STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045440	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARRIS HEALTH AND REHAB	287 SOUTH COUNTRY CLUB ROAD OSCEOLA, AR 72370

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 0640 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** Based on observation, record review, and interview the facility failed to ensure 3 Minimum Data Sets were transmitted for discharge within the required time frame after completion for 3 of 3 (Resident #1, #2, and #3) residents who required discharge assessments transmittal. The findings are: 1. On 07/16/2020 at 11:12 a.m., record reviewed did not documented a Discharge Minimum Data Set for Residents #1, #2, and#3 was not transmitted within 14 days after completion. 2. On 07/17/2020 at 10:00 a.m., the facility's nursing consultant was asked, Should the Minimum Data Set had been transmitted for discharged for Residents #1, #2, #3 within 14 days of completion? She stated, Yes.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, record review, and interview the facility failed to ensure fingernails were regularly trimmed and filed to maintain good health and prevent potential complications for (Resident (R) #64, #16 and #37) of 23 (#5, #23, #46, #64, #24, #26, #119, #16, #30, #320, #47, #20, #36, #7, #34, #25, #55, #32, #19, #120, #43, #17, #37, and #51) sample residents who were dependent upon staff for nail care. This failed practice had the potential to affect 56 residents who were dependent upon staff for nail care, according to the list provided by the Administrator on 07/16/2020 at 03:22 PM. The findings are: The facility failed to ensure oral care was regularly provided to maintain good hygiene for 1 (Resident #20) of 8 (Residents #20, #65, #6, #58, #37, #43, #28, and #25) sample residents who were dependent for assistance with oral care. This failed practice had the potential to affect 23 residents who resided in the facility and required assistance with personal hygiene, according to a list provided by the Nurse Consultant on 7/17/2020. The findings are: 1. Resident #64 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD)pf 06/23/2020 documented the resident was moderately impaired in cognitive skills for daily decision making skills per a Staff Assessment of Mental Status (SAMS); and required extensive assistance of one person for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. a. On 7/13/2020 at12:38 PM, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Nurse Consultant came into the resident's room. The Nurse Consultant was asked, Who trims residents' nails? She stated, Normally we have a podiatrist that come out but since COVID 19 they haven't been coming. She was asked, Should the Resident nails still be cleaned and trimmed by the staff? She stated, The Certified Nursing Assistant (CNA's) should be trimming and cleaning fingernails and toenails if the resident is a not a diabetic. b. On 07/14/2020 at 01:38 PM, record review of the resident Care Plan documented, Resident is total dependent. related to (r/t) missing limb of left arm above elbow left sided weakness stroke Date Initiated: 08/01/2016 c. On 7/13/2020 at 03:37 PM, the DON was asked, Who is responsible for trimming the resident's nails? She stated, The shower team when they give showers if the resident is not diabetic. If the resident is diabetic the licensed nurse is responsible for nail care and as needed if the nurse or the CNA see a problem as long as they are not diabetic the. The CNA can trim the resident's nails. d. On 07/16/2020 at 10:55 AM, the resident was sitting in his wheelchair in his room. His left arm was missing, and his right hand was resting in his lap. His right hand and arm had multiple darkened [MEDICAL CONDITION] on it. The resident's right hand was contracted. The resident's wife was sitting beside him and she was asked to lift the resident's arm so the surveyor could observe the resident's hand. His wife lifted his hand and the surveyor observed the resident's fingers were contracted into the palm of his hand with long thick fingernails that measured approximately 3 centimeters (cm) long embedded into his hand. The first digit of his ring finger was hanging down. There was a black substance underneath his fingers, in his palm, between the thumb, and the first finger, and had a foul odor. A photograph of the resident's right hand was taken at this time. e. On 07/16/2020 at 09:05 AM, the last 3 months of the Intervention / Task sheets were provided by the DON on 07/13/20 at 04:03 PM and reviewed. The resident refused bath / shower on 04/07/2020, 04/14/2020, and 04/18/2020. Refused bath/shower 05/12/2020 and 05/26/2020. Refused bath 06/02/2020, 0617/2020 and 06/30/2020. There was no documentation of resident refusing nail care. f. On 07/17/2020 at 10:46 AM, a form titled Care of Fingernails/Toenails provided by the Administrator on 07/13/2020 at 03:17 PM documented: PURPOSE: The purpose of the procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections . GENERAL GUIDELINES: 1. Nail care included daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her self. 5. Watch for and report any changes in color of the skin around the nail bed, blueness of the nails, any signs or poor circulation and swelling or bleeding. 6. STOP and report to the nurse supervisor if there is evidence of ingrown nails, infection, pain or if nails are too hard or to thick to cut with ease. REPORTING: Notify the supervisor if the resident refuses the care. 2 Report other information in accordance with facility policy and professional standards of practice. g. On 07/17/2020 at 10:57 AM, the Registered Nurse Consultant provided a statement that documented, No policy on diabetic nail care. Nurses are responsible for diabetic nail care weekly. 2. Resident #20 had a [DIAGNOSES REDACTED]. a. Plan of Care with a revised dated 4/20/2020 documented the resident needed assist with 1 staff for oral care. b. On 07/13/2020 at 12:17 PM, Resident # 20's lips were dry and cracked. Residents #1's teeth were corroded with a light yellowish substances, on the upper and lower teeth. c. On 07/14/2020 at 10:07 AM, Resident #20's lips remained dry. d. On 07/16/2020 at 03:05 PM, Registered Nurse (RN) #1 was asked, How often is mouth care for Resident # 20 provided? RN #1 stated, Every shift. A photograph that was taken Monday was shown to RN #1. RN #1 was asked, What do you see in the picture? RN #1 stated, Looks like she hasn't had mouth care done in a while. RN #1 was asked, Would you say mouth care had been done or not? RN #1 stated, I looked at her mouth and I couldn't tell that mouth care had been done at all. So I have to say no, resident has not been receiving mouth care? 3. Resident #16 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 04/24/2020 documented the resident scored 11 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required limited assistance of one person physical assistance for dressing, and extensive assistance of one person physical assistance for bed mobility, transfers, personal hygiene, and total dependence on bathing. a. The Care Plan dated 06/30/2020 documented, The resident has an ADL (activities of daily living) self-care performance deficit r/t (related 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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) dementia and ataxia . The resident will maintain current level of function in ADLs through the review date. PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on (1) staff for personal hygiene . b. On 07/13/2020 at 11:50 AM, R #16 was seated in a wheelchair in his room. The resident's fingernails extended past the fingertips on both hands and were approximately 1/4 inch long and were jagged. c. On 07/13/2020 at 2:15 PM, the resident was asked if he preferred his nails this length. The resident stated, No. They need cut. A photograph was taken of the residents' fingernails at this time. 4. Resident #37 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 05/29/2020 documented the resident scored 10 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status; and required limited assistance of one person physical assistance for dressing, extensive assistance of one person physical assistance for bed mobility and transfers, extensive assistance of two person physical assistance personal hygiene, and total dependence on bathing. a. The Care Plan dated 04/29/2020 documented, The resident has an ADL (Activities of Daily Living) self-care performance deficit .BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse . The resident has potential impairment to skin integrity r/t (related to) fragile skin . Keep fingernails short . b. On 07/13/2020 at 11:36 AM, R #37's fingernails were extended past the fingertips, had sharp corners, and had a brown substance under them on both hands. The left index fingernail was jagged. c. On 07/14/2020 at 10:36 AM, R #37 stated she had a shower this morning. The fingernails were cleaner. There was no indication that the resident's fingernails had been trimmed or filed. The fingernails had sharp corners with the left index fingernail jagged. R #37 stated, They need some work. A photograph of the resident's fingernails were taken at this time. 5. On 07/16/2020 at 9:10 AM, Certified Nursing Assistant (CNA #6) was asked, Who was responsible for diabetic nail care? CNA #6 stated, We are. Depends if they are diabetic. If they're not, we do every other day, or the nurse does if they're diabetic. 6. On 07/16/2020 at 9:15 AM, Certified Nursing Assistant #3 was asked, Who is responsible for diabetic nailcare? CNA 3 stated, They're cut on shower days by the shower team. Unless they're a diabetic, then the CNA 3 is not allowed, then the nurse does it. 7. On 07/16/2020 at 9:30 AM, Licensed Practical Nurse (LPN #2), the Treatment nurse, Was asked who is responsible for diabetic nail care? LPN #2 stated, The Treatment nurse or a nurse. LPN 2 was asked how fingernails should be trimmed? LPN 2 stated, They should be trimmed and filed. No points because they could scratch. The nurse was shown the photo of R #16's fingernails from 07/13/2020 and was asked if R #16's fingernails had points or needed nailcare? The nurse stated, They need trimming and filing. 8. On 07/16/2020 at 9:50 AM, LPN #1 was asked, Who is responsible for diabetic nailcare? LPN #1 stated, The Treatment nurse .but nurses can if they're diabetic. The LPN #1 was asked how groomed nails should look. LPN #1 stated, Short, clean. No shaggy edges. LPN #1 was shown the photo of R #16's fingernails from 07/13/2020 and was asked if R #16's fingernails were short and free of jagged edges? LPN #1 stated, They need to be trimmed and filed.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure nail care was provided on a consistent basis, an assessment was completed and the physician was consulted so treatment could be promptly initiated to prevent further skin deterioration of the hand due to hand contractures and long fingernails pressing into the hand for 1 (Resident #64) of 7 (Residents #21, #47, #30, #64, #25, #320, and #20) sampled residents who had contractures and was dependent on staff for nail care. These failed practices caused actual harm to Resident #64 who had deterioration of range of motion and development of necrotic tissue and had the potential to affect 11 residents who had contractures and were dependent on staff for nail care according to a list provided by the Administrator on 07/16/2020 at 12:16 p.m. The findings are: 1. Resident #64 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD)pf 06/23/2020 documented the resident was moderately impaired in cognitive skills for daily decision making skills per a Staff Assessment of Mental Status (SAMS); and required extensive assistance of one person for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. a. On 07/14/2020 at 01:38 PM, record review of the residents Plan of Care documented, Resident is total dependent. related to (r/t) missing limb of left arm above elbow left sided weakness stroke Date Initiated: 08/01/2016 b. On 07/16/2020 at 10:55 AM, the resident was sitting in his wheelchair in his room. His left arm was missing, and his right hand was resting in his lap. His right hand and arm had multiple darkened [MEDICAL CONDITION] on it. The resident's right hand was contracted. The resident's wife was sitting beside him and she was asked to lift the resident's arm so the surveyor could observe the resident's hand. His wife lifted his hand and the surveyor observed the resident's fingers were contracted into the palm of his hand with long thick fingernails that measured approximately 3 centimeters (cm) long embedded into his hand. The first digit of his ring finger was hanging down. There was a black substance underneath his fingers, in his palm, between the thumb, and the first finger, and had a foul odor. A photograph of the resident's right hand was taken at this time. c. On 7/16/2020 at12:38 PM, the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the Nurse Consultant came into the resident's room. The Nurse Consultant was asked, Who trims resident's nails? She stated, Normally we have a podiatrist that comes out but since COVID 19 they haven't been coming. She was asked, Should the resident's nails still be cleaned and trimmed by the staff? She stated, The Certified Nursing Assistant (CNA's) should be trimming and cleaning fingernails and toenails if the resident is a not a diabetic. d. On 7/16/2020 at 03:37 PM, the DON was asked, Who is responsible for trimming the resident's nails? She stated, The shower team when they give showers if the resident is not diabetic. If the resident is diabetic the licensed nurse is responsible for nail care and as needed if the nurse or the CNA see a problem as long as they are not diabetic the. The CNA can trim the resident's nails. e. On 07/16/2020 at 09:05 AM, the last 3 months of the Intervention / Task sheets were provided by the DON on 07/13/20 at 04:03 PM and reviewed. The resident refused bath / shower on 04/07/2020, 04/14/2020, and 04/18/2020. Refused bath/shower 05/12/2020 and 05/26/2020. Refused bath 06/02/2020, 0617/2020 and 06/30/2020. There was no documentation of resident refusing nail care. f. On 07/16/2020 at 09:15 AM, the Nurse Consultant was asked, Do you have a policy for body audits? She stated, I'm not sure but I will check and see. g. On 07/16/2020 at 10:33 AM, the Administrator returned with a statement that documented, No policy on body audits. Body Audits are completed on admission and weekly by treatment nurse or designee using weekly assessment with skin audit UDA. h. On 07/16/2020 at 10:37 AM, the Nurse Consultant was asked, Is there any other documentation regarding this resident's right hand condition, assessment or care since 07/23/19? She stated, I don't think so, but I will check again to make sure. The Nurse Consultant was asked, Are the nurses trained to do Body audits and assessments? She stated, I can tell you we had a change in treatment nurse on 06/24/20 and the one we have now has been doing it for 2 weeks. We do have a check off for the treatment nurse, but it hasn't been done on the current treatment nurse LPN #2 yet. The Nurse Consultant was asked, What should the treatment nurse assess when he/she does a body audit? She stated, They should do a head to toe assessment and document it. i. On 07/17/2020 at 10:46 AM, a form titled Care of Fingernails/Toenails provided by the Administrator on 07/13/2020 at 03:17 PM documented: PURPOSE: The purpose of the procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections . GENERAL GUIDELINES: 1. Nail care included daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her self. 5. Watch for and report any changes in color of the skin around the nail bed, blueness of the nails, any signs or poor circulation . and swelling or bleeding. 6. STOP and report to the nurse supervisor if there is evidence of ingrown nails, infection, pain or if nails are too hard or to thick to cut with ease. .REPORTING: Notify the supervisor if the resident refuses the care. 2 Report other information in accordance with facility policy and professional standards of practice . j. On 07/17/2020 at 10:57 AM, the Registered Nurse Consultant provided a statement that documented, No policy on diabetic nail care. Nurses are responsible for diabetic nail care weekly. k. On 7/17/2020 at 12:16 PM, Certified Nursing Assistant (CNA) #1 was asked, Can you tell me about Resident #64's right arm? She stated, He has little scabs on the back of his arm and he's a 2-person transfer, I think. CNA #1 was asked, Have you observed any problem with his right hand? She stated, I have never bathed him, and I have never looked inside his right hand. l. On 7/17/2020 at 12:25 PM, the Nurse Consultant was asked to look at this resident's right hand. She entered room, put on gloves, and the resident's wife assisted her to look at his hand. She was asked, Were you aware of the condition of this resident's right hand? She stated, No. I wasn't aware. I'm going to get the DON to come in and look at his hand also. The Nurse Practitioner is going to be here today, so we are going to have her look at him to get more guidance on what we need to do. m. On 7/17/2020 at 12:29 PM, Licensed Practical Nurse (LPN) #1 was asked, Can you tell me about (R #64's) right arm and hand? She stated, I think he

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) had a stroke and he have some type of [MEDICAL CONDITION] that's why he has all those [MEDICAL CONDITION]. LPN #1 was asked, Have you observed any problem with his right hand? She stated, No. I haven't. n. On 7/17/2020 at 12:33 PM, the DON and the Nurse Consultant returned to the resident's room. The DON was asked, Were you aware of the condition of (R #64's) right hand? She stated, No. I was just informed by The Nurse Consultant. She was asked, Should the CNA's have reported this to you? She stated, Yes. If they should have. o. On 7/17/2020 at12:36 PM, LPN #1 was asked, Who is responsible for doing nail care? She stated, The treatment nurse/ADON is doing resident nail care. p. On 7/17/2020 at 12:38 p.m., the DON, the ADON, and the Nurse Consultant came into the R #64's room. The Nurse Consultant was asked, Who trims residents' nails? She stated, Normally we have a podiatrist that come out but since COVID-19 they haven't been coming. The Nurse Consultant was asked, Should Resident nails still be cleaned and trimmed by the staff? She stated, The CNA should be trimming and cleaning fingernails and toenails on bath days and as needed. If they are not a diabetic. The DON was asked to remove the resident's shoes and socks so the surveyor could observe the resident's toenails. A photograph of the resident's feet and toenails were taken at this time. The resident's toenails were thick, long, and jagged with dry flaky debris on them. The DON was asked, Does this resident need foot care done, and toenails trimmed? She stated, Yes. He need foot care done and definitely need his toenails trimmed. We are going to try and get him an appointment with the podiatrist as soon as possible. The Consultant asked for some soap and water and gauze to clean resident's hand. She attempted to clean between the right thumb and the hand but was only able to get the gauze between it. The Nurse Consultant was unable to clean the palm due to contractures. She said she was afraid to mess with it much because what appeared to be the first digit of his ring finger was hanging. q. On 7/17/2020 at 01:26 PM, CNA #2 was asked, Can you tell me about Resident 64's right hand? She stated, He has sores on his arm, and they put medicine on them. CNA #2 was asked, Have you observed any problem with his right hand? She stated, No. I never open his hand or looked in it. No one ever said anything about him having a problem with it. He is total care. We have a shower team that bathes him. r. On 7/17/2020 at 01:28 p.m., the DON was asked, Should the CNAs have reported the condition of the resident's hands to you? She stated, Yes. They should have reported the condition in normal situations. But they didn't know about it. He refuses his bath also. The resident refuses all lab and diagnostic tests except for Chest X-rays. s. On 7/17/2020 at 02:35 PM, LPN #2 (the ADON) was asked, Have you done a body audit on (R #64)? He stated, Our wound care nurse quit about two weeks ago. This is my 2nd week for treatments and doing the body audits. I'm not sure if I have done an audit on this resident. I have done so many and they do some on the weekend also, so his may have been done on the weekend. I've been trying to get things in order and doing catch up. Sometimes I will go into the shower with the CNAs and I tell them if they notice anything abnormal to come and get me. He was asked, Were you aware of the condition of R #64's right hand? He stated, No. I wasn't because all of his cream is topical, the majority of the time he has his hand in his lap and doesn't want me to move it. I didn't think there was anything underneath his hand to be concerned about. He was asked, If you were doing a body audit would you look at his hand and his entire body? He stated, Yes. I would in a normal situation; but he doesn't want anyone to mess with his hand. t. On 7/17/2020 at 02:40 PM, CNA #4 was asked, Can you tell me about (R #64's) right hand? She stated, I know he has a problem with [MEDICAL CONDITION]. CNA #4 was asked, Have you observed any problem with his right hand? She stated, No. I haven't because I usually work on the 500 and 600 Halls and I have never showered him. u. On 7/17/2020 at 02:47 p.m., CNA #3 was asked, When did the resident have his last shower? CNA #3 stated, He refuses his showers due to his [MEDICAL CONDITION]. I usually just wash his peri area on Tuesday, Thursday, and Saturday. I wasn't here on Saturday; but I did wash his peri area when I got him up this morning. We always ask if he wants a shower when we shower his wife, even though we know he is going to refuse. But we do let the charge nurse know he refused. v. On 7/17/2020 at 02:50 p.m., the DON was asked who does the body audits? She stated, The treatment nurse/ADON does the body audits. Our treatment nurse quit about 2 weeks ago so the ADON does all the treatments and body audits now. w. On 7/17/2020 at 03:10 p.m., record review of the Nursing Weekly Assessments/Note with Skin Audit other, documented last audit 07/10/20 (2). Current skin issue assessment summary no skin issues noted. Signed by LPN #2 the treatment nurse. x. On 7/17/2020 at 05:16 PM, the resident's wife was asked, Were you aware of the condition of R #64's hand? She stated, His hand has been contracted for a long time and I still don't know what it looks like on the inside because I can't see it. He hasn't had a good shower or bath in years. I can't see in his hand. Can you show the picture you took of his hand. The surveyor showed the resident's wife a picture of the resident's hand. She stated, No. I did not know his hand was this bad. They don't do a lot for him. I mostly take care of him. My son and I are trying to get us moved out of here and into another facility. The ADON entered the resident's room. He was asked to perform a full body audit on resident. He stated, I did a body audit about an hour ago, but I will do another one if you want me too. He then stated, Okay let me go get some help. y. On 7/17/2020 at 05:25 PM, the ADON returned to the room with the DON and CNA #5. CNA #5 assisted the resident from his wheelchair into bed. The resident was very cooperative and pleasant and was transferred to his bed without any resistant. The resident's clothes were removed, and a complete body audit was done. The resident had dry, patchy, dark, [MEDICAL CONDITION] on his right arm, the back of his hand, chest area, on his forehead, on the top of both ears, on his hairline, and behind both of his ears. The ADON went to get a dressing to go on the area and he returned with hydrogel and Mepalex dressing. He cleansed the buttocks area with wound cleanser and applied dressing. The ADON was asked, Have you been trained on treatments and body audits? He stated, Yes. I started in 1980 when I was in the military. I've done skin assessments and would care at other facilities also. So, I've had over [AGE] years of wound care experience. I've only been doing the wound care here for 2 weeks.
F 0687 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate foot care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure foot care was provided to prevent potential complications for (Resident (R) #64, #16 and #37) of 23 (#5, #23, #46, #64, #24, #26, #119, #16, #30, #320, #47, #20, #36, #7, #34, #25, #55, #32, #19, #120, #43, #17, #37, and #51) sample residents who were dependent upon staff for nail care. This failed practice had the potential to affect 56 residents in the facility who were dependent upon staff for nail care, according to the list provided by the Administrator on 07/16/2020 at 03:22 PM. The findings are: 1. Resident #64 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD)pf 06/23/2020 documented the resident was moderately impaired in cognitive skills for daily decision making skills per a Staff Assessment of Mental Status (SAMS); and required extensive assistance of one person for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. a. On 7/13/2020 at12:38 PM, the Director of Nursing (DON), the ADON, and the Nurse Consultant came into the resident's room. The Nurse Consultant was asked, Who trims resident's nails? She stated, Normally we have a podiatrist that come out but since COVID-19 they haven't been coming. She was asked, Should resident's nails still be cleaned and trimmed by the staff? She stated, The Certified Nursing Assistant (CNA) should be trimming and cleaning fingernails and toenails on bath days and as needed. If they are not a diabetic. The DON was asked to remove the resident's shoes and socks so the surveyor could observe the resident's toenails. A photograph of the resident's feet and toenails were taken at this time. The resident toenails were thick, long, and jagged with dry flaky debris on them. The DON was asked, Does this resident need foot care done, and toenails trimmed? She stated, Yes. He needs foot care done and definitely need his toenails trimmed. We are going to try and get him an appointment with the podiatrist as soon as possible. b. On 7/13/2020 at 01:26 PM, CNA #2 was asked, Who is responsible for trimming residents' toenails? She stated, The CNAs can trim them if the resident is not a diabetic and the nails are not too thick. c. On 7/13/2020 at 03:37 PM, the DON was asked who is responsible for foot care/trimming and cleaning toenails? She stated, The shower team should be cleaning and trimming the resident's nails when they give showers if the resident is not diabetic. If the resident is diabetic the nurse is responsible for nail care and as needed if the nurse or the CNA see a problem as long as they are not diabetic. d. On 07/17/2020 at 10:46 AM, a form titled Care of Fingernails/Toenails provided by the Administrator on 07/13/2020 at 03:17 PM documented: PURPOSE: The purpose of the procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections . GENERAL GUIDELINES: 1. Nail care included daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or herself. 5. Watch for and report any changes in color of the skin around the nail bed, blueness of the nails, any signs or poor circulation cracking of the skin between the toes, and swelling or bleeding. 6. STOP and report to the nurse supervisor if there is evidence of ingrown nails, infection, pain or if nails are too hard or too thick to cut with ease. REPORTING: Notify the supervisor if the resident refuses the care. 2 Report other information in accordance with facility policy and professional standards of practice.

F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate**

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview the facility failed to ensure a sign was placed to warn of a wet bathroom floor to prevent a fall for 1 of 1 (Resident (R) #21) of 1 resident who fell due to a wet floor. This failed practice had the potential to affect 1 residents who fell due to a wet floor, according to a list provided by the Nurse Consultant on 07/16/2020. The findings are: The facility failed to ensure the resident's environment was free of accident / hazards as as evidence by leaving open [MEDICATION NAME] on a residents (Resident #47) bedside table. This failed practice had the potential to affect 46 residents who are incontinent and require [MEDICATION NAME] as documented on list provided by the Administrator on 7/17/2020 at 3:06pm. 1. Resident #21 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 4/23/2020 documented the resident scored 15 (13 - 15 indicates cognitive intact) on a Brief Interview for Mental Status (BIMS); and required limited physical assist of one person with most Activities of Daily Living (ADLs). a. The Plan of Care dated 6/30/2020 documented, .Resident had fall with no injury (7/8/20) .Interventions: (1) continue at risk interventions (initiated 7/9/20) (2) resident will receive therapy consult (7/9/20) (3) staff will ensure floors are dried and make resident aware if wet (7/9/20) . b. An Incident/Accident (I/A) Progress Note provided by the Nurse Consultant was reviewed and documented, .7/8/2020 1900 (7:00 p.m.) . Resident approached nurse and said I slid earlier in the bathroom .The staff helped me up .Nurse assessed resident .No injuries or bruises noted .Resident stated I slid out of my wheelchair on my but (butt) into the floor in the bathroom. The floor was wet from when the housekeeper cleaned it. There was water on the floor .Immediate Intervention: dried floor. Educated resident to ensure bathroom floor is dry before entering .Author: (DON (Director of Nursing)) . c. On 07/16/2020 at 10:51 AM, R #21 was asked, Can you tell me about the fall you had in your bathroom not too long ago? She stated, They had mopped the floor and it was still wet and damp and I fell , but I wasn't hurt. She was asked, How did you get up? She stated, Some of the Certified Nurses Assistants (CNAs) helped me. It was a lot of them. She was asked, Did you see a yellow wet floor sign at the bathroom door or anywhere near? She stated, No. I didn't see no yellow sign. I wouldn't have went in there if I saw a sign. d. On 07/16/20 at 3:36 PM, Certified Nursing Assistant (CNA) #5 was asked, Do you recall assisting R #21 after she fell in her bathroom on 7/8/2020? She stated, Yes. She said it wasn't a fall. She slid out of the chair. CNA #5 was asked, Do you have knowledge of the resident sliding out of her chair any time in the past? She stated, No. CNA #5 was asked, When were you trained to report a resident falling or being found on the floor? She stated, Immediately. But the nurse was on that COVID unit. CNA #5 was asked, Do you have access to a phone or the intercom system? She stated, Yes 'mam. CNA #5 was asked, Could you have reached her by these means? She stated, Yes. I probably could have. CNA #5 was asked, Was the floor in the resident's room wet or damp when you got to the room? She stated, No ma'am. CNA #5 was asked, Did you see the yellow wet floor sign near or in the bathroom? She stated, No. e. On 07/16/2020 at 03:52 PM, the Housekeeping Supervisor was asked, Do you recall mopping the floor in R #21's room on 7/8/2020 before she fell ? He stated, To be honest, I don't remember. I just remember hearing on the intercom that they needed help in that room because someone had fell . He was asked, Did you go in after the incident to dry the floor? He stated, No. I didn't. He was asked, Do you know who dried the floor? He stated, No. I don't Know. He was asked, Should a yellow wet sign be placed in the bathroom doorway if the bathroom floor is wet? He stated, Yes. We were just putting them in the door (way) to the room, but since that happened, we are putting them in the door (way) to the bathroom now. f. On 07/17/2020 at 08:15 AM, the DON was asked, Who is responsible for ensuring a safe environment for the resident? She stated, All staff. The DON was asked, Should a wet floor sign be placed where-ever there's a wet floor? She stated, Yes. The DON was asked, When is staff trained to report a fall or a resident being found on the floor? She stated, Immediately. She was asked, Why was R #21's fall not reported by the CNAs? She stated, I asked them, and they said they were waiting for me to come out of the COVID Unit. I was actually the nurse that evening, and I was passing meds (medications) on the COVID unit when it happened. I told them going forward, they need to let me know immediately when a resident is observed on the floor. I told them they could have paged me, and I would have stopped what I was doing and come immediately. g. On 07/17/2020 at 08:31 AM, the Nurse Consultant was asked, Who is responsible for ensuring a safe environment for the resident? She stated, Everybody. She was asked, Should a wet floor sign be placed where-ever there's a wet floor? She stated, Yes. She was asked, When is staff trained to report a fall or a resident being found on the floor? She stated, Immediately. h. On 07/17/2020 at 08:42 AM, the Administrator was asked, Who is responsible for ensuring a safe environment for the resident? She stated, All staff. She was asked, Should a wet floor sign be placed where-ever there's a wet floor? She stated, Yes. She was asked, When is staff trained to report a fall or a resident being found on the floor? She stated, Immediately. i. On 07/16/2020 at 10:02 AM, an in-service titled SAFE WORK PRACTICES INSERVICE provided by the Administrator documented, . Date: 7/9/20 .Given by District Manager .Location: Harris Healthcare-Due to Rm. 206B Fall .Purpose: To review Slip/Trip & Fall Prevention . (b) General Housekeeping Procedures: Do not leave floors wet after cleaning-clean them to a completely dry finish if possible. If (clean to dry) is not possible . use barriers and (wet floor) warning signs to keep people off the wet area, especially when mopping . The in-service bore the signature of all the Housekeeping staff. i. On 07/17/2020 at 09:47 AM, a form titled Falls Policy provided by the Administrator documented, .Policy Statement .the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling .Fall Risk Factors: 1. Environmental factors that contribute to the risk of falls include: a. wet floors . 2. Resident #47 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 6/4/2020 documented the resident scored 9 (8-12 indicated moderately impaired) on Brief Interview for Mental Status (BIMS); and required extensive assist for bed mobility, personal hygiene, transfers, dressing, toileting; was independent with locomotion; frequently incontinent of bladder and bowel. a. On 7/13/2020 at 11:00 a.m., a [MEDICATION NAME] packet was open and laying on the bedside table. The Resident was not in the room at this time. A photograph of the open [MEDICATION NAME] packet was taken at this time. b. On 07/14/2020 at 01:58 PM, there was an open [MEDICATION NAME] packet on the bedside table. c. On 07/14/2020 at 01:59 PM, Licensed Practical Nurse (LPN) #2, was asked, What is this and should it be on the table? LPN #2 stated, It is used for when the Certified Nursing Assistant (CNA) changes the resident. It should be in his bag in the bedside table. Normally, the CNA's can go get more when they need it. But it should be put in their bag in the table.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure nectar thicken fluids were accessibly available and stored in a resident's room for 1 of 1 (Resident #19) sampled resident that was dependent on staff for hydration. This failed practice had the potential to affect 18 residents who were dependent on staff for hydration, according to a list provided by the Administrator on 7/20/2020. The findings are: Resident #19 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 5/14/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment of Mental Status (SAMS); and was total care with Activities of Daily Living (ADL)'s. a. The Plan of Care dated 4/29/2020 documented .The resident has dehydration or potential fluid deficit; Ensure The resident has access to fluids and offer drinks during rounds, meals, and snacks . b. Physician orders [REDACTED]. Hi-Cal with meals for weight loss give 240ml (milliliters) PO TID (daily three times a day) with meals; Regular-Enhanced diet, Pureed texture, Thick fluids-Nectar consistency . c. On 07/13/2020 at 12:18 PM, Resident #19 was sitting up in her Geri chair pulling her clothes off yelling I want a drink of water. d. On 07/13/2020 at 12:20 PM, Restorative Aide #1 came to resident's room after the surveyor pushed the resident's call light. Restorative Aid #1 knocked and announced. Restorative Aid #1 asked the resident if she needed anything and resident yelled out I need water. The Restorative Aid looked in the resident's refrigerator and stated, She is on thicken liquids and there is no water or anything for her to drink in her refrigerator. Restorative Aid #1 was asked, Should there have been thicken liquids available in the room for the resident? Restorative Aid #1 stated, Yes. I will have to go to dietary and get her some. Restorative Aid #1 was asked, How often is resident offered fluids? Restorative Aid #1 stated, They are supposed to be offered every hour. Restorative Aid #1 was asked, Do you know when the last time she was offered a drink of water? Restorative Aid #1 stated, No. I have no idea. e. On 07/15/2020 at 10:16 AM, Licensed Practical Nurse (LPN) #1 was asked, Should a resident on thickened liquids dependent on staff for assist have thickened liquids available in the room? LPN #1

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F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) stated, Yes. Liquids should always be available. f. On 07/16/2020 at 03:57 PM, Registered Nurse (RN) 1 was asked, If a resident is on thicken liquids, should the thickened liquids be accessible in resident's room? RN #1 stated, Yes. They should be in a container with ice or a cooler with ice in the resident's room. RN #1 was asked, Should they be placed in a resident's refrigerator? RN #1 stated, No. But I guess if the other options weren't available then that would be the only time they would be in refrigerator. e. On 7/16/2020 at 12:26 PM, the Nurse Consultant provided a form titled Resident Hydration and Prevention of Dehydration that documented .This facility will endeavor to provide adequate hydration and to prevent and treat dehydration; .Nurses' Aides will provide and encourage intake of fluids on a daily and routine basis as part of daily care report intake of less that 1200 milliliters (ML)/day to nursing staff .
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the observation, record review, and interview the facility failed to ensure physician orders [REDACTED].#68) of 1 sample resident who had physician orders [REDACTED]. The failed practice had the potential to affect 9 residents who had physician orders [REDACTED]. The findings are: Resident #1 had a [DIAGNOSES REDACTED]. a. A physician's orders [REDACTED].Inject as per sliding scale .subcutaneously before meals and at bedtime . For blood sugar 251-300, the resident was to receive 4 units of [MEDICATION NAME]. For blood sugar 310-350, the resident was to receive 6 units of [MEDICATION NAME]. b. On 7/15/2020 at 12:18 p.m., Licensed Practical Nurse (LPN) #1 stated, Her blood sugar was 321 so she will get 6 units of [MEDICATION NAME]. LPN #1 opened the medication cart and searched for resident's [MEDICATION NAME]. LPN #1 stated, I need to go to the other nurse's station because her [MEDICATION NAME] is not in this cart. c. On 7/15/2020 at 12:35 p.m., LPN #1 returned to the medication cart and stated, The pharmacy was called, and they did not get our fax for the refill. The Nurse Consultant is going to pick up the medication now at (pharmacy). d. On 7/15/2020 at 1:16 p.m., LPN #1 received the medication from the Nurse Consultant. e. On 7/15/2020 at 1:19 p.m., LPN #1 rechecked the resident's blood sugar. The resident's blood sugar was 263. LPN #1 stated, Resident will get 4 units of [MEDICATION NAME]. f. On 7/15/2020 at 1:27 p.m., LPN #1 gave the resident 4 Units of [MEDICATION NAME] in the left upper arm subcutaneously. g. This was a significant medication error due to the type of medication (Diabetic) and condition of the resident.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on observation, record review, and interview the facility failed to ensure medication boxes were locked and secured in accordance with facility policy of stored medications in 1 of 2 medication rooms. This failed practice had the potential to affect 68 residents who reside in the facility according to the Resident Census and Conditions of Residents form provided by the Director of Nursing (DON) on 7/13/2020. The findings are: On 7/15/2020 at 10:49 a.m., this Surveyor along with the Director of Nursing toured the medication storage room on nursing station 1. There were two boxes that looked like tackle boxes that were stored with medications. They did not have locks and they were opened. Green box #1 had sticker on top of it that documented, IV (Intravenous) Start Kit and Supplies was open with no secure lock/tag in place. The DON was asked, What is this box used for? The DON stated, It is used for starting new IV's and has fluids in it for when we need to start fluids on residents. We are trying to start an IV in a room right now, is why the box is open. Tan box #2 closed with no securing lock/tag in place. There was a list of medications attached to handle of the tan box. The DON was asked, What medications are in that box? The DON stated, Emergency back-up supply and antibiotics. The DON was asked, Should the boxes be left opened? The DON stated, No. They should be closed. The DON was asked, Should there be a lock/tag on the boxes after medications are removed from the box? The DON stated, Yes. You should always put one of those green tags on the box after medication is removed. I will put one on there now. a. On 7/15/2020 at 10:56 a.m., the DON asked Licensed Practical Nurse (LPN) #3 to come into the medication room. LPN #3 was asked, What is the process of receiving medications in the tackle boxes from pharmacy and removing medications in the box? LPN #3 stated, We log the tag number of the box that is received from pharmacy into the ER book. Once we remove a medication from the box, we write medication in the ER (Emergency) book and fax it to the pharmacy for a replace. Then the person removing medication should put a new lock/tag on the box. b. The policy and procedure for the storage of medication provided by the Nurse Consultant was on 7/16/2020 at 12:26 p.m., documented, 1. .The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. 2. .Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others .
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation record review, and interview the facility failed to ensure the planned menu was followed to meet the nutritional needs of the residents. This failed practice has the potential to affect 70 residents who receive meals from the kitchen according to a list provided by the Dietary Consultant on 7/15/2020 at 8:35 p.m. The findings are: 1. On 07/13/2020 at the noon meal, the menu called for chocolate cake. At 1:15 p.m., in the main dining room, the residents were served mandarin oranges instead of chocolate cake. At 1:30 p.m., the Dietary Manager was asked, Why wasn't chocolate cake served? He stated, I don't know. Dietary employee #1 spoke up and stated, That was my fault. I overlooked it. Where it said margarine, I thought it said mandarin oranges.
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 and interview the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent the potential for foodborne illness. The failed practice has the potential affect 70 residents who receive meals from the kitchen according to a list provided by the Dietary Consultant on 7/15/2020 at 8:00 a.m. The findings are: 1. On 07/14/2020 at 11:35 a.m., there were food crumbs in a drawer at the puree food station. The Dietary Manager was asked what he saw, he stated, A lot of food crumbs. 2. On 07/14/2020 at 11:35 a.m., there was a shelf above the puree station with a layer of sticky unidentified black substance on it. The Dietary Manager was asked, How would you describe this? He stated, Rusty, sticky, and black. 3. On 07/14/2020 at 11:35 a.m., near the puree station there were several different colored substances seen on the wall. The Dietary Manager was asked, What do you see? He stated, Food splatters. 4. On 07/14/2020 at 11:35 a.m., near the microwave there was a drawer with food crumbs in it and build-up of food on the rim. The Dietary Manager was asked what he saw in the drawer. He stated, Food crumbs and build up. 5. 07/14/2020 at 11: 35 a.m., above the ice machine on the wall there were fuzzy particles on the wall. The Dietary Manager was asked, What is on the wall above the ice machine? He stated, Dust.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure staff followed universal precautions to prevent the potential spread of infection/Covid-19 to residents, as evidenced by staff not sanitizing their hands while providing laundry services to the residents. This failed practice had the potential to effect 68 residents residing at the facility according to the Resident Census and Condition of Residents form provided by the DON on 7/13/2020 at 4:22 p.m. The facility failed to ensure Personal Protective Equipment (PPE) was available, accessible, and used by staff to prevent the potential of spread for infectious diseases, as evidenced by failed to ensure the facility had biohazard bins to contain contaminated bags in the laundry room. This failed practice had the potential to affect 68 residents according to the Resident Census and Conditions of Residents form provided by the DON on 7/13/2020 at 4:22 p.m. The findings are: 1. An

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) in-service dated 3/30/3030 located in the COVID-19 facility binder documented all staff were educated with a return demonstration on hand washing, donning, and doffing gloves. a. On 07/15/2020 at 12:08 PM, Laundry Employee #1 pushed a clean linen cart that had gray mesh material draped over the cart that covered residents' clean linen. Laundry Employee #1 delivered clean clothes to residents in their rooms on 500 Hall. There were hand sanitizer dispensers secured to the wall on each hall. The rooms had a hand sanitizer secured to the wall in the residents' rooms on the left as you entered their rooms. b. On 07/15/2020 at 12:14 PM, Laundry Employee #1 did not sanitize her hands upon entering resident rooms. Gloves were not being donned and doffed. She was taking resident clothes from the covered linen cart, and delivered clothes directly to the residents' closet in their rooms. She was asked, Do you sanitize your hands between rooms while delivering clean laundry to the residents? She stated, Yes. I sanitize my hands before enter and coming out of the rooms. She was asked, Did you sanitize your hands when you went from room [ROOM NUMBER]A to 503B delivering their clean clothes to them? She stated, No ma'am. She was asked, Should you have sanitized your hands before entering and exiting residents' rooms? She stated, Yes ma'am. It's crazy in laundry right now. But usually I do sanitize my hands going from room to room delivering clean laundry. I just forgot to do it. c. On 07/16/2020 at 04:00 PM, a form titled Hand washing / Hand Hygiene provided by the Nurse Consultant documented, This facility considers hand hygiene the primary means to prevent the spread of infections. d. On 07/17/2020 at 01:08 PM, the DON was asked, When laundry is being delivered to residents' room, when should staff sanitize their hands? The DON stated, Between residents. e. On 07/17/2020 at 01:15 PM, the Administrator was asked, When laundry is being delivered to residents' room, when should staff sanitize their hands? The Administrator stated, In-between residents, and it should be on our policy and procedure for sanitizing hands. 2. On 07/14/2020 at 3:36 p.m., the Housekeeping Supervisor was asked, How do you dispose of the used contaminated yellow bags? He stated, I put it in the trash over there. He was asked, The grey one without a lid? He stated Yes. 3. On 07/14/2020 at 3:36 p.m., the Housekeeping Supervisor was asked, Do you have a biohazard trash can? He stated, No. 4. On 07/14/2020 at 3:36 p.m., the Housekeeping Supervisor was asked, What personal protective equipment (PPE) do you use when handling contaminated laundry? He stated, I don't really know. We have our face mask. He was asked, Do you have face shields or gowns? He stated, No. 5. 0n 07/14/2020 at 5:09 p.m., the District Manager of the Health Services Group who oversees the facility's housekeeping and laundry services was asked, Do the laundry staff have PPE to handle contaminated linen? He stated, It was back there hidden. He was asked, Where was it hidden? He stated, On the clean side in a box. When asked if the PPE was ever out and available the manager answered, Yes. Now it is in the chemical closet close to the washer, across from the sink. He was asked, What do they do with the used contaminated bag after putting contents into the washer? He stated, I know I need to get a bio bin set up back there, a box with a red bag. I will do that as soon as I get up from here.