STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265308	A. BUILDING _____ B. WING _____	05/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW MARK CARE CENTER	11221 NORTH NASHUA DRIVE KANSAS CITY, MO 64155

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 and interviews, the facility failed to maintain social distancing by staying six feet apart from each other and did not wear a facial masks appropriately in a common area in the facility to assist with preventing the spread of COVID-19 (a respiratory disease caused by a novel coronavirus). Additionally, staff failed to follow facility policies and the Centers for Disease Control and Prevention (CDC) guidelines for proper hand washing techniques, including washing hands before and after glove removal, and failed to assist residents with proper hand hygiene before a served meal. The facility census was 148. 1. Review of the CDC website for long term care facilities showed: -Nursing home residents are at high risk for infection, serious illness, and death from COVID-19; - Keep COVID-19 from entering your facility: Implement universal use of source control (the use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing) for everyone in the facility; -Prevent spread of COVID-19: Actions to take now: Enforce social distancing among residents (measures to reduce the spread of contagious disease by maintaining a physical distance between people and reducing the number of times people come into close contact with each other); Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others; Ensure all HCP wear a facemask or cloth face covering while in the facility; Review of the facility's Crisis Standards of Management for COVID-19 policy, dated 3/30/20, showed the following efforts have been implemented to reduce the risk of COVID-19: -Ensure staff clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing PPE; -Ensure alcohol based hand rub (ABHR) is readily available; -Ensuring tissues are available and sinks are well-stocked with soap and paper towels for hand washing; -Handwashing signage available throughout the building; -Ensure environment cleaning and disinfection procedures are consistently followed and high touch surfaces are cleaned at least daily; Review of a memorandum, titled Staff Update, and dated 3/25/20, showed the following additional efforts to mitigate the risk of COVID-19 were implemented: -Residents who are able will continue to eat in their rooms until further notice. Residents who require assistance will sit 2 at a table in the main dining room with tables spread apart as much as possible; -Residents may leave their rooms. We should encourage social distancing. No groups more than 10 people at a time including staff; -Continue to remind residents to wash their hands frequently; 2. Observation on 5/26/20, at 11:16 A.M., showed 28 residents gathered in the common area of Unit 1 without facial masks in place. Residents were seated in various chairs along the walls and seated in wheelchairs the open area while listening to a staff member read a story from a book. Residents were not socially distanced and many were positioned side by side, less than 1 foot from one another. Observation on 5/26/20 at 11:21 A.M., showed Licensed Practical Nurse (LPN) A seated at the nurse's station, with a resident seated in a wheelchair across the counter. LPN A was observed reaching up to his/her cloth facial mask with his/her hand and pulling the mask down, exposing his/her mouth, to speak to the resident on two occasions. LPN A did not perform hand hygiene after touching facial mask. Observation on 5/26/20 at 11:26 A.M., showed LPN A standing at the nurse's station, with another staff member standing across the counter. LPN A was observed reaching up to his/her cloth facial mask with his/her hand and pulling the mask down, exposing his/her mouth, to speak to the other staff member. LPN A did not perform hand hygiene after touching facial mask. Observation on 5/26/20 at 11:27 A.M, showed pre-poured beverages, in disposable plastic cups placed at each place setting on the dining room tables, left unattended and uncovered while two residents were seated in the dining room without facial coverings in place. Observation on 5/26/20 at 11:39 A.M., showed staff member standing in the hallway, with his/her facial mask lowered, exposing his/her nose and mouth, while speaking with a resident. The staff member did not attempt to socially distance his/herself from the resident while he/she leaned over to speak to the resident. Observation on 5/26/20 at 11:43 A.M., showed a chocolate pudding cup, used for medication administration for multiple residents, sitting on top of a medication cart. The pudding cup was left unattended and with the foil lid ajar when three residents without facial coverings were self-propelling in wheelchairs and ambulating with walkers within two feet of the cart. During which time, Certified Nurse Aide (CNA) A provided assistance to the residents in passing through the area due to limited clearance space. CNA A pushed one resident's wheelchair into the dining room to the resident's place setting. CNA A's facial mask was lowered with his/her nose exposed while providing assistance to the residents and no hand hygiene was observed for the staff member following this contact. Observation on 5/26/20 at 11:50 A.M. of the large dining room on Unit 1 showed the following: -Multiple residents seated in the dining room together; -No residents wore facial masks; -Staff assisting residents in wheelchairs and with walkers into the dining room, where residents were seated 3 residents to a four by four foot square table; -CNA A leading a resident to the dining room, hand in hand, without wearing gloves and without the use of hand hygiene for the staff member or the resident after the resident was positioned at the dining table; -CNA B assisted resident in wheelchair to their place setting at a table, then exited the dining room to get another resident without performing hand hygiene; -Staff assisting residents with applying clothing protectors and with cutting their food with the resident cutlery without hand hygiene after every resident contact; -Residents at the same or adjacent tables sat approximately 18 inches to two feet away from one another throughout the meal. -Staff served lunch to the residents and did not attempt to socially distance any of the residents from one another; Observation on 5/26/20 at 11:57 A.M. of the smaller dining room on Unit 1 showed the following: -Multiple residents seated in the dining room together; -No residents wore facial masks; -Staff assisting residents in wheelchairs and with walkers into the dining room, where residents were seated three residents to a three by three foot square table; -Staff assisting residents with applying clothing protectors and with cutting their food with the resident cutlery without hand hygiene after every resident contact; -Residents at the same or adjacent tables sat approximately 18 inches to two feet away from one another throughout the meal. -Staff served lunch to the residents and did not attempt to socially distance any of the residents from one another; Observation on 5/26/20 at 12:02 P.M., showed CNA A exit the smaller dining room into the hallway, while removing his/her gloves in the process, then enter the larger dining room, obtain new gloves and apply without hand hygiene between glove applications. CNA A proceeded to serve multiple residents food trays and assist with applying clothing protectors without changing gloves or performing hand hygiene between resident contact. CNA A also used his/her gloved hand to adjust his/her own facial mask between some resident contact. Observation throughout the dining process showed no hand hygiene was offered to or performed for residents by staff assisting in meal service. Observation on 5/26/20 at 12:09 P.M., showed LPN A standing in the hallway, at his/her medication cart preparing a resident's medications to be administered. LPN A used an alcohol based hand sanitizer (ABHR) but did not apply gloves before preparing the residents medication and used his/her ungloved hand to touch his/her computer mouse, keyboard and keys to unlock a drawer during the preparation. LPN A did not perform hand hygiene after contact with his/her equipment and did not apply gloves before administering the medications to the resident by placing the medications in the resident's mouth with a spoon. During an interview on 5/26/20, at 12:31 P.M., LPN A said: -He/she has been employed at the facility for one year; -He/she has received recent training regarding COVID-19 precautions and infection control strategies; -He/she should have performed hand hygiene before and after medication administration to

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** - Some	(continued... from page 1) the residents; -Face masks should cover both the nose and mouth and be worn at all times by staff while in the facility; During an interview on 5/26/20, at 12:37 P.M., LPN B said: -He/she has been employed at the facility for four years; -He/she received recent training on infection control strategies related to COVID-19; -The facility recently has provided training on COVID-19, hand hygiene, and infection control strategies to all staff in small groups to facilitate social distancing; -All staff should wear masks and gloves while working with residents in resident care areas; -Staff are expected to wear masks that cover the face from nose to chin; During an interview on 5/26/20, at 12:46 P.M., CNA A said: -He/she has been employed by the facility for three months; -He/she has received recent training for infection control strategies to prevent the spread of COVID-19; -Staff should performed hand hygiene before applying and after removing gloves and before and after any resident care; -Staff should perform hand hygiene and apply gloves before serving residents their meals; -When describing serving resident's trays in the dining room at lunch, he/she said: I'm sure I missed some steps in there, it's hard when you are so busy. -He/she said that residents in the memory care unit cannot really be socially distanced; During an interview on 5/26/20, at 12:51 P.M., the Unit Manager said: -In response to COVID-19, the facility implemented the following infection control strategies: increased PPE requirements for staff, staff must wear facial masks at all times while in resident care areas, screening residents and staff for fever and signs and symptoms of respiratory infection, restricting visitors including hospice personnel except in end of life care, utilizing disposable dinnerware and cutlery, and increasing cleaning regimen to reduce the spread of germs. -The facility has discontinued communal dining on other units but that this is not feasible for the memory care unit as the residents require supervision by staff; -He/she expects all staff to wear facial masks at all times in resident care areas; -Facial masks should cover both the nose and mouth completely and staff should refrain from touching their facial masks; -He/she expects staff to launder their facial masks daily; 3. Observations on 5/26/20 starting at 11:40 A.M., showed the following: - Registered Nurse (RN) A passed room trays to residents on the 300 hall; - He/she pulled a meal tray from the highboy cart and took it into resident room [ROOM NUMBER], adjusted items on the resident's over-the-bed table, set the tray down and returned to the hall; - Without using hand sanitizer or washing his/her hands, RN A touched his/her hair, adjusted his/her mask and retrieved another meal tray, taking it into resident room [ROOM NUMBER]; - RN A continued down the hall passing meal trays to resident rooms 326, 327, 328, and 329; - Between each tray, RN A did not use hand sanitizer or wash his/her hands before entering the resident room, after delivering the meal tray or after leaving the residents' rooms; - He/she touched his/her mask, eyeglasses and hair multiple times, as well as multiple items in each resident room. During an interview on 5/26/20 at 11:45 A.M., RN A said staff should use hand sanitizer or wash their hands whenever they enter a resident room or when they leave the resident's room. They should use hand sanitizer or wash their hands after touching their face in anyway, such as glasses, hair, and mask. Masks should be cover the mouth, chin and nose. 4. Observations on 5/26/20 starting at 11:50 A.M., showed 16 residents in the main dining room seated two to a table with multiple staff in the dining room assisting the residents and did the following: - Certified Nurse Aide (CNA) C stood over a resident to feed him/her as his/her mask rested just under his/her nose. CNA C then touched his/her mask to raise it over his/her nose, did not perform hand hygiene and continued to feed the resident. CNA C moved from resident to resident and did not perform hand hygiene in between assisting the residents. - CNA E walked down the hall toward the main dining room not wearing a mask. - CNA F sat at the far back table of the dining room assisting a resident to eat. He/she had his/her fist resting on his/her mask-covered chin. He/she did not perform hand hygiene before picking up a napkin to wipe the resident's face, then placed his/her fist back under his/her chin. - Two more staff entered the dining room with their masks down, not covering their noses. Both staff pulled the masks up after being reminded by other staff. Neither staff used hand hygiene after touching their masks. During an interview on 5/26/20 at 12:30 P.M., CNA C and CNA D said: - Staff should use gloves, gowns and masks to provide direct care to residents. - Staff should perform hand hygiene (wash their hands or use hand sanitizer) whenever they touch their faces, masks or a resident; should perform hand hygiene when entering a resident room or when leaving a resident room; - Staff should ensure their masks cover from nose to chin and should perform hand hygiene after adjusting the mask. 5. During an interview on 5/26/20 at 12:45 P.M., the Director of Nursing (DON) and Administrator said: - Staff should perform hand hygiene anytime they touch their masks, cell phones, hair, glasses, after touching a resident and before entering and after leaving a resident room. This includes delivering meal trays as generally staff are touching items on the residents' over-the-bed tables to set the trays down. - Staff have not been wearing gloves in the dining rooms. If they do wear them, they should be performing hand hygiene when removing them. Gloves do not replace good hand hygiene. - Staff should always have on their masks if they are in the hallways or anywhere residents would be. - Masks should cover from nose to chin, and should never be allowed to slide down under the nose. - Social distancing has been difficult in the memory care unit. The have tried staggered dining but it has been hard with that population as they do not understand the reasoning behind social distancing. Some of the residents like to hold hands, and get completely out of sorts if their routine is disrupted.