STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395309	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-YORK SOUTH	**200 PAULINE DRIVE YORK, PA 17402**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on review of facility policy, observations and staff interviews it was determined that the facility failed to ensure implementation of an effective infection control program for 4 out of 7 residents on droplet precautions in the 800 and 600 hallways (Resident 1, 2, 3, and 6). Findings include: Review of facility policy titled PPE Requirements based Upon Clinical Situation, dated May 21, 2020 revealed COVID19 positive patient = N-95 mask, universal eye protection, gowns, and gloves. Observation on July 14, 2020, at approximately 11:39AM outside of Resident 6's room revealed an isolation bin; Nursing Assistant 2 (NA2) entered Resident 6's room to deliver a meal tray without wearing a gown. NA2 exited the room, utilized hand sanitizer, then retrieved another tray from the food truck. At approximately 11:40AM Nursing Assistant 1 (NA1) entered Resident 1's room to deliver a meal tray without wearing a gown, and an isolation bin was observed outside of Resident 1's room. Resident 1 was in a wheelchair between the bed and the window facing the head of the bed. NA1 walked between Resident 1 and the window, was in close proximity to Resident 1, to place the meal tray on the over the bed table in front of Resident 1. At approximately 11:41AM, Nursing Assistant 2 (NA2) retrieved a tray from the food truck and entered Resident 1's room without wearing a gown. NA 2 revealed to NA 1 that the incorrect meal tray was delivered to Resident 1. NA2 walked between Resident 1 and the window, was in close proximity to Resident 1, to replace the meal tray on the over the bed table. The meal tray retrieved from Resident 1's over the bed table was then placed on the over the bed table for A bed in the same room. Both NA1 and NA2 exited the room and utilized hand sanitizer. During an interview with NA2 on July 14, 2020, at approximately 11:43 AM, it was revealed that all of the isolation bins outside of rooms on the 800 hall were for residents who were confirmed positive for COVID19 or pending a result of a COVID 19 test. Surveyor then asked NA2 if a gown should be worn to deliver meal trays, and NA 2 replied, isolation gowns are worn when they provide care to residents on isolation precautions. During an interview on July 14, 2020, at approximately 11:45 AM with Licensed Practical Nurse 1 (LPN 1) it was stated that gowns should not to be worn when delivering a meal to a resident on droplet isolation precaution because the staff shouldn't be near the food truck with a gown on. LPN1 stated that she would check with her supervisor and get back with the surveyor to verify is staff should wear a gown when serving a meal to a resident on droplet precautions. Observation on July 14, 2020, at approximately 11:45AM, NA1 was delivering a meal tray to Resident 2 without wearing a gown, and an isolation bin was observed outside of Resident 2's room. Observation on July 14, 2020, at approximately 11:46AM, NA2 entered Resident 3's room without a gown on, and an isolation bin was observed outside of Resident 3's room. NA 2 asked Resident 3 if she wanted a lunch tray, and then exited the room. On July 14, 2020, at approximately 11:50AM, LPN1 informed the surveyor that a gown should be worn when delivering meal trays to residents on droplet precautions. During an interview with the DON on July 15, 2020 at approximately 1:00PM it was revealed that the expectation is for staff to wear a gown into a droplet isolation precaution room at any time, to include when delivering meal trays. 28 Pa Code 211.12(c)(d)(1)(5) Nursing Services

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.