STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. BUILDING _____ B. WING _____	**05/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES - PIKE CREEK	**5651 LIMESTONE ROAD WILMINGTON, DE 19808**

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, review of the facility's infection control policy and review of the Centers for Disease Control and Prevention (CDC) guidelines, it was determined that the facility failed to implement appropriate infection control practices on four out of four units. Staff failed to wear full personal protective equipment (PPE) during direct care of all residents in a COVID-19 positive facility. Staff failed to properly use disposable PPE by storing it in plastic bags for reuse. Staff failed to supply clean PPE outside isolation rooms. Staff failed to change PPE between residents with different COVID-19 status. Findings include: 3/17/2020 - The Centers for Disease Control and Prevention (CDC) website for Coronavirus Disease 2019 (COVID-19) Strategies for Optimizing the Supply of Facemasks, stated, . Purpose: This document offers a series of strategies or options to optimize supplies of facemasks in healthcare settings when there is limited supply . Crisis Capacity Strategies . mask can be stored between uses in a clean sealable paper bag or breathable container . 4/2/2020 - The Centers for Medicare & Medicaid Services (CMS) and the CDC issued COVID-19 Long-Term Care Facility Guidance that included: Long-term care facilities should separate patients and residents who have COVID-19 from patients and residents who do not, or have an unknown status .When possible, facilities should exercise consistent assignment, or have separate staffing teams for COVID-19-positive and COVID-19-negative patients .If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 [DIAGNOSES REDACTED]. Implement CDC approved universal PPE conservation practices. Conduct PPE inventory and secure additional supplies as needed. 4/15/2020 (last reviewed) CDC - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes included: - Health care providers who enter the room of a patient with known or suspected COVID-19 should adhere to standard precautions and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred. -Signage on the use of specific PPE for staff need to be posted in appropriate locations in the facility (e.g., outside of a resident's room). 1. Use of PPE: Arcadia Unit: 5/7/2020 2:35 PM - During an interview with E2 (DON), it was revealed the facility had COVID-19 positive residents. 5/7/2020 3:15 PM - E9 (CNA) and E10 (CNA) were observed on the facility's Arcadia Dementia Unit wearing a mask, but no other PPE. 5/7/2020 3:25 PM - During interviews, both E9 (CNA) and E10 (CNA) stated they did not wear gowns or eye protection when providing direct care for any of the residents on the Arcadia Dementia Unit. Second Floor Long-Term Care Unit: 5/7/2020 3:45 PM - E12 (CNA) was observed providing incontinence care for R2, an asymptomatic resident, wearing a mask, but no other PPE. 5/7/2020 4:03 PM - During an interview, E12 (CNA) confirmed that she did not wear a gown or eye protection when providing direct care for R2. E12 explained she had a gown (behind the clean linen cart on the handrail) that she used when going into resident rooms on isolation. 5/7/2020 4:06 PM - E8 (LPN) was observed providing direct patient care for R3, who was in the bathroom. E8 was wearing a mask and gloves, but no other PPE. 5/7/2020 4:15 PM - During an interview, E8 (LPN) stated her gown was at the nurse's station and she only wore it when going into isolation rooms. 5/7/2020 4:25 PM - E13 (respiratory therapist) was observed leaving R4's room without wearing PPE, then entering R5's room. 5/7/2020 4:30 PM - During an interview, E13 stated that she was a consultant who visited her patients at this facility once a week. E13 stated she only wears PPE if a resident is on isolation and that the facility has never informed her that full PPE was required for direct care for all residents in the facility. 5/7/2020 8:00 PM - During an interview, E4 (former NHA) was informed that because COVID-19 transmission occurred in the facility, staff need to wear full PPE for the care of all residents, irrespective of a COVID-19 [DIAGNOSES REDACTED]. 5/8/2020 4:00 PM - During a teleconference with E2 (DON), E3 (Assistant NHA), and E4 (former NHA), it was communicated that staff must wear full PPE facility wide with direct patient care. 2. Improper storage of PPE: 5/7/2020 3:45 PM - An observation of the staff lounge on the Second Floor Long-Term Care Unit revealed multiple plastic bags with staff names written on the outside of the bags and disposable gowns/coveralls being stored inside the bags. 5/7/2020 4:05 PM - During an interview, E16 (CNA) explained that at the end of their shift, staff store the gowns/coveralls they wore that day in the plastic bags and reuse these gowns/coveralls the next time they worked. E16 stated that staff needed to ask supervisors or the receptionist if they need new, clean PPE. 5/7/2020 4:20 PM - During an interview, when asked why the isolation rooms did not have clean PPE stored outside of the door, E5 (RN, unit manager) stated that PPE was handed out to staff on an individual basis and if their PPE became dirty or damaged they needed to request additional PPE from their supervisor. 5/7/2020 4:35 PM - An observation of the MedBridge Unit's anteroom revealed multiple plastic bags with staff names written on the outside of the bags and disposable gowns/coveralls inside the bags. 5/7/2020 4:40 PM - During an interview, E17 (CNA) explained that at the end of their shift, staff have to store the gowns/coveralls they wore that day in the plastic bags and reuse these gowns/coveralls the next time they worked. E17 stated that he has been wearing the same coveralls for at least two weeks. 5/7/2020 5:00 PM - During an interview, E18 (LPN) tearfully explained that at the end of her shift, she takes her coveralls home, sprays it with disinfectant, airs it out overnight, then brings it back to the facility to wear during the next shift she works. E18 stated that she has reused the same N-95 mask for at least four weeks and the same coveralls for 10 to 14 days. E18 stated that staff need to ask supervisors or the receptionist if they need new, clean PPE, and that the night shift did not know how to obtain clean PPE because it is locked in a room and night shift does not have the key to the room. 5/7/2020 5:30 PM - An observation of the Linden Unit's two COVID positive wings revealed both wings had anterooms with multiple plastic bags with staff names written on the outside of the bags and disposable gowns/coveralls inside the bags. 5/7/2020 6:00 PM - During an interview, E19 (RN) revealed that PPE was not available to staff and he had to buy his own PPE online. E19 stated that he keeps this new PPE in his car so he can give it to other staff that need clean PPE to work in the COVID-19 positive units. 5/7/2020 8:00 PM - During an interview, E4 (former NHA) was informed that the deficient practice of staff putting contaminated gowns/coveralls in plastic bags at the end of their shift for reuse was high risk for the spread of [MEDICAL CONDITION] because staff have to fold it to put in the bag and the plastic bag was likely to grow [MEDICAL CONDITION] (same rationale for storing masks in paper bags). E4 confirmed this finding and stated he had over 1,500 gowns in the facility but was conserving PPE for the future. E4 was informed that, based on observations and interviews with staff, clean PPE was not readily available to all staff on all shifts and was not stored outside of isolation rooms so staff can don before entering isolation rooms. 5/8/2020 4:00 PM - During a teleconference with E2 (DON), E3 (Assistant NHA), and E4 (former NHA), the practice of staff putting contaminated gowns/coveralls in plastic bags at the end of their shift for reuse was high risk for the spread of [MEDICAL CONDITION] was reviewed. 5/13/2020 2:05 PM - E15 (CNA) was observed at the Arcadia Dementia Unit nurses' station, removing her coveralls, rolling it up and placing in a plastic bag. When asked why she did not dispose of the coveralls since it was the end of her shift, E15 said she was going to put the coveralls and bag in her locker. 5/13/2020 2:20 PM - During an interview, E14 (CNA) said that he wore the same PPE all day today and his coveralls were not changed. E14 stated he has been re-wearing the same coveralls for patient care for at least two weeks and after his shift he must put the coveralls in a plastic bag and leave the bag in room [ROOM NUMBER] (changing room). 5/13/2020 2:30 PM - An observation of the Med Bridge Unit's anteroom revealed multiple plastic patient belonging bags with staff names written 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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) the outside of the bags and used disposable gowns/coveralls inside the bags. 5/13/2020 2:50 PM - During an interview with E1 (NHA) and E3 (Assistant NHA), the improper practice of staff putting contaminated gowns/coveralls in plastic bags at the end of their shift for reuse was high risk for the spread of [MEDICAL CONDITION] was reviewed. E1 (NHA) explained that staff now have clean PPE available, but they may need additional education to ask for and wear clean PPE every day. 3. Available PPE outside isolation rooms: 5/7/2020 3:15 PM - E9 (CNA) and E10 (CNA) were observed on the facility's Arcadia Dementia Unit wearing a mask, but no other PPE. In addition, outside of R1's and R6's rooms a sign was posted that said, Isolation: See Nurse Before Entering, but there was no clean PPE stored outside any of these rooms. 5/7/2020 4:00 PM - An observation of the Second Floor Long-Term Care Unit, revealed that outside the rooms of R7, R8, R9, R10, R11 and R12 (six different rooms) a sign was posted that said, Isolation: See Nurse Before Entering, but there was no clean PPE stored outside any of these rooms. 5/7/2020 4:15 PM - During an interview, E8 (LPN) confirmed that there were signs on the doors of R7 and R8 rooms (two different rooms) that said, Isolation: See Nurse Before Entering, but there was no clean PPE stored outside any of these rooms. 5/7/2020 8:00 PM - During an interview, E4 (former NHA) was informed of the above deficient practice and E4 stated that it would be corrected. 5/8/2020 4:00 PM - During a teleconference with E2 (DON), E3 (Assistant NHA), and E4 (former NHA), the above deficient practice was reviewed. 5/13/2020 2:00 PM - During an interview, E20 (LPN) stated that R1, R13, and R6 were PUI and on COVID-19 precautions. 5/13/2020 2:15 PM - During an observation of the Arcadia Dementia Unit with E14 (CNA) it was confirmed that outside R1, R13, and R6 rooms (in three different rooms) a sign was posted that said, Droplet Precautions, but there was no clean PPE stored outside any of these rooms. 5/13/2020 2:50 PM - During an interview with E1 (NHA) and E3 (Assistant NHA), it was reviewed that clean PPE needs to be available outside isolation rooms. 4. Changing contaminated PPE: 5/13/2020 2:00 PM - During an interview, E20 (LPN) stated that R1, R13, and R6 were PUI and on COVID-19 precautions. 5/13/2020 2:05 PM - During an interview, E15 (CNA) confirmed she had worn the same coveralls all day and did not change it between providing direct care to any residents. 5/13/2020 2:20 PM - During an interview, E14 (CNA) said that he was not aware that he needed to change PPE after providing care to R1, R13, and R6 before providing care to the rest of the residents on the unit (who were asymptomatic). Further, E14 confirmed that he and E15 (CNA) worked together this morning to provide sponge baths to all the residents on the unit without changing their coveralls. 5/13/2020 250 PM - During an interview with E1 (NHA) and E3 (Assistant NHA), the above deficient practice was reviewed. These findings were reviewed on May 14, 2020 at 1:00 PM during a telephone exit conference with E1 (NHA) and E3 (Assistant NHA).