ill personnel home. Sick leave policies should be flexible and non-punitive. -Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry. -Screen visitors for fever (T=100.0 F), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility. -Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature* and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. Observation on 05/28/20 at 9:40 A.M., showed the exterior and interior facility entrance doors unlocked and unattended by staff. Observation showed the areas between the two doors and the front area of Station 2 unattended by staff which allowed visitors to walk freely into the facility. Observation showed the areas did not contain direction for individuals who entered the building to be screened for signs and symptoms of COVID-19. Further observation showed eight residents without facemasks seated near the entrance to Station 2. During an interview on 05/28/20 at 11:15 A.M., Activity Director A said staff have their temperatures taken daily at the nurses' station, but they are not asked questions about sign or symptoms of COVID-19 and they do not complete a screening form. During an interview on 05/29/20 at 2:20 P.M., Licensed Practical Nurse (LPN) C said when staff arrive for work, their temperature is checked and they wash their hands, but staff are not asked questions about symptoms, travel, or contact with potentially ill people unless the staff member is showing an illness symptom such as fever, cough, or diarrhea. During an interview on 05/29/20 at 2:50 P.M., the Director of Nursing (DON) said visitors should have their temperatures taken and be screened by staff upon entrance to the facility. The DON said staff are to have their temperature taken and be evaluated by the Station 2 charge nurse or medication technician before they start their shift. The DON said copies of the screening questionnaire were available at the Station 2 nurses' station and staff should document the screenings. During an interview on 05/29/20 at 3:32 P.M. the administrator said the facility did not allow visitors or vendors into the facility. The administrator said the charge nurse is responsible for taking staff temperatures and is expected to use the questionnaire to ask staff about travel and symptoms. The administrator said staff only document the temperatures on the shift report sheets and do not document signs and symptoms. 2. Review of the CDC's guidance for United States Nursing Homes and Long-term Care Facilities about COVID-19, updated 05/19/20, showed the following: -Restrict all visitors except for [MEDICATION NAME] care situations (e.g., end-of- life). -Restrict all volunteers and non-essential healthcare personnel (HCP), including consultant services (e.g., barber, hairdresser). During a telephone interview on 06/05/20 at 9:18 A.M., the administrator said a beautician comes to the facility on Wednesdays to do perms and haircuts for the residents. The Administrator said the beautician is contracted for his/her service and not employed by the facility. During a telephone interview on 06/05/20 at 10:22 A.M., the beautician said he/she usually goes to the facility on ce a week and provides perms and haircuts to the residents. The beautician said he/she provides service for about five residents on average per visit. The beautician said the facility asked him/her to stay home when not at the facility to decrease risk of transmission. The beautician said for the last three to four weeks, he/she had also provided the same services at another facility once a week. The beautician said the residents at both facilities are not required to wear masks when out of their rooms or while he/she provides services to the residents. 3. Review of the CDC's guidance for United States nursing homes and long-term care facilities about COVID-19, updated 05/19/20, showed the following: -Cancel all field trips outside of the facility. -Cancel all group activities and communal dining. -Enforce social distancing among residents. -Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. Review of an undated letter addressed to families and friends and signed by the administrator showed We continue to have communal dining and activities for our residents as we believe their social interaction is a vital factor to maintain good health as well as continued contact with family. Observation on 05/28/20 from 9:40 A.M. to 10:30 A.M., showed Residents #1, #2, #3, #4, #5, #6, #7 and #8 sat in the common area of Station 2 without facemasks. Further observation showed Residents #2 and #3 and Residents #5 and #6 sat together on couches in the common area directly beside one another. During an interview on 05/28/20 at 10:30 A.M., LPN C said none of the residents in the common area had difficulties with breathing. The LPN also said the facility conducts activities in groups on each wing of the facility. The LPN said the residents do the activities on the wing in which they reside and they do not social distance or wear facemasks. Observation on 05/28/20 at 11:13 A.M., showed four residents without facemasks playing cards at a table in the dining room. Observation showed the residents sat less than six feet from one another. Observation also showed Resident #9 licked his/her finger to separate the playing cards and touched the other cards on the table. During an interview on 05/28/20 at 11:15 A.M., Activity Director A said the facility still conducted group activities, but the residents stay on the wing in which they reside for the activities. The Activity Director said the group activities could have up to 15 residents in one area and the residents do not wear facemasks or sit at least six feet apart from one another. Observation on 05/29/20 at 10:45 A.M. showed 13 residents sat in the common area near the entrance of Station 2 without facemasks. Further observation showed two sets of two residents sat on couches in the common area directly next to one another sharing a blanket. During an interview on 05/29/20 at 11:15 A.M., Resident #1 said bingo is offered every Monday and Thursday for the residents. The resident said there are four residents to a table and residents are not required to wear masks. Review of the Station 2 Activity Board posted in the common area, dated 05/29/20, showed the activities listed as follows: -10:15 A.M. Manicures -2 P.M. Country Ride -2 P.M. Music and Drinks -4 P.M. Yahtzee During an interview on 05/29/20 at 12:03 P.M., Certified Nursing Assistant (CNA) F said a country ride was scheduled for the afternoon during which residents are loaded into the van for a ride through the country. Observation on

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A378	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYLVIA G THOMPSON RESIDENCE CENTER, INC	3333 W TENTH STREET SEDALIA, MO 65301

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 1) 05/29/20 at 1:30 P.M., showed Activity Director B loaded Residents #9, #10, #11, #12, #13, #14, #15 and #16 into the facility van. Observation showed the residents without facemasks and seated in the van less than two feet apart from one another. During an interview on 05/29/20 at 1:50 P.M., Activity Director B said he/she loaded the residents into the van for the country ride activity. The activity director said the CDC guidance for activities and outings was that residents should wear facemasks and be spaced six feet apart. When asked if the activity being conducted met the CDC guideline for activities, the activity director said the administrator said it was okay to take residents on outings since they all live in the same house and no one had gotten anything. During an interview on 05/29/20 at 2:50 P.M. the DON said the CDC guidelines direct long-term care facilities to not have communal activities for residents. During an interview on 05/29/20 at 3:32 P.M., the administrator the CDC guidance directs long-term care facilities to have residents stay in their rooms, but the residents had been together since 03/10/20 without visitors or infections and they stay with the same people. The administrator said since staff do not live at the facility, they were asked not go out unnecessarily and, if they did go out, they were asked to wear a mask to reduce the risk of infection. The administrator said he/she chose to allow the residents out of their rooms without facemasks and to continue group activities and meals because they already had those practices prior to the guidance and believed it would not make a difference to change those practices. 4. Review of the CDC's guidance for United States nursing homes and long-term care facilities about COVID-19, updated 05/19/20, showed the following: -Cancel all group activities and communal dining. -Enforce social distancing among residents. -Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. Review of an undated letter addressed to families and friends and signed by the administrator showed We continue to have communal dining and activities for our residents as we believe their social interaction is a vital factor to maintain good health as well as continued contact with family. During an interview on 05/28/20 at 10:30 A.M., LPN C said he/she did not know of the CDC recommendations regarding dining in long-term care facilities and the residents ate in the dining rooms just as they did before the pandemic. During an interview on 05/28/20 at 10:55 A.M., Cook I said the facility had not changed any of the dining practices and the residents still ate in the dining rooms as a group. During an interview on 05/28/20 at 11:00 A.M., Cook J said the facility had not changed any of the dining practices and the residents still ate in the dining rooms as a group. During an interview on 05/28/20 at 11:15 A.M., Activity Director A said there had not been any changes to the facility dining practices and residents still ate in the dining rooms. Observation on 05/28/20 at 11:50 A.M., showed 42 residents sat at 12 tables in the Station 1 dining room for lunch service. Observation showed two to four residents, without facemasks, at each table seated less than six feet apart. Observation on 05/28/20 at 11:57 A.M., showed 33 residents sat at 11 tables in the Station 2 dining room for lunch service. Observation showed two to four residents, without facemasks, at each table seated less than six feet apart. During an interview on 05/29/20 at 2:50 P.M. the DON said the CDC guidelines direct long-term care facilities to not have communal meals for residents. During an interview on 05/29/20 at 3:32 P.M., the administrator the CDC guidance directs long-term care facilities to have residents stay in their rooms, but the residents had been together since 03/10/20 without visitors or infections and they stay with the same people. The administrator said since staff do not live at the facility, they were asked not go out unnecessarily and, if they did go out, they were asked to wear a mask to reduce the risk of infection. The administrator said he/she chose to allow the residents out of their rooms without facemasks and to continue group activities and meals because they already had those practices prior to the guidance and believed it would not make a difference to change those practices. 5. Review of the facility's Handwashing/Hand Hygiene policy dated August 2019, showed the following: -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and [DIAGNOSES REDACTED]icile. -Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications; d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters, IV access sites); f. Before donning sterile gloves; g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; i. After contact with a resident's skin; j. After contact with blood or bodily fluids; k. After handling used dressings, contaminated equipment, etc.; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves; n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals; q. After personal use of the toilet or conducting your personal hygiene. -Hand hygiene is the final step after removing and disposing of personal protective equipment. -The use of gloves does not replace hand washing/hand hygiene. Integration of glove us along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Further review showed the policy directed staff to wash their hands as follows: -Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands; -Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers; -Rinse hands with water and dry thoroughly with a disposable towel; -Use towel to turn off faucet; -Avoid using hot water, because repeated exposure to hot water may increase the risk of [MEDICAL CONDITION]. Observation on 5/28/20 from 10:23 A.M. to 11:00 A.M. showed CNA D and CNA E provided bathing assistance and perineal care to Resident #17 in the shower room. Further observations at this time also showed the following: -CNA D removed his/her gloves after bathing the resident, washed his/her hands for less than five seconds and then turned the faucet off with his/her wet bare hands; -CNA E left the shower room to obtain additional supplies. Further observation showed the CNA returned to the shower room, washed his/her hands for 12 seconds and then continued to provide bathing assistance to the resident; -CNA D placed soiled bath linens in a cart, removed his/her gloves, washed his/her hands for less than five seconds, turned the faucet off with his/her wet bare hands, and then left the room to obtain clean supplies. Observation showed, when the CNA returned to the shower room, he/she washed his/her hands for less than five seconds and then turned the faucet off with his/her wet bare hands; -CNA D, removed his/her gloves, washed his/her hands for five seconds, turned the faucet off with his/her wet bare hands and then left the shower room. Further observation showed the CNA returned to the shower room, donned a pair of gloves, cleaned the soiled shower chair used to bathe the resident and then removed his/her soiled gloves. Observation showed the CNA then washed his/her hands for less than five seconds and turned the faucet off with his/her wet bare hands; -LPN C, entered the shower room, examined the resident's ears with his/her bare hands, and then left the room without performing hand hygiene. Observation showed the LPN walked to the bathroom behind the nurse's desk and washed his/her hands for 10 seconds. Observation on 05/29/20 at 10:53 A.M., showed LPN C changed Resident #18's leg wound dressing. Further observation showed the LPN removed his/her gloves and then washed his/her hands for 10 seconds. During an interview on 05/29/20 at 10:55 A.M., LPN C said handwashing should occur before and after caring for a resident and if gloves become soiled. The LPN said in-service trainings are done at least monthly and include proper handwashing procedures. The LPN said the DON usually does the trainings for staff and staff are directed to wash their hands for 20 seconds and turn the water off with a dry towel after they dry their hands. The LPN said the only reason for a staff member to not wash their hands for 20 seconds would be if a resident was in danger. Observation on 05/28/20 at 11:00 A.M., showed Cook I washed his/her hands at the kitchen sink. Observation showed the cook turned the faucet off with a paper towel and then used the contaminated paper towel to dry his/her hands. Observation showed the cook then prepared salads for service to the residents at the noon meal. Observation on 5/29/20 at 11:45 A.M. showed CNA F provided perineal care to Resident #19 with gloved hands. Further observation showed the CNA removed his/her soiled gloves and, without performing hand hygiene, donned a pair of clean gloves to assist the resident into his/her wheelchair where another employee then took the resident to the dining room for lunch. During an interview on 05/29/20 at 2:50 P.M. the DON said staff are expected to wash their hands with soap and water for 20 seconds and use alcohol-based hand rub between glove changes. The DON said the staff are directed by flyers/posters in the facility to use a towel to turn off the faucet and not their bare hands. During an interview on 05/29/20 at 3:32 P.M. the administrator said staff are expected to wash their hands for 20 seconds with soap and water and a paper towel should be used to turn off the faucet. The administrator said staff should not use the paper towel used to turn off the faucet to dry their hands. 6. Observation on 05/28/20 at 12:12 P.M., showed Resident #20 coughed into his/her hand at the dining table and then touched the table that he/she shared with two other residents and two facility staff. Further observation showed staff did not offer the resident the opportunity to perform hand hygiene. Observation on 5/29/20 at 11:45 A.M. showed CNA F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A378	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYLVIA G THOMPSON RESIDENCE CENTER, INC	**3333 W TENTH STREET SEDALIA, MO 65301**

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 2) provided care to Resident #19 in his/her room. Further observation showed the CNA assisted the resident into his/her wheelchair where another employee then took the resident to the dining room for lunch. Observation showed neither employee offered the resident the opportunity to perform hand hygiene before the meal. Observation on 05/29/20 at 12:06 P.M., showed CNA F asssited a resident into his/her wheelchair and fixed the resident's hair. The CNA did not offer the resident the opportunity to wash his/her hands prior to go to the dining room for lunch. During an interview on 05/29/20 at 2:20 P.M., LPN C said staff are expected to offer residents the opportunity to wash their face and hands prior to leaving their room to go eat. During an interview on 05/29/20 at 3:32 P.M. the administrator said the facility did not have a policy for resident hand hygiene, but resident hand hygiene should be done after toileting and before meals. 7. Review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy dated October 2018, showed the following: -Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and OSHA Bloodborne Pathogens Standard. -Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment). -Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. Observation on 05/28/20 at 12:03 P.M., showed CNA G, assisted Resident #20 from his/her wheelchair to a dining room chair with the use of a gait belt placed around the resident's waist. Further observation showed the CNA removed the gait belt from the resident's waist and passed it to CNA H who then secured it around his/her waist. Observation on 05/29/20 at 11:23 A.M. showed LPN C used a gait belt to assist Resident #2 to a standing position to ambulate him/her to the bathroom. Observation showed the LPN assisted the resident from the bathroom to the dining room chair, removed the gait belt from the resident's waist and then placed the gait belt around the waist of Resident #21. Further observation showed the LPN removed the gait belt from Resident #21's waist and then took the gait belt to the nurses's station where he/she set it on the desk. The LPN did not clean the gait belt after resident use or before it was sat on the desk. During an interview on 05/29/20 at 2:20 P.M., LPN C said he/she did not know gait belts should be cleaned between each resident. During an interview on 05/29/20 at 2:50 P.M. the DON said gait belts should be cleaned between residents, but he/she is unsure how aides were cleaning them. During an interview on 05/29/20 at 3:32 P.M. the administrator said gait belts are part of the employee's uniform and should be cleaned as a part of their uniforms. The administrator said he/she would not expect staff to disinfect their gait belts between residents.