STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235399	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF PORTAGE	7855 CURRIER DR PORTAGE, MI 49002

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

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services based on resident needs and choices for 1 of 19 residents (Resident #47), resulting in Resident #47 not being transferred to his chair for meals, not eating and the potential for continued significant weight loss. Findings include: Resident #47 Review of a Face Sheet revealed Resident #47 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #47, with a reference date of 7/1/20 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #47 was cognitively impaired. Review of the Functional Status revealed that Resident #47 required supervision - oversight, encouragement or cueing and setup help with eating and total dependence and 2 staff physical assistance with transfers to or from his bed or chair. Review of a Minimum Data Set assessment or Resident #47, with a reference date of 7/1/20 revealed, Behavior: Rejection of Care indicated that Resident #47 did not exhibit this behavior. Review of a Care Plan for Resident #47 revealed, The resident needs activities of daily living assistance related to hx (history) (history) (history) (history) (history) (history)[MEDICAL CONDITION](stroke)-rt (right) sided [MEDICAL CONDITION] and [MEDICAL CONDITION] (paralysis) .Date Initiated: 02/01/2020, INTERVENTIONS: .EATING/DRINKING - Resident needs assistance x1 with feeding. Date Initiated: 09/03/2020 Revision on: 09/03/2020 . During an observation and interview on 9/1/20 at 12:25 P.M., Resident #47 was observed lying in his bed, with the HOB (head of bed) at approximately 10 degrees. Resident #47 reported that he had not been out of bed yet today and prefers to sit in his chair to eat. During an observation on 9/1/20 at 12:28 P.M., Resident #47 was observed lying on his back in his bed. Certified Nursing Assistant (CNA) P brought Resident #47's lunch tray and placed it on his over the bed table. CNA P raised the HOB to approximately 30 degrees and left the room. During an observation and interview on 9/1/20 at 2:34 P.M., Resident #47 was observed lying on his back in bed with the HOB at approximately 30 degrees, with an uneaten lunch tray on his over the bed table. When asked about his uneaten lunch meal, Resident #47 reported that he ate better in his chair and stated, .I would love to get up! . Review of CNA documentation Nutrition-Amount Eaten revealed, 9/1/2020, .14:00 (2:00 P.M.) 50% . Note that this was not consistent with the observation made by this surveyor. During an observation and interview on 9/2/20 at 2:00 P.M., Resident #47 observed in his bed, with HOB at approximately 45 degrees, with his uneaten lunch tray on his over the bed table. Resident #47 reported he didn't feel like eating now. During an interview on 9/3/20 at 10:20 A.M., Family Member (FM) QQ reported that Resident #47 had not been out of bed for the past 4 days. FM QQ stated, .he is not eating there .he has lost weight . Review of CNA documentation Nutrition-Amount Eaten revealed, 9/2/2020, 09:00 (9:00 A.M.) 75% 13:00 (1:00 P.M.) 50% . Note that this was not consistent with the observation made by this surveyor. Review of Progress Notes from 6/25/20-9/2/20 revealed, no indications that Resident #47 refused to get out of bed. During an interview on 9/2/20 at 2:10 P.M., CNA H who was assigned to Resident #47's care today, reported that Resident #47 had not been out of bed today. CNA H stated, .I am new .I don't know if he prefers to get up for meals or not .I don't know if he ate lunch .he eats by himself . During an interview on 9/2/20 at 2:41 P.M., CNA O reported that Resident #47 prefers to be in his chair for meals, but that Resident #47 required the hoyer lift to transfer out of bed and there was not a sling available. CNA O reported that Resident #47 does not require assistance to eat. During an interview on 9/3/20 at 9:27 A.M., Licensed Practical Nurse (LPN) Q reported that Resident #47 normally only eats about 25% of his meals. During an interview on 9/3/20 at 10:53 A.M., Director of Nursing (DON) B stated, .I fed (Resident #47) yesterday in his bed and he did great .ate all of his breakfast .but he needs encouragement . Review of Weight Documentation indicated, 8/8/2020 263.0 Lbs (a severe weight loss of 8.04%) 7/10/2020 265.0 Lbs 7/9/2020 266.0 Lbs 7/2/2020 271.0 Lbs 6/28/2020 286.0 Lbs. During an interview on 9/3/20 at 1:00 P.M., Resident #47 reported that he can feed himself easier when he is in his chair and stated, .I don't know why I am losing weight .I don't really want to . During an interview on 9/3/20 at 12:57 P.M. CNA JJ reported that Resident #47 prefers to be in his chair for meals and stated, .he was up for lunch and breakfast and ate everything today . During an interview on 9/3/20 at 1:06 P.M., Registered Nurse (RN) KK reported the Resident #47's appetite has decreased, but that she was not aware of a weight loss concern for him. RN KK reported that Resident #47's most recent weight from 8/8/20 and was 263 pounds and stated .we can check his weight now if you want . During an observation and interview on 9/3/20 at 1:21 P.M., RN KK was observed obtaining Resident #47's weight using a hoyer lift with a scale and reported Resident #47's weight was 249.4 pounds. Indicating that Resident #47's weight had decreased by >5% over the past 26 days. During an interview on 9/3/20 at 2:41 P.M., DON B reported that Resident #47's weight today of 249.4 pounds was thought to be an error and would be rechecked. During an interview on 9/3/20 at 2:45 P.M., RN KK reported that Resident #47's weight was recheck and it was 244 pounds. Note this indicated a 7.22% severe weight loss in the past 4 weeks. Review of Progress Note dated 8/13/2020 at 13:39 (1:39 P.M.) revealed, Weight gain/loss; Hydration concern: WEIGHT WARNING: Value: 263.0 .7.5% change . Resident is triggering for weight loss. He had a 6.9% weight loss from June to July. Weight loss has been intentional .Weight has been stable x ~ 1 month around 265# .Since resident's weight has been stable x ~1 month, and weight loss was intentional will d/c (discontinue) from SOC but continue to monitor. Review of Progress Note dated 8/10/2020 at 15:49 (3:49 P.M.) revealed, NP/PA (Nurse Practitioner/Physician Assistant) Progress Note .being seen for concern from the nursing staff that pt seems to be having some problems with word finding - he was also having some trouble with trying to eat a supplement today . nursing staff to continue to monitor and report changes . Review of Progress Note dated 6/29/2020 at 11:55 A.M. revealed, Admission Meeting Note .Resident is on a controlled carb (carbohydrate) diet with regular texture and regular fluid and was weighed on 6/28 weighing 286.0 LB . Resident attempted to return home with his spouse but ended up having multiple falls and felt that returning to the facility would be what's best at this time as his spouse is unable to care for him r/t (related to) extensive care needs. Resident and family have no concerns at this time and are in agreement with plan of care.
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.** Based on observation, interview, and record review the facility failed to: 1. Maintain cleanliness of Food contact and Non-food contact surfaces; 2. Hold potentially hazardous items under refrigeration once opened; 3. Properly store raw animal product; and 4. Maintain general cleanliness of the kitchen. These conditions resulted in an increased risk of contaminated foods and an increased risk of food borne illness that affected 91 residents who consume food from the kitchen. Findings Include: 1. During the initial tour of the kitchen at 11:17 AM on 9/1/20 it was observed that the stand

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) up mixer had a clear plastic cover over the unit. When asked if the mixer is used often, Dietary Aide PP stated, here and there, when asked if it was used today, Dietary Aide PP stated, No. Observation of the under arm of the unit found numerous spots of dried and caked on white debris. During this same time a review of the clean utensil drawer found a yellow mechanical scoop with half the scoop portion covered in food debris. The scoop was shown to Cook OO and he took the scoop back to be re washed. At 11:37 AM on 9/1/20, and interview with Cook OO found that Yes the meat slicer still gets used, and that No, it had not been used today. At this time, it was found that an accumulation of food debris was evident on the backside of the blade and blade guard as well as a streak of sticky food debris around the knob of the unit that determines thickness of the cut. At 11:50 AM on 9/1/20 it was observed that the Ice Machine in the dining room was found with a dense accumulation of white spots and growths around the spout for the dispensing of ice and water. During a revisit to the kitchen at 9:48 AM on 9/02/20, with Certified Dietary Manager (CDM) NN and Regional Dietician (RD) MM, it was observed that the top gaskets of the two door McCall and two door Victory units found an accumulation of slimy black debris. During a revisit to the kitchen at 10:10 AM on 9/02/20, with CDM NN and RD MM, it was observed that an egg slicer was found stored in the clean utensil drawer (across from the cook line). The egg slicer was sticky to the touch. When asked if she thought this item was ever used, RD MM shook her head and said not used. According to the 2013 FDA Food Code section 4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: . (5) At any time during the operation when contamination may have occurred. According to the 2013 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch . 2. During the initial tour of the kitchen at 11:28 AM on 9/1/20 it was observed that a gallon container of Teriyaki Marinade was found stored under the preparation table with only a few cups of marinade left in the container. Upon review of the container the manufacture's direction states to Refrigerate After Opening. Upon showing the product to Dietary Aide PP, she stated Dump it we use that for stir fry and we haven't had that in awhile. According to the 2013 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) .TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11 . or (2) At 5C (41F) or less . 3. During the initial tour of the kitchen at 11:32 AM on 9/1/20 it was observed that a case of pasteurized shell eggs were found stored in the two door McCall unit, next to ready to eat cool whip. It was also found that a case of liquid egg product was on the second to bottom shelf (on the left side of the cooler) stored above puree bread (that was on the bottom shelf). During a revisit to the kitchen at 9:55 AM on 9/02/20, with CDM NN and RD MM, it was observed that the two door Victory unit was found with liquid egg product stored over two cases of 2% milk. When asked if this was a proper set up for the unit CDM NN stated No and rearranged the unit so raw products were stored below ready to eat products. At this time, observation of the two door Hoshizaki unit found a couple cases of raw bacon stored over containers of ready to eat potato salad. According to the 2013 FDA Food Code 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(c) below, separating raw animal FOODS during storage, preparation, holding, and display from: .(b) Cooked READY-TO-EAT FOOD; .(b) Arranging each type of FOOD in EQUIPMENT so that cross contamination of one type with another is prevented . 4. During the initial tour of the kitchen at 11:35 AM on 9/1/20, it was observed that food crumbs, dirt, one shriveled grape, and box debris was found under the racks in the dry storage room. Under the rack opposite the door it was observed that a large splatter mark was evident on the wall, coving, and floor underneath the storage rack. During a revisit to the dry storage area at 10:14 AM on 9/02/20, with CDM NN and RD MM, it was observed that the condition of the room was the same from the previous day. Food crumbs and debris were found underneath the racks, shriveled grape was still under the storage shelf, and the back floor, coving, and wall still had a large splatter mark. According to the 2013 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean .
F 0813 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a policy regarding use and storage of foods brought to residents by family and other visitors.** Based on observation, interview and record review, the facility failed to fully implement a policy regarding use and storage of resident foods brought in from outside sources. This deficient practice resulted in unknown discard dates and potentially hazardous foods being held passed their discard date, increasing the risk of contamination and food borne illness among residents who store food in their rooms. Findings Include: During a Review of the resident refrigeration unit at 11:50 AM on 9/01/20, it was observed that numerous food products that were stored in the refrigeration unit were found to have no discard date or was held passed the discard date set by the facility. The items found were the following: Fruit Tray with melons dated 8/10 to 8/17, small box of Fried chicken and potato wedges with no dates, container with butter and cake dated 8/12, container with a slice of pie dated 8/10, A Meijer bag with cake, pie, and cooked mac and cheese with no name or dates, Styrofoam cup with brown liquid dated 7/18, a container of whole intact strawberries with mold looking growths dated 8/5, Small box of fried chicken with no date, small container of pie with a date of 8/12, and a bag with salad fixings dated for 8/17. During this time a thermometer to record the proper temperature of the refrigeration unit was not found in the unit. At 11:58 AM on 9/01/20 the resident food items held passed their use by dates were shown to Director of Nursing B and she stated she would take care of the items at this time. At 8:30 AM on 9/3/20 and review of the facility policy entitled, Foods Brought by Family and Visitors, dated April 2018, found that Perishable foods must be stored in re-sealable containers with tight fitting lids in the refrigerator, the policy goes on to state that The nursing staff is responsible for discarding any perishable foods on or before the use by date.
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 1). ensure resident assisted feeding equipment was properly cleaned for 1 of 4 residents (Resident #54) reviewed for tube feedings, 2). ensure shared resident equipment was properly cleaned and sanitized between uses, 3). perform incontinence care using adequate infection control practices for 1 resident (Resident #47) and 4). properly use of PPE (personal protective equipment) for 2 residents (Resident #47 and #51), who required transmission based precautions, resulting in the potential for the spread of infection, cross-contamination and disease transmission for all residents residing in the facility. Findings include: Resident #54 Review of a Face Sheet revealed Resident #54 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #54, with a reference date of 7/10/20 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #54 was cognitively intact. During an observation on 9/01/20 at 1:49 p.m., Resident #54's tube feeding was observed on hold Resident #54 was not in his room. The base, computer screen, and the pole which hung the tube feeding was visibly soiled with dried liquid tube feeding droplets/spillage on various areas of the machine. The machine had an overall dirty appearance. During an observation on 9/01/20 at 11:37 a.m., observed a vitals machine on the B hall, the blood pressure cuffs were visibly soiled, as well as the finger probe (measures oxygen in the blood) which had grime inside the crevasses and the surface where the residents fingers are placed. During an observation on 9/01/20 at 11:40 a.m., observed a sit to stand lift parked outside room B5. The base of the lift where residents plant their feet, was soiled with dust, debris and food crumbs. The sling, and handlebars were also noted to be visibly soiled. During an observation on 9/01/20 at 11:44 a.m., observed a sit to stand in the hallway between A & B hall was noted to be visibly soiled on the base, where food crumbs, dust and debris were observed. During an observation on 9/01/20 at 11:47 a.m., observed a shower chair in the hallway between A & B hall was noted to be visibly soiled with debris and food crumbs on the base. During an interview on 9/01/20 at 11:51 a.m., Housekeeper (Hsk) U reported she was unsure who was responsible for cleaning the lifts, and shower chairs. During an interview on 9/01/20 at 12:07 p.m., Certified Nurse Aide (CNA) M reported nursing/CNA's are to clean/sanitize resident shared equipment such as hoyer, sit to stand lifts, and vital machines. During an observation on 9/01/20 at 12:25 p.m., observed 2 vital machines on the C unit the vital machines were both visibly soiled on the base with dust and debris, the finger probes were visibly soiled with a dried crusted substance on the inside of the finger probes. 1 vital machine parked next to room C8, had visible wires showing outside of the protective wire covering (cord). During an observation on 9/03/20 at 9:02 a.m., observed a sit to stand lift parked outside room #B2, the base of the lift was visibly soiled with food crumbs. The knee area (which stabilizes residents' legs) had a dried stuck on substance, white in color.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) The back of the knee area had a smudge of a light brown dried substance. During an observation on 9/03/20 at 9:13 a.m., observed a hoyer lift parked outside of room #C1, the handlebar area where the sling (mesh fabric which resident sites in to be lifted, was visibly soiled with a orangish colored smear. The remote-control cord was visibly soiled with an overall dirty appearance. During an observation on09/03/20 at 9:17 a.m., observed a vitals machine on the C hall, which was visibly soiled on the base, the finger probe was visibly soiled with a dried crusted residue on the inside, as well as in the crevasses. The cord to the finger probe was visibly soiled with areas of a stuck-on substance, the cord was not coiled up on the area of the machine where it could be wrapped up. The cord hung loosely near the floor approximately 3-4 inches from touching the floor. During an interview on 9/03/20 at 9:23 a.m., CNA G reported any staff who uses a lift, or a vitals machine should be wiping the equipment after each use, and whenever it is noticed to be soiled. During an observation on 9/03/20 at 9:26 a.m., observed an exercise bike (hand style for arms) in room C14, the hand peddles were visibly soiled with a buildup of residue in the crevasses, and dust and debris on the frame of the equipment. During an interview on 09/03/20 09:28 a.m., Hsk S reported therapy uses the room which has the seated elliptical machine, and hand bike, Hsk S reported staff including therapy staff who assists residents with any equipment is supposed to clean/sanitize the equipment between resident use. During an interview on 9/03/20 at 9:30 a.m., Occupational Therapist (OT) W reported therapy equipment is supposed to be cleaned/sanitized between each resident, and housekeeping deep cleans daily. During an interview on 9/03/20 at 9:35 a.m., Physical Therapy Manager (PTM) V reported the therapy equipment should be cleaned between residents. During an observation on 9/03/20 at 9:42 a.m., observed a sit to stand lift on A hall, the base of the lift was soiled with food crumbs, and the knee area had a dried substance that was white in color stuck on it. During an observation on 9/03/20 at 9:49 a.m., observed a vitals machine in the corridor between A & B hall, the finger probe had residue on it, as well as a dried crusted substance. The cord attached to the finger prove had visible wires showing outside of the protective wire covering (cord). During an observation on 9/03/20 at 9:51 a.m., observed a sit to stand labeled A on the base, was visibly soiled food crumbs, dirt, and debris in the crevasses. The knee area of the machine was soiled with dried substances on the back in various spots. During an interview on 9/03/20 at 9:55 a.m., Environmental Service Manager (EVS) R reported nursing staff, and CNA's are responsible for cleaning/sanitizing resident equipment such as vital machines, lifts, sit to stands. EVS R reported housekeepers are responsible for cleaning/sanitizing items such as beds, common areas, bedrooms, bathrooms, handrails and when they can assist nursing/CNA staff they would. EVS R reported any staff who sees something visibly soiled is responsible for cleaning/sanitizing the item or equipment. During an interview on 9/03/20 at 10:07 a.m., Director of Nursing (DON) B reported nursing staff is responsible for cleaning tube feeding machines, poles and equipment. DON B reported nursing staff including CNA's are responsible for cleaning/sanitizing resident shared equipment. DON B reported any staff who notices something soiled is responsible for cleaning the item or asking for assistance from another staff member. Review of a facility Policy dated 2/2018 revealed: Policy Statement Reusable resident care equipment/instruments/devices will be maintained and decontaminated according to manufacturer's instructions to prevent resident-to-resident transmission of infections. Review of a facility Policy Interpretation and Implementation dated 2/2018 revealed: 1. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. 2. Wherever possible/practical, equipment and devices will be designated single-use for residents who are on transmission-based precautions. 3. Organic matter (visible dirt, blood, body fluids, etc.) must be removed prior to disinfection or sterilization of equipment. 4. Environmental services will decontaminate and/or sterilize equipment as necessary, unless decontamination must be performed by an outside service agency. 5. The Infection Preventionist (or designee) will ensure that appropriate decontamination procedures are followed. 6. Should the equipment need to be sent to an outside service for decontamination or sterilization, the Environmental Services Director or designee will affix a biohazard label and a warning label to the equipment. The warning label will include at least the following information: a. That the equipment is contaminated; b. Identification of the portions of the equipment that remain contaminated; c. The address to which the equipment is to be shipped; d. The address from which the equipment was removed (including telephone number); e. The name of the person who examined and identified the portions of the equipment that remain contaminated; and f. The date and time the label was affixed to the equipment. Devices that are used by staff but not in direct contact with residents (i.e, computer keyboards, PDAs, etc.) shall be disinfected regularly to prevent cross-contamination of pathogenic organisms. Resident #47 Review of a Face Sheet revealed Resident #47 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. Review of a Minimum Data Set (MDS) assessment for Resident #47, with a reference date of 7/1/20 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #47 was cognitively impaired. Review of the Functional Status revealed that Resident #47 required supervision - oversight, encouragement or cueing and setup help with eating and total dependence and 2 staff physical assistance with transfers to or from his bed or chair. Review of Resident #47's Physician order [REDACTED]. every shift. Active 09/02/2020. During an observation on 9/2/20 at 2:30 P.M., CNA H and CNA O provided incontinence care to Resident #47 (who was currently on droplet precautions due to exposure to COVID-19). CNA H was observed not wearing goggles while assisting with positioning during incontinence care for Resident #47. Resident #47's incontinence brief was observed to be saturated with urine. CNA O was observed to use wipes to wash Resident #47's groin area and buttocks. CNA O did not directly visualize or wash Resident #47's genitals. CNA O and CNA H continued to get Resident #47 dressed and transferred into his wheelchair using the hoyer lift. CNA O was observed to touch surfaces of the bed, nightstand, wheelchair, privacy curtain and hoyer lift, all while wearing the same pair of gloves that were used to provide incontinence care. There was no observation of hand hygiene by CNA O or CNA H during this task. During an interview on 9/2/20 at 2:41 P.M., CNA O reported that she had just forgotten to wash Resident #47's genitals during incontinence care and furthermore stated, .I should have changed my gloves after I finished washing him up .before I did anything else . Resident #51 Review of a Face Sheet revealed Resident #51 was a [AGE] year-old male, originally admitted to the facility on [DATE]. Review of Resident #51's Physician order [REDACTED]. every shift. Active 09/02/2020. During an observation on 9/2/20 at 2:13 P.M., Certified Nursing Assistant (CNA) H was observed in full PPE (Personal Protective Equipment) (gown, gloves, goggles, mask) providing incontinence care to Resident #51. CNA H was then observed to exit Resident #51's room, while still wearing full PPE, including gown and gloves, carrying a plastic bag of soiled linen and a styrofoam plate leftover from Resident #51's lunch meal. CNA H walked down the hall and entered the soiled utility room, where she discarded the bag of linen, and then proceeded to walk down the hall towards the exit doors. This surveyor called out to the Licensed Practical nurse (LPN) Q alerting her that CNA H had exited a Droplet Precautions room and was about to exit the unit, all while wearing full PPE. LPN Q was observed redirecting CNA H and verbalizing orders to remove her PPE prior to leaving an isolation room. During an interview on 9/2/20 at 2:45 P.M., Nursing Home Administrator A reported that the facility educator was currently auditing staff for proper PPE use, but that CNA H had not been audited yet. Review of facility document Personal Protective Equipment (PPE) Clinical Performance Evaluation Checklist provided by Nursing Home Administrator (NHA) A revealed, .Determine if staff appropriately use PPE, including but not limited to gloves are removed after contact with blood, bodily fluid, mucous membrane or non-intact skin. Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care . Is PPE appropriately removed and discarded after resident care, prior to leaving room . Review of the Centers for Disease Control website (https://www.cdc.gov/handhygiene/providers/index.html) last revised on June 25, 2018 revealed, .The CDC Guideline for Hand Hygiene in Healthcare Settings recommends: .Steps for Glove Use .Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) .Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Failure to remove gloves after caring for a patient may lead to the spread of potentially deadly germs from one patient to another.