STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065241	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES-DENVER	290 S MONACO PKWY DENVER, CO 80224

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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 observations, interviews and record review the facility failed to ensure infection control practices were followed to prevent the spread of COVID-19 infection. Specifically, the facility failed to ensure: -Staff and visitors were actively screened for all COVID-19 symptoms, provided only one screening access point, require staff/visitors to perform hand hygiene after screening, and have hand sanitizer available at the screening desk; -Staff protected Resident #2 from possible COVID-19 exposure after the resident's roommate (Resident #1) returned from a six day stay at the hospital without evidence of their COVID-19 status for one of one residents observed; -Staff offered hand hygiene to residents before receiving a snack or a meal; -Staff offered and encouraged residents to use face masks for one of five out of five residents; -Staff cleaned and disinfected vital sign equipment appropriately after each use; and -On-going training for hand hygiene was provided to staff, staff used alcohol based hand rub products appropriately, and staff performed hand hygiene after touching potentially contaminated surfaces while performing cares to multiple residents. Findings include: I. Professional standards The COVID-19 Preparation and Rapid Response: Checklist for Long-Term Care Facilities, revised 5/13/2020 was developed by the Communicable Disease Branch of the Colorado Department of Public Health and Environment. The document revealed the following items should be immediately implemented by every facility: -All staff should be screened at the beginning of their shift for fever (take temperature) and symptoms such as cough, shortness of breath, difficulty breathing, chills, rigors, myalgia, headache, sore throat, new smell or taste disorders; also consider rhinorrhea, diarrhea, nausea or vomiting, -All essential visitors must be screened upon entrance to the facility, to include fever, respiratory symptoms, other symptoms of infection and any potential exposure to COVID-19, -All visitors should perform hand hygiene . , and -Ensure adequate hand hygiene supplies . , II. Facility policies and forms The COVID 19 Screening Questions staff/visitors form, dated 3/11/2020, was provided by the director of nursing (DON) on 6/17/2020 at 4:30 p.m. The form revealed a designated space for the staff/visitor to write their name, date and time. The form had a designated space for the screening employee to write their name. The staff/visitor was to check either yes or no for the following questions: -Have you had a fever within the past 24 hours? This form did not provide the definition or parameters of a fever. The form did not have a place for the screener to document the temperature of the person entering the facility. -Do you have a cough or sneeze? -Do you have a sore throat? -Do you have shortness of breath? -Within the past 14-days have you had recent travel to high risk areas? -Within the past 14-days have you been exposed to someone with documented or suspected COVID-19? -Within the past 14-days have you resided in a community where community based spread of COVID 19 was occurring? -If the staff/visitor answered yes to any of these questions, do not allow them into the facility. Follow your facility's protocols for what to do next. -Please contact your supervisor if needed for additional guidance. All completed forms must be saved. A document entitled, When Entering the Facility, not dated, was provided by director of nursing (DON) on 6/17/2020 at 7:00 p.m. The DON said this document was developed on 6/17/2020, after the survey team had entered the facility. The document revealed, upon entrance at the front door, please sign in at the front desk and answer the COVID-19 screening questions. The document also revealed, to see the receptionist to have your temperature taken and to sanitize your hands once completion of the screening process. III. Facility screening observations On 6/17/2020 at 4:00 p.m., four state surveyors entered the facility. The receptionist at the front desk conducted the screening process for further entrance to the facility. She had each surveyor complete the COVID-19 screening questions on the staff/visitor form. The screener took the temperatures of each surveyor with a laser thermometer. She told each surveyor their temperature and instructed them to write the temperature somewhere on the form. The form did not have a designated space to document a temperature. She did not ask any of the screening questions and did not review any of the forms. There was no visible hand sanitizer on the desk and the screener did not ask the surveyors to use hand sanitizer or wash their hands at the nearby bathrooms. On 6/17/2020 at 5:09 p.m., the dietary director (DD) was observed filling out the screening form. The screener took the DD's temperature and asked her to write the temperature on the form. The screener did not ask the DD any of the screening questions and did not ask her to wash her hands or to use any hand sanitizer after completing the screening process. On 6/17/2020 at 5:13 p.m., the minimum data set coordinator (MDSC) was observed filling out the screening form. The screener took the MDSC's temperature and asked him to write the temperature on the form. The screener did not ask the MDSC any of the screening questions and did not ask him to wash his hands or to use any hand sanitizer after completing the screening process. IV. Staff interviews On 6/17/2020 at 4:45 p.m., the receptionist said she did the infection control screening procedures at the front desk Monday through Friday from 8:30 a.m., to 5:30 p.m. She said staff/visitors were screened only at that desk. She said staff were able to enter the facility through a second entrance at the back of the facility. She said the staff walked from the back door to the front desk to be screened. She said no screening occurred at the back door. She said any medical personnel that came into the facility were screened at the front desk. -The receptionist said she had been in-serviced on how to use the laser thermometer and explained how the device did not touch the skin of the person having their temperature taken. She said 99 degrees Fahrenheit (F) was the upper limit for temperatures and if someone had a temperature of 99 degrees F or higher, she would have them sit in a chair in the front lobby, wait for 15-minutes and recheck their temperature. She said she instructed staff/visitors to write their own temperature on the entrance screening form. -The receptionist said if any person with an elevated temperature or answered yes to any of the questions on the screening form, she called the DON to the front lobby area, where the person was seated. She said the DON would ask any additional questions. On 6/17/2020 at 5:07 p.m., the activity director (AD) said she did not work at the front screening desk often. She said she had been in-serviced on how to take temperatures, but had to learn how to use the laser thermometer herself. She said staff/visitors completed the entrance screening themselves, she took their temperature and had them write their temperature on the form. She said she did not ask staff/visitors to wash their hands or use hand sanitizer after screening. She looked all around the desk area, in the cabinets adjacent to the screening desk and agreed there was no hand sanitizer available for staff/visitors to use for hand hygiene. On 6/17/2020 at 5:26 p.m., the DON said the rear entrance door to the facility required a key code and allowed staff to enter the facility from the back parking area. She said staff were not screened at this back entrance. She said staff had to walk down a hallway, through a door, and proceed to the entrance screening front desk to be screened. She said all screening was completed at the front desk. She said the staff/visitors completed the screening form and the screener was to verify all the information. -The DON said the screener at the front desk took each staff/visitor's temperature, told them the temperature and had them write the number on the screening form. She said if the temperature was high (99 degrees F or higher) or there was a yes answer, she was called 24 hours a day seven days a week. She said she would meet with the person in the front lobby area and ask them additional questions. She said she did not document any additional information provided by the individual on the screening form. -The DON said hand sanitizer should be provided at the screening front desk and staff had been educated on hand hygiene practices. She said she would have to check the facility policy to see if the receptionist/screener needed to tell the person being screened to wash their hands or use hand sanitizer. On 6/18/2020 at approximately 9:30 a.m., the nursing home administrator (NHA) and

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

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The DON said if anyone answered yes to any of the screening questions, she would be notified, she would ask additional probing questions and document the answers on the screening form. On 6/18/2020 at 2:45 p.m. the DON and the regional director (RD) were interviewed. The DON said the screener should have the staff/visitors wash their hands or use provided hand sanitizer. She said hand sanitizer should be available at the front desk for staff/visitors use. She said the screener at the front desk should have asked the staff/visitors all of the screening questions and not have had the staff/visitors fill out the screening form. V. Failure to ensure staff protected Resident #2 from possible COVID-19 exposure after the resident's roommate (Resident #1) returned from a six day stay at the hospital without evidence of their COVID-19 status. 1. Observation On 6/17/2020 at 4:20 p.m. Emergency medical service (EMS) team of two people were observed as they brought in Resident #1 on a gurney into the facility. The EMS team were wearing personal protective equipment (PPE) which included facemask, gown and gloves. The resident they brought into the facility also had the same PPE on. The facility did not screen or offer a separate PPE to the EMS team and likewise the admitting resident. The EMS team and the resident were received by the unit manager (UM) #1of the 300 hallway. The UM #1 led the EMS team to room [ROOM NUMBER] where the resident was transferred from the gurney to the bed. While the UM #1 led the EMS team and Resident #1 to the room, the facility failed to ensure the 300 hallway was free of five residents who were out in the hallway without wearing a facemask. On arrival in room [ROOM NUMBER], an isolation cart was observed outside of the room, the room also had another resident. The resident in the room had her bed by the door while the re-admitting resident's bed was in the inner room. The transfer process failed to ensure the privacy curtain was drawn to prevent exposure of the re-admitting residents' roommate as she was not wearing a mask or any type of PPE. After Resident #1 was transferred from the gurney to the bed, the EMS team left the resident room without doffing their PPE. Specifically, one member of the EMS team walked back out into the ambulance without doffing her gown, gloves and mask, while the other, initially stepped out of the room, took several steps into the hallway and was later called back into the room by the UM #1 who instructed him to doff his gown. This same EMS staff left the room, still wearing the same gloves he had on. While, Resident #1 layed in bed, the UM #1 told her it was safe to take off her face mask. There was no instruction to the two residents (Resident #1 and Resident #2) as for the need to observe social distancing or to draw the privacy curtain. There was no instruction on how to protect the residents from each other. After settling in the room, Resident #1 was approached at her bedside by Resident #2. Both residents had an extensive verbal conversation without maintaining the recommended six feet social distancing and without protecting their faces by any means. 2. Record review A review of Resident #1 and Resident #2's June 2020 computerized physician orders [REDACTED]. Neither resident had a plan of care related to COVID-19 isolation or treatment. A review of Resident #2's progress notes revealed conflicting reports of Resident #2's isolation status. Specifically, the progress notes dated and 6/15/2020 at 3:50 p.m., 6/16/2020 at 8:50 a.m., 6/17/2020 at 10:06 a.m., 6/17/2020 at 10:10 p.m. and 6/18/2020 at 10:11 a.m., all reported Resident #2 was on airborne respiratory isolation. Conversely, the progress notes dated 6/15/2020 at 10:18 a.m., 6/16/2020 at 10:09 a.m., 6/16/2020 at 12:00 a.m., 6/17/2020 at 9:42 a.m., 6/17/2020 at 1:12 a.m., 6/18/2020 at 9:10 a.m. and 6/18/2020 at 2:04 a.m. reported Resident #2 was not on airborne respiratory isolation. The 5/3/2020 COVID-19 testing for Resident #1 and Resident #2 came back negative. However, there was no laboratory report verifying Resident #1's COVID-19 status [REDACTED]. Interview UM #1 was interviewed on 6/17/2020 at 4:33 pm. She verified Resident #1 was the resident who just returned from the hospital. She said that the resident went to the hospital on Friday (6/12/2020) because she was septic. She said the resident was returned to the same room she was before her hospital admission. She said the resident would be on isolation for 72 hours. She confirmed the resident is cohorting with the same roommate she had prior to her hospital admission. She verified that Resident #1 had once tested positive for COVID-19 prior to her hospital visit. She also said the facility did not know the current COVID-19 status of the resident post her hospital admission. UM #1 said the criteria for isolation was temperature greater than 99 degrees. She reported that there were currently four residents on isolation on the grant heritage unit. She stated rooms #330, #333, #307 and #306 were on isolation. She said the four residents tested positive for COVID-19 about a month ago and did not fit the criteria for isolation anymore because they were asymptomatic. She said they were on isolation at this time because of the directive from their cooperate to isolate any resident whose temperature was 99 degrees and above. She did not recall if the residents received a second test for COVID-19. 4. Follow-up interviews On 6/18/2020 at 11:13 a.m., the director of nursing (DON) and staff development coordinator/infection preventionist (SDC/IP) were interviewed. The SDC said Resident #1 had been moved into a private room after further investigation last night. She said moving forward readmitted residents would go into private rooms. She said staff are to wear full PPE (mask gown and gloves) for the first 72 hours. The DON said Resident #1 had a temperature of 103 degrees and [MEDICAL CONDITION] a week ago, she was sent to the hospital and was diagnosed with [REDACTED].#1 had a rapid test at the hospital on [DATE] which was positive for COVID-19. She said the hospital's procedure is two negatives COVID-19 tests before returning the resident back to the facility. However, she said the facility has no record of two negative tests from the hospital prior to Resident #1's readmission. The DON said they had quality assurance performance improvement (QAPI) with the medical director regarding her (Resident #1's) return and he said she was not actively infected just shedding virus. The facility then considered her COVID-19 recovered. The DON said Resident #1 should have went into a private room last night, but this was not done. She said her thought was the nurse who put her back in her old room with her roommate may have thought it was ok because they had been on isolation previously. She said Resident #1 has been moved to a private room. She said all new/readmission will go to a private isolation room for 14 days regardless of COVID-19 status. She said staff do not know that they are to go to a private room. She said she started an in-service with all staff about new/readmitting residents going to a private room. Specifically, the DON said This resident should have gone into a private room. She said Resident #2 was on isolation according to criteria, she was on airborne precautions with every shift vital signs and respiratory signs symptoms. The DON added that Possibly the nurse knew the roommate was on isolation and the new arrival would need to be on isolation so they were put together. She said she provided re-education to the nurse last night that admitted Resident #1 following her attention and agreement to the surveyors findings and observations. VI. Improper hand hygiene Professional standards The Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. The following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. The Preparing for COVID-19 in Nursing Homes CDC recommendations, dated 5/19/20, was provided by the director of nursing on 6/18/20 at 5:53 p.m. The recommendations read in pertinent part: As demonstrated by the COVID-19 pandemic, a strong prevention and control (ICP) is critical to protect both residents and healthcare personnel (HCP). 1. Observations A. Resident hand hygiene during meals and snacks On 6/17/20 at 5:10 p.m. Resident #3 was seated in front of the nursing station. Her hand frequently touched the hand rail in front of her and the top surface of the nursing desk. -At 5:12 p.m. licensed practical nurse (LPN) #1 provided

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The resident pushed the washcloth farther from the plate with her left hand and continued to eat. The CNA did not ensure hand hygiene was performed. On 6/18/20 CNA #6 served in-room meal trays of plated breakfast on the Heritage unit. Between 8:55 a.m. and 9:20 a.m., room [ROOM NUMBER] and room [ROOM NUMBER] were observed for hand hygiene before meals. The residents in room [ROOM NUMBER] and #130 were not offered hand hygiene before their breakfast trays were served. -At 9:02 a.m. CNA #6 entered resident room [ROOM NUMBER] and delivered the meal tray. The CNA did not offer hand hygiene to the resident as she served the meal tray. The resident was not provided hand hygiene before he ate his meal. -At 9:17 a.m. CNA #6 entered resident room [ROOM NUMBER] and delivered the meal tray. The CNA did not offer hand hygiene to the resident as she served the meal tray to the resident. The resident was not provided hand hygiene before she ate her meal. B. Staff hand hygiene when donning and doffing gloves and after touching potentially contaminated surfaces On 6/17/20 at 4:54 p.m. LPN #1 was observed in front of her nursing cart. She pulled her face mask on her chin with her hand and took a drink from her personal drink container located on the cart. She placed the mask back over her face to cover her nose and mouth. She the touched the computer mouse to navigate her computer screen LPN #1 did not use hand hygiene after she touched her face mask and personal drink container. -At 5:01 p.m. Resident #3 notified LPN #1 that her leg hurt. On the left leg of the resident was a patch of blood on her sock. LPN #1 donned a pair of gloves over her hands. She did not perform hand hygiene before donning the gloves. With gloved hands, LPN #1 gripped the wheelchair handles of Resident #3 and assisted her into her room. -At 5:09 a.m. LPN #1 exited the room of Resident #3 with gloves still donned. She doffed the right glove to enter a code on the keypad to the room labeled Biohazard and opened the door with use of her right hand on the door handle. She did not perform hand hygiene after doffing her right glove and before touching the keypad and door handle. LPN #1 doffed the left glove and threw the pair gloves away in a bin next to the room entrance. She did not perform hand hygiene after she doffed both gloves. LPN #1 exited the doorway of the biohazard room and walked behind the nursing station. LPN #1 touched the door handle to a room labeled Staff Only and entered the room, closing the door behind her with her hand. LPN #2 was observed on 6/18/20 at 9:11 a.m. preparing medication for room [ROOM NUMBER]. LPN #2 used her right hand to navigate her computer screen with her computer mouse. She retrieved keys from her pocket and unlocked the medication cart. She pulled the drawer open with her left hand and pulled the cart draw open. LPN #2 donned gloves over hands and popped out a pill from a medication card into a medication cup. She did not perform hand hygiene before donning gloves and after touching potentially contaminated items before preparing to administer medication. C. Staff hand hygiene before delivering in-room meal trays On 6/17/20 at 5:59 p.m., CNA #5 collected a plated meal from the food cart. She did not perform hand hygiene before she handled the tray. -At 9:17 a.m., CNA #5 delivered a meal tray to room [ROOM NUMBER]. She did not perform hand hygiene when she entered the room. The CNA donned gloves without hand hygiene as she set up the resident's meal on his table, touching the resident's straw and cup. On 6/18/20 at 9:15 a.m., CNA #5 collected a plated meal from the food cart. She did not perform hand hygiene before she handled the tray. -At 9:17 a.m. CNA #6 delivered a meal tray to room [ROOM NUMBER]. She did not perform hand hygiene when she entered the room. The CNA set up the resident's meal tray, touching the resident's plate and cup. 2. Staff interviews C.N.A #5 was interviewed on 6/17/20 at 5:31 p.m. According to the CNA, staff should have provided residents with hand hygiene before the resident was offered a meal or snack. The CNA said hand hygiene should have been performed before donning gloves. CNA #6 was interviewed on 6/18/20 at 10:07 a.m. She said residents should receive hand hygiene before meals to ensure they had clean hands to eat. She said hand hygiene should have been offered five to 10 minutes before the residents were served or as meals are delivered. She said she had been very busy so hand hygiene was conducted whenever they could assist with it. The DON was interviewed on 6/17/20 at 7:38 p.m. with the infection control preventionist and the nursing home administrator (NHA). The DON said all residents should have hand hygiene before they were served meals to prevent cross-contamination. She said staff should perform hand hygiene through the day, to include when donning and doffing gloves and after touching potentially contaminated surfaces. 3. Facility follow up A hand hygiene staff inservice, dated 6/17/20, was provided by the facility on 6/18/20. According to the in-service, residents must be offered, assisted and receive hand hygiene Immediately prior to consuming food. VII. Improper or lack of cleaning of resident equipment Facility policy The cleaning equipment instructions for use, undated, was provided by the facility on 6/18/20. According to the instructions, reusable non-dedicated patient care equipment such as vital signs machines were to be sanitized with Micro Kill in between resident use. 1. Observations On 6/17/20 at 5:12 p.m., CNA #5 entered the Heritage unit. She observed a sweet roll wrapper on the floor next to Resident #3. CNA #5 picked up the wrapper off the floor with her right hand and placed it in a waste bin. She did not perform hand hygiene after picking the wrapper off the floor. She opened a door labeled Staff Only with use of her right hand and placed her purse on the counter before she exited the room. A vital sign machine was located at the nursing station near the staff only room. CNA #5 exited the staff only room and placed her right hand on top of the machine as she guided it down the hallway. -At 5:14 p.m., CNA #5 entered resident room [ROOM NUMBER]. She did not perform hand hygiene before entering the room. The CNA collected vitals on the resident including taking her temperature and blood pressure. She wrote down the results using a pen from her pocket. -At 5:17 p.m., CNA #5 exited room [ROOM NUMBER]. She did not perform hand hygiene after taking and recording the resident's vitals and after exited the resident room. She returned the vital sign machine to the nursing station. She did not disinfect the vital machine after resident use and after touching it with her potentially cross-contaminated hands. Between 5:17 p.m., and 5:20 p.m., CNA #5 handed a yellow card to LPN #1, touched a security keypad and door handle to the clean utility room, and handed two tissues to Resident #3. The resident used the tissues to wipe her nose. CNA #5 did not perform hand hygiene before touching multiple shared surfaces. -At 5:20 p.m., LPN #1 retrieved the vital sign machine, touching the surface of the machine as she entered room [ROOM NUMBER]. 2. Staff interview CNA #5 was interviewed on 6/18/20 at 2:58 p.m. According to the CNA hand hygiene should be conducted after touching potentially contaminated surfaces to reduce the spread of infections [MEDICAL CONDITION]. CNA #5 said hand hygiene should have been conducted with either soap and water, washing for 20 seconds or use of alcohol based hand rub (ABHR), for 30 seconds, completely covering the hands. She said she has had hand hygiene training through in-services and through years of experience. The CNA said shared medical equipment should have been disinfected after resident use. She said staff should use the Micro Kill wipes to disinfect potential contaminants. She did not know the dwell time of the wipes until identified on the package. 3. Facility follow up A staff development program attendance record was provided by the facility on 6/18/20. According to the record, staff was in-serviced on 6/17/20 and 6/18/20 for proper cleaning of resident care equipment. VIII. Resident face covering Professional reference The Preparing for COVID-19 in Nursing Homes, dated 5/19/2020, was provided by the director of nursing (DON), on 6/18/20 at 5:53 p.m. The recommendations read in pertinent part: Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room Facility policy and procedure The Facemasks for Residents instructions for use, undated, was provided by the regional director on 6/18/19 at 2:00 p.m. The instructions read All residents who come out of their room will be offered and educated on wearing a facemask. If they refuse, it will be documented that staff attempted and then educated on the reason for wearing the mask, and then the resident's response/refusal. This will be done throughout the shift if the resident continues to be out of their room. Please encourage any resident who refuses a facemask, to stay in their room as much as possible. 1. Observations On 6/17/20 at 4:33 p.m., Resident #3 was observed sitting in her wheelchair in front of the nursing station. The nursing station was located in the center of the Heritage unit between three resident room hallways. The third hallway was an attached secured unit. Staff entering the heritage unit to access resident rooms, the nursing station or the secured unit, would have to pass Resident #3. Resident #3 did not wear or have access to a facemask covering her nose and mouth as she sat in a common area. Between 4:33 p.m. and 5:52 p.m. Resident #3 was not provided or encouraged to wear a face mask as she continued to sit in front of the nursing station. Resident #3 frequently interacted with passing staff. -At 5:53 p.m., Resident #3 was offered a face mask. The resident accepted the mask with minimal encouragement. On 6/18/20 at 8:38 a.m., Resident #3 sat in front of the nursing station. She did not wear or have access to a face mask as she waited to be served her meal at 8:42 a.m. -At 9:11 a.m. Resident #3 completed her meal. She was not offered a face mask as she remained in a common area in front of the nursing station. Between 9:11 a.m. and 10:30 a.m. Resident #3 was not offered or encouraged to wear a face

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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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 3) mask while she sat in front of the nursing station. Between 11:10 a.m. and 11:40 a.m. Resident #3 was not offered or encouraged to wear a face mask. -At 2:58 p.m., Resident #3 was observed in front of the nursing station, she did not wear a face mask. 2. Staff interview The DON was interviewed with the IPS on 6/18/20 at 12:05 p.m. According to the director of nursing (DON), Resident #3 would refuse to wear a mask but acknowledged that the resident should have been encouraged to wear a face cover when she was outside of her room. 3. Record Review Review of the June 2020 care plan did not indicate the resident frequently refused to wear a face covering when outside of her room. The care did not indicate the resident could not tolerate the face covering based on medical concerns. IX. Failure to ensure vital sign equipment was disinfected appropriately after each resident use Facility policy and procedure The policy titled Practise Guidelines, dated 5/2013, was received from the nursing home administrator (NHA) on 6/17/2020 at 5:03 p.m. The policy documented in pertinent part, Standard Precautions include: hand hygiene (handwashing with soap and water or use of an alcohol-based hand sanitizer) before and after patient contact and after contact with the immediate patient care. Disinfect reusable equipment between patients (e.g. glucometers, lifts, scissors, blood pressure cuffs, etc.) with an EPA-registered disinfectant or hypochlorite so