STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265784	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIVING COMMUNITY OF ST JOSEPH	**1202 HEARTLAND ROAD SAINT JOSEPH, MO 64506**

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 ensure staff provided care in a manner to prevent infection or the possibility of infection when the facility failed to ensure the designated isolation hall which housed positive COVID-19 (a new virus, caused by a novel (or new) coronavirus that has not previously been seen in humans) residents contained signage to alert staff and visitors to see nursing prior to entering and what personal protective equipment (PPE, equipment worn to minimize exposure to a variety of hazards examples include gloves, gowns, and masks) should be used prior to entering the unit, failed to ensure staff used PPE correctly for residents who tested positive for COVID-19 when staff did not use appropriate techniques for donning (putting on) and doffing (taking off) PPE, when staff failed to don PPE prior to entering the designated isolation hall and failed to use appropriate techniques for doffing PPE, when staff failed to use proper hand washing techniques including washing hands after glove removal and after donning PPE which affected two of three sampled residents (Residents #1 and #2). Additionally, the facility failed to follow their policy to ensure all residents were screened upon returning to the facility from outside medical appointments in a community known to have community transmission of COVID-19 for one sampled resident (Resident #3). The facility census was 74. Review of the Centers for Disease Control and Prevention (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: - Healthcare personnel (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before donning and doffing PPE, including gloves; - Hand hygiene after removing PPE is particularly important to remove any pathogens (tiny disease causing organism) that might have been transferred to bare hands during the removal process; - Designate a location to care for residents with suspected or confirmed COVID-19, separate from other residents; - Isolate symptomatic (active symptoms) patients as soon as possible; - Set up separate, well-ventilated triage areas, place patients with suspected or confirmed COVID-19 in private rooms with the door closed and with private bathrooms (as possible). Review of facility policy titled Caring for a Confirmed Case of COVID-19, dated April 2020, showed: - If a resident presents with symptoms of COVID-19, staff should implement contact (used for infections, diseases, or germs that are spread by touching the patient or items in the room, healthcare workers should wear a gown and gloves while in the resident's room) and droplet precautions (germs that can be spread to others by speaking, sneezing, or coughing, healthcare workers should wear a mask, gown and gloves); - PPE: If available, an N95 respirator (filters at least 95 percent of airborne particles) offers a higher level of protection and should be used if a resident needs an aerosol-generating procedure, such as suctioning or nebulization; - Put on eye protection upon entry into the resident room; - Put on clean gloves prior to entering the resident room; - Remove and discard gloves before leaving room, and always perform hand hygiene immediately after removing. Review of the facility's policy titled Hand Hygiene, dated June 2017, showed: - Infection Prevention begins with the basic hand hygiene; - By following proper hand hygiene practices, associates will reduce the spread of potentially deadly germs, as well as reduce the risk of HCP colonization (presence of a microorganism on/in a host, with growth and multiplication of the organism) caused by germs acquired from the residents; - Staff should perform hand hygiene before and after entering isolation precaution settings and after removing gloves. 1. Observation on 6/25/20 at 11:20 A.M., of the facility's COVID -19 unit showed: - No signage on the closed double doors to the entrance of the designated COVID-19 isolation unit to alert staff and visitors to instruct them to see nursing prior to entering the unit or what personal protective equipment to be worn on the unit; - No cart and/or PPE supplies for staff to don prior to entering the unit. During an interview on 6/25/20 at 11:55 A.M., Unit Manager (UM) A said: - He/She is a registered nurse (RN) and his/her responsibilities include acting as a resource for staff; - He/She said there is no PPE available outside the closed double doors of the COVID-19 isolation unit; - Staff on this unit should wear full PPE which included N-95 respirators, goggles or face shields, gowns, and gloves; -He/She left the area and a few minutes later returned with the appropriate PPE for the surveyor to don prior to entering the unit; -He/She said there should be signage posted on the double doors posted outside the closed double doors to alert staff and visitors to check with the nurse prior to entry and the PPE should be donned prior to entering the unit; - After entering the unit all persons should exit the facility to the outside. 2. Review of Resident #1's medical records showed the resident tested positive for COVID-19 on 6/14/20. Observation on 6/25/20 at 12:00 P.M., showed RN A did the following: - Walked over to the plastic isolation three-drawer cart outside Resident #1's room and removed his/her face shield and surgical mask from his/her face; - Placed the surgical mask in the small paper bag that sat on the top of the plastic three-drawer cart, then removed an N95 respirator from the paper bag, donned the N95 respirator and face shield placing them over his/her nose and mouth; - Removed a gown and gloves from the plastic cart; - Did not wash his/her hands or use hand sanitizer before or after removing the surgical mask, face shield, and before donning the gown and gloves; - The top of the isolation cart did not contain any hand sanitizer; - Entered the resident's room and pulled the blue plastic bag from the metal trash can that contained trash, tied the bag of trash, and placed the plastic bag on the floor in the resident's room near the door; - Removed his/her gown and gloves as he/she exited the resident's room; - Did not wash his/her hands or use hand sanitizer after removing PPE; - Walked down the hall to the nurses' desk and with dirty hands used the phone; - Returned to the resident's room, did not use hand sanitizer before he/she applied clean gloves, and did not don a gown before he/she reached into the resident's room and obtained the bag of trash from the floor, then carried the bag of trash to the dirty utility room; - Returned to the plastic three-drawer cart outside the resident's room, removed his/her gloves. He/She did not wash his/her hands or use hand sanitizer after glove removal; - With ungloved hands, he/she doffed the face shield and N-95 respirator, the outside of the N-95 respirator rubbed against the back of his/her ungloved hand as he/she removed it from his/her face; - He/She did not wash his/her hands or use hand sanitizer before he/she removed a surgical mask from the paper bag that sat on the top of the plastic cart outside the resident's room; - With potentially contaminated ungloved hands, he/she donned the surgical mask, which had come in contact with the N95 in the bag, over his/her nose and mouth while standing near the entry way of the resident's room; - Then placed the N95 respirator into the paper bag that sat on the top of the plastic cart outside the resident's room. During an interview on 6/25/20 at 12:15 P.M., RN A said: - The COVID-19 unit currently has three residents that recently tested positive for COVID-19; - The UM told him/her that it is not necessary to change the N95 respirator or face shield between residents; - He/She does not feel it is safe to use the same N95 respirator; - All three residents on the unit have a paper bag on their plastic isolation cart which contains an N95 respirator; - After exiting each resident's room, he/she removes the plastic face shield and the N95 respirator and puts on a surgical mask; - He/She stored a surgical mask and the N95 respirator in the same paper bag for Resident #1; -Hand hygiene should be done before donning PPE and after doffing PPE. 3. Review of Resident #2's medical records showed the resident tested positive for COVID-19 on 6/21/20. Observation on 6/25/20 at 12:20 P.M., showed Physical Therapy Assistant (PTA) A did the following: - Exited Resident #2's room wearing PPE which included a gown, plastic face shield, gloves, and an N95 respirator; - He/She removed his/her gown, gloves, and plastic face shield; - The top of the isolation

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) cart did not contain any hand sanitizer; - Did not wash his/her hands or use hand sanitizer after removing the PPE; - With an ungloved hand, he/she removed the N95 respirator pulling it up over his/her head; - Held the N95 respirator by the elastic straps as it rubbed up against his/her clothing; - Did not wash his/her hands or use hand sanitizer and with dirty hands applied a surgical mask that was in his/her pant's pocket. During an interview on 6/25/20, at 12:25 P.M., PTA A said: - Resident #2 tested positive for COVID-19 and is receiving therapy services; - Staff should wash their hands or use hand sanitizer after doffing PPE; - The only hand sanitizer available near the plastic isolation cart is in the resident's room; - It is acceptable to remove the N95 respirator after exiting the COVID-19 positive resident's room. During a telephone interview on 6/29/20 at 10:20 A.M., PTA A said: - Today, he/she received training on the appropriate PPE to be used on the isolation unit; - Staff should apply PPE prior to entering the unit and staff should not remove their N95 respirator while on the unit; - Staff should not wear a surgical mask while on this unit; - On 6/25/20, he/she mistakenly thought it was acceptable to remove his/her N-95 respirator and apply a surgical mask in the resident's doorway; - Staff should wash their hands or use hand sanitizer after removal of PPE. During a telephone interview on 6/30/20 at 11:42 A.M., UM A said: - On 6/25/20, there were no bottles of hand sanitizer on the isolations carts for staff to use; - On 6/25/20, PPE was not available outside the double doors of the isolation unit so staff could don PPE prior to entering the unit. During an interview on 6/29/20, at 3:06 P.M., the Director of Nursing (DON) said: - The isolation hall which housed COVID-19 positive residents should have appropriate signage on the outside of the closed double doors; - A resident on isolation precautions for COVID-19 should be on contact and droplet precautions; - Staff should apply PPE prior to entering the COVID-19 unit; - PPE included an N-95 respirator, face shield or goggles, gowns, and gloves; - Staff should perform hand hygiene before and after removing gloves; - The isolation cart outside Resident #1 and #2's rooms should have contained hand sanitizer; - Staff should wash their hands or use hand sanitizer after removing and disposing of PPE; - It is not acceptable for staff to remove their N-95 respirator on the unit. 4. Review of the facility's policy titled COVID-19 Screening for Healthcare Employees and Residents, dated May 2020, showed: -Screen residents on entry to the facility; - Has the individual washed their hands or used alcohol-based hand rub on entry: If no, please ask them to do so; - Temperature greater than 100 degrees Fahrenheit: Record temperature; - Symptoms of new onset of [MEDICAL CONDITION] illness in the past 72 hours; - Close contact with a person who has been diagnosed with [REDACTED].#3's documentation provided by the facility showed: -On 6/24/20, facility staff transported him/her to two out of the facility appointments. -No documentation indicating staff screened the resident upon re-entry. During an interview on 6/25/20 at 11:30 A.M., the resident said: - Yesterday, staff transported him/her to a physician's appointment, via the facility van, when he/she returned to the facility, facility staff did not asses him/her prior to returning him/her to his/her room. During an interview on 6/25/20 at 11:10 A.M., Entrance Screener (ES) A said: - All persons entering the facility are screened for signs and symptoms of COVID-19; - He/She instructs them to use hand sanitizer upon entering and he/she obtains their temperature; - Residents that leave the facility for outside appointments re-enter the facility through the lower level doors; - He/She does not instruct residents re-entering the facility to use hand sanitizer and does not do their screenings as they are taken directly up to their room and parked in the hall and their charge nurse does their screening. During an interview on 6/25/20 at 11:55 A.M., UM A said: - The resident went out for a physician's appointment yesterday. - The van driver or facility staff take the residents back to their rooms upon re-entry to the facility. -A nurse would later go the the resident's room to screen them. Review of the resident's medical records showed the resident tested positive for COVID-19 on 6/26/20. During a phone interview on 6/30/20 at 12:56 P.M., Van Driver A said: - Sometimes the drivers will take residents back to their rooms and sometimes facility staff take them back. - Residents were not assessed by facility staff prior to returning residents to their rooms. During an interview on 6/30/20 at 3:00 P.M., the Administrator said: -Residents should be screened upon entry back into the facility. During an interview on 6/29/20, at 3:06 P.M., the DON said: - Residents that go into the community are screened at the lower level entrance doors.