STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265156	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DELMAR GARDENS ON THE GREEN	15197 CLAYTON ROAD CHESTERFIELD, MO 63017

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to properly contain COVID-19 by not following facility policies and current standards of practice regarding the control of infection transmission. The facility failed to follow the facility's transmission based precautions policy for five of six sampled residents who tested positive or were on isolation precautions for COVID-19 (Residents #2, #3, #4 and #5), and for one resident who was on contact precautions for an infectious disease (Resident #6). The facility failed to ensure the entrance to the residents' rooms contained signage to notify staff and visitors of the precautions needed and failed to ensure personal protective equipment (PPE) was in place and accessible to staff for five of six sampled residents. The facility also failed to provide signage upon entrance to the designated COVID-19 unit, as well as the self-quarantine isolation unit. Additionally, the facility failed to ensure staff were knowledgeable about and adhered to proper PPE usage when providing services to residents and how to appropriately dispose of used PPE. The census was 123. Review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID 19 in Nursing Homes guidelines, updated 6/25/20, showed the following: -Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19; -Identify health care personnel (HCP) who will be assigned to work only on the COVID-19 care unit when it is in use; -The facility is to provide supplies necessary to adhere to recommended infection prevention and control practices. The facility should position a trash can near the exit, inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room; -Reinforce adherence to standard infection prevention and control (IPC) measures including hand hygiene and selection and correct use of PPE. Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities. Review of the facility's Emergency Preparedness-COVID-19 Policy, undated, included the following: -Definition Outbreak: One lab confirmed case of COVID-19 and at least three or more residents or staff with new onset of respiratory symptoms within 72 hours of each other; -Procedure: Administrative Measures included the following: -Plan to be reviewed and revised in accordance with updated CDC, Centers for Medicare and Medicaid Services (CMS), state licensing agency and local health departments guidance and recommendation and the individual needs of our residents and total amount of COVID-19 positive, symptomatic and/or exposed residents and/or staff; -Preplan for COVID-19 cohort recovery area regardless if COVID-19 positive residents residing in the community; -Use the Cohort Recovery Area Plan template to design and review/adjust plan as needed to ensure individualized care for those on cohort and size appropriate for COVID-19 positive census; -Management of Residents with Symptoms of COVID-19: -If resident has been screened and tests positive for COVID-19 or if resident has signs/symptoms of COVID-19 to include, but not limited to respiratory [MEDICAL CONDITION] infection: -Move roommate (if not in private room) to ensure resident is isolated in private room if person under investigation (PUI) is off cohort recovery area prior to test results. Move to designated cohort recovery area once COVID-19 test verified positive; -Maintain Standard and Transmission-Based Precautions (Contact and Droplet Precautions); -Consider that staff caring for positive or symptomatic residents/persons under investigation (PUIs, while waiting for test results) not care for negative or asymptomatic residents to the extent possible; -The isolation process should be implemented and reviewed by the Infection Preventionist (IP) Nurse -Residents with signs and/or symptoms of COVID-19 waiting for test results or confirmed COVID-19 should receive all services in room with door closed (meals, physical and occupational therapy, activities and personal hygiene, etc.). Review of the facility's Interim Guidance for Suspected or Confirmed Cases 2020 COVID-19 Pandemic, dated 4/10/20, included the following: -When a resident is suspected or confirmed of having COVID-19, call the campus regional nursing supervisor, and initiate contact and droplet transmission-based precautions. This process includes: -Placing the resident in a private bedroom with the door closed; -Signage on the corridor door as well as the bedroom to alert staff of the isolation and necessary PPE to care for the resident; -Educate and instruct staff to wear gowns, gloves, goggles and N95 masks when caring for the resident; -Ensure isolation carts with needed supplies are kept outside of the resident's room, as well as instructions on how to don (put on) and doff (take off) PPE; -Instruct staff to perform hand hygiene before entering and after exiting the room. Review of the facility's Isolation Precautions policy updated 3/20, showed the following: -Purpose: To prevent the transmission of infections within the community; -Staff would determine the category of precautions needed; -Standard precautions were used when giving care for all residents regardless of diagnosis. This included barrier protections for healthcare workers such as gloves, gowns, masks and goggles when exposure to blood or body fluids; -Transmission-Based precautions: Staff would use the CDC guidelines for isolation materials, precautions needed, etc. This included precautions for COVID-19; -Contact Precautions: These would be used for residents known or suspected to be infected with microorganisms that could be easily transmitted by direct or indirect contact, such as handling environmental surfaces or resident care items. This included such highly transmissible infections such as [MEDICAL CONDITION] ([MEDICAL CONDITION], an infectious bacterium which causes inflammation of the colon); -Staff would be informed about the need for isolation precautions. This would include explaining the procedures that must be initiated and maintained. The facility would educate staff as appropriate; -Staff would obtain a moveable table/cart for a 24 hours supply of masks, gowns, etc. needed to maintain isolation precautions; -Staff would obtain appropriate signage and post outside the door frame (no resident name or organism should appear on the signage); -At the end of the shift, staff would replenish supplies of PPE for the next shift's use; -All personal protective equipment (disposable isolation gowns, mask, gloves, etc.) should be used once and discarded in either the trash or used linen receptacle before leaving the room; -Procedures for contact isolation: Wear clean gloves when entering the resident's room or unit. Wear a gown when entering resident area if you anticipate you will have substantial contact with the resident, resident items or environmental surfaces or if the resident is incontinent. Remove gown carefully before leaving the room and wash hands. Remove gloves before leaving resident area. 1. Review of the facility's resident line list (residents with COVID-19 symptoms) on 8/14/20, showed the following: -Resident #2 tested positive for COVID-19 on 8/8/20; -Resident #4 tested positive for COVID-19 on 8/13/20. During an interview on 8/14/20 at 8:00 A.M., the administrator confirmed there were two positive cases who resided on the West 300 hall and this would be the designated COVID-19 hall. Staff were in the process of converting the end of the hall into an isolation unit for all positive residents. Review of Resident #2's medical record, showed the following: -An admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. Observation on 8/14/20 at 7:02 A.M., of Resident #2's room, showed a closed door and a sign posted that said Stop. See nurse before entering. An over the bed table was placed outside the door and held Sani-wipes, red biohazard bags, gloves, gowns and wash cloths. No signage posted regarding what PPE should be worn in the room or how to properly don/doff PPE. 2. Review of Resident #3's medical record, showed the following: -An admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. Observation of Resident #3's

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) room on 8/14/20 at 7:03 A.M., showed the door open. A sign posted on the door, showed Stop. See nurse before entering. The resident laid in the bed closest to the door without a facemask. 3. Review of Resident #4's medical record, showed the following: -An admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. results were positive for COVID-19. Observation of Resident #4's room on 8/14/20 at 7:05 A.M., showed the door open. The resident laid in the bed closest to the window without a facemask. Staff did not post signage instructing staff to see the nurse or what PPE should be worn inside. Staff did not place PPE supplies outside the room. Observation on 8/14/20 at 9:34 A.M., showed Nurse A wore goggles, an N95 and surgical mask. He/she donned a gown and gloves and took a breakfast tray into Resident #4's room. He/she came out of the room without wearing the gloves or gown. Nurse A said there was not a biohazard container in the room, so staff doffed the used PPE in the room. He/she opened the door to the room to show a night stand next to the door with a pile of used gowns and gloves on top of it. 4. Review of Resident #5's medical record, showed the following: -An admission face sheet with an admission date of [DATE]; -[DIAGNOSES REDACTED]. The resident was placed on isolation precautions and will be retested on [DATE]. Observation on 8/14/20 at 7:13 A.M., of Resident #5's room, showed the door open and resident seated inside the room without a facemask. Staff did not post signage to indicate the resident was on isolation precautions. Observation on 8/14/20 at 9:20 A.M., showed a sign posted on the door of Resident #5, instructing staff to stop and see the nurse before entering. No other instructions were posted on the door. Employee C wore goggles, an N95 mask and a surgical mask. He/she donned a gown and gloves in the hallway and then entered the room and did not close the door. Employee C entered and exited the room three times to obtain items and then re-entered the room without doffing or changing his/her PPE. He/she then exited the room and doffed the gown and gloves and discarded them in the trash can on the housekeeping cart. 5. Observations of the West 300 Hall on 8/14/20 from 7:02 A.M. to 7:13 A.M., showed the following: -The fire doors in the corridor remained opened; -No signs to alert staff, residents or visitors of positive COVID-19 cases in the area or what PPE should be worn; -Residents without a positive or suspected COVID-19 [DIAGNOSES REDACTED]. The doors to these rooms remained open. During interviews on 8/14/20 at 6:58 A.M. and 8:50 A.M., Nurse A confirmed Residents #2 and #4 had tested positive for COVID-19. One tested positive on 8/8/20 and one tested positive on 8/13/20. Two other residents had been exposed to COVID-19, Residents #3 and #5. Resident #3 was previously the roommate of Resident #2. Resident #3 was now in a private room and under isolation precautions. He/she said staff have not received any direction to keep the doors to the entrance of the hall closed. Staff knew what PPE to wear based on signage and he/she also told staff what to wear, and he/she made sure PPE was available. They discard used PPE in red biohazard bags. There were not biohazard containers in the residents' rooms. During an interview on 8/14/20 at 8:40 A.M., Employee C said he/she felt scared to work on the West 300 hall because of the positive cases. No one told him/her which residents were positive and which were under isolation precautions. He/she would only know someone was positive or under precautions if a sign were posted on the resident's door. During an interview on 8/14/20 at 8:55 A.M., Certified Medication Technician (CMT) F said he/she would know if a resident was on isolation/quarantine if there was signage on their doors. They should have barrels in their room to dispose of PPE. During an interview on 8/14/20 at 9:25 A.M., Certified Nurse's Aide (CNA) G said the nurse was supposed to tell staff if there was a resident on isolation and there should be signage on the door somewhere. During an interview on 8/19/20 at 9:30 A.M., the infection preventionist said they had an online template for what to do in a COVID-19 outbreak, but did not designate a specific area for quarantine, because they did not have any positive residents until recently, and they were not sure how to proceed. If a resident was newly admitted or readmitted , they would be isolated in their rooms for 14 days. The first resident tested positive at the hospital and had not returned yet. The second person was isolated in his/her room for 14 days (Resident #2). She was not working when the third resident (Resident #4) tested positive. Staff should have placed PPE equipment outside Resident #4's door and signage on the door to indicate isolation. Staff should have disposed of their PPE in appropriate containers. During an interview on 8/14/20 at 10:25 A.M., the Director of Nursing (DON) said they used to put bins in the room, but she thought the CDC recommended immediate trash removal. Staff should have bagged their used PPE and then taken it immediately to the trash room. It was not okay to leave the used PPE in a pile in the resident's room. If left in the room, a resident could touch them or put them in their mouth. PPE should be outside isolation rooms so staff have it available. This includes gown, gloves, N95 masks and face shields. They did not have a designated COVID-19 unit because they did not have any positives until recently. When staff were alerted about a positive result, they should immediately put signage on the resident's door. Nursing staff should immediately place a table outside the door with the necessary PPE. During interviews on 8/14/20 at 7:45 A.M., 9:40 A.M., and 11:25 A.M., the administrator said she did not know there needed to be a designated COVID-19 unit once a resident tested positive. They were working on developing the end of the 300 hall as the designated unit. They did not already have a plan in place to do this, because they had not had any positive residents until recently and were not sure how to proceed. The positive residents should have had their doors closed to prevent spread of the infection. There should have been signage on their doors to notify staff and residents of potential infection and proper PPE needed. There should have been PPE set up outside of their doors. Staff should have removed used PPE and put the disposable items into a designated bag. 6. Observation of the isolation 100 hall (rooms 100 - 114) on 8/14/20 at 7:00 A.M., showed the following: -The fire doors in the corridor remained opened; -No signs to alert staff, residents or visitors of isolation, potential exposure or what PPE should be worn; -Licensed practical nurse (LPN) E walked out of a resident room with a surgical mask on his/her face. He/she did not wear a face shield, goggles or a gown; -CMT F stood at the end of the hall and wore a gown, face shield, mask and gloves. During an interview on 8/14/20 at 7:10 A.M., LPN E said he/she only had to wear a surgical mask when on the hall and gloves when providing care to the residents. He/she did not have to wear a gown or a face shield. He/she thought the isolation hall was the 200 division. During an interview on 8/14/20 at 7:15 A.M., CMT F said staff told him/her the 100 hall was an isolation unit and all staff were supposed to wear masks gowns and goggles or face shields when working on the hall. He/she knew about the isolation hall because the nurse told him/her in a staff meeting that morning. He/she gathered the necessary PPE and stored it on his/her medication cart. 7. Observation of the 100 hall on 8/14/20 at 9:05 A.M., showed CNA H wore a surgical mask. He/she did not wear gloves or a gown. He/she entered several resident rooms to let them know breakfast was going to run late. At 9:15 A.M., CNA G pushed the meal cart onto the floor and CNA I brought the drink cart. Both CNAs wore masks, but no gloves or gowns. CNA I pulled out a Styrofoam cup and poured coffee into it. He/she then walked into a resident room, moved his/her bedside table close to the bed and placed the cup on the table. He/she moved several items around on the table and then left the room without washing his/her hands or using hand sanitizer. He/she walked back to the beverage cart, pulled out another Styrofoam cup, poured juice and put a lid on it. He/she walked into another resident's room and put the cup on the table. He/she picked up the bed remote and tried to move the resident's bed up but it would not work. CNA G came into the room without a gown, gloves or a face shield. He/she helped lower the bed. CNA I and CNA G each grabbed a side the of resident's bed pad and lifted it to move the resident back up in the bed. CNA I then covered up the resident, pulled the bedside table back over to the bed and left the room without washing his/her hands or using hand sanitizer. He/she then went to the tray cart and removed a tray and took it into a resident's room and put in on his/her bedside table. He/she left the room without washing his/her hands or using hand sanitizer. CNA H stood at the beverage cart. He/she pulled out a Styrofoam cup and poured water in it. He/she put a lid on the cup, entered a resident's room and placed the cup on the resident's side table. He/she did not wash his/her hands or use hand sanitizer. He/she left the room and reached into the cart, removed a tray and carried it into the resident's room. He/she placed it on the resident's bedside table and moved the table close the resident. He/she then came out of the resident's room without washing his/her hands or using hand sanitizer, obtained another tray and took it into another resident's room. During an interview on 8/14/20 at 9:50 A.M., CNA G said he/she was pulled over to the hall after another staff had to leave unexpectedly. He/she was not told it was an isolation hall or that he/she needed to wear gloves, face shield or a gown when providing care. 8. Review of Resident #6's medical record, showed the following: -admitted [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's nurse's notes, showed on 8/13/20 at 2:35 P.M., staff received a new order for [MEDICATION NAME] (antibiotic) treatment for [REDACTED].M., showed no PPE supplies outside or inside the resident's room. There was no signage to notify staff or visitors the resident was on isolation precautions. During an interview on 8/14/20 at 9:45 A.M., CNA I said he/she was an agency worker and this was his/her first day. No one told him/her the 100 hall was an isolation unit. Staff told him/her there was a resident on the unit with [MEDICAL CONDITION], and he/she would need to wear a gown and gloves when he/she worked with the resident. The CNA said no one told him/her to wear gowns and gloves with all of the residents and he/she was concerned, because he/she did not even know where to get a gown if he/she needed it. During an interview on 8/14/20 at 10:20 A.M., the DON acknowledged the resident had an active [DIAGNOSES REDACTED]. They did not post a sign on the resident's door, because he/she did not get visitors and the staff were aware of

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) his/her diagnosis. Staff should be wearing gloves and gowns when providing care. PPE should have been placed outside his/her door. During an interview on 8/19/20 at 9:45 A.M., the infection preventionist said they did not place signage outside of the resident's room due to dignity issues and staff were informed in the morning meetings which residents were on contact precautions. The staff had to wear masks and gloves if they were providing care. The staff could choose to wear a gown or not based on their comfort level. They did not have to place PPE equipment at the door because it was available at the nurse's station. 9. During interviews on 8/14/20 at 7:45 A.M., 9:40 A.M., and at 11:25 A.M., the administrator said after a staff member tested positive on 8/6/20, they put a plan in place to monitor the 100 hall by having the residents stay in their rooms. They received notification that morning that another staff member who worked the 100 hall tested positive and were going to have to extend the self isolation period. Staff were supposed to wear full PPE including masks, gloves and gowns until the isolation period was over. PPE was kept at the nurse's station. The agency staff should have been told they would be working on an isolation unit, what PPE would be needed and where to find the PPE before they started working the shift. She did not realize the unit needed to be separated with the doors closed and/or signage to prevent people from going onto the unit. Resident #6 should have had signage at his/her door to warn people who entered of potential infection risk. There should have been a table in front of the door with the necessary PPE.