STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265682	A. BUILDING _____ B. WING _____	06/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
INDEPENDENCE MANOR CARE CENTER	**1600 SOUTH KINGSHIGHWAY INDEPENDENCE, MO 64055**

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 maintained infection control practices to prevent cross contamination when using personal protective equipment (PPE) during laundry services and to ensure appropriate hand sanitation and gloving while passing ice and water on the COVID-19 (a new disease caused by a novel (new) coronavirus) unit. The facility further failed to ensure proper use of PPE and hand hygiene during accuchecks and failed to ensure staff social distancing while smoking. The facility census was 53 residents. Record review of the facility COVID 19 Action Plan, dated 3/20/20, showed the primary goal was to prevent COVID-19 from being introduced into the facility. The following efforts were implemented to reduce the risk of COVID-19: -Hand hygiene (way of cleaning ones hands that substantially reduces potential harmful microorganisms on the hands) - Hand hygiene is considered a primary measure for reducing the risk of transmitting infection among residents and health care personnel. Hand hygiene procedures include the use of alcohol-based hand rubs containing 60 to 90 percent alcohol, and hand washing with soap and water. -The Infection Control Interventionist will provide education on hand hygiene, use of PPE donning (putting on) and doffing (taking off), avoiding touching eyes, nose and mouth with unwashed hands; avoiding close contact with people who are sick; maintaining social distancing when possible of six feet or greater; and reminding employees to stay home if they are experiencing fever or respiratory symptoms. -Utilization of standard precautions which are the minimum infection prevention practices that apply to all resident care, regardless of suspected or confirmed infection status of the resident in any setting where health care is delivered. -Information has been made available to staff, residents, and visitors regarding hand hygiene, cough etiquette and Covid-19 symptoms. -Hand sanitizer, facemasks, and tissues are available at the community entry and throughout the community, in addition to soap and water at all sinks. -Droplet precautions (used for diseases or germs that are spread in tiny droplets caused by coughing and sneezing) would be immediately initiated with new onset of respiratory symptoms or fever. -Standard precautions for all residents will include hand hygiene, PPE, respiratory etiquette, and disinfecting of the environment. Record review of the facility's undated Laundry Process for COVID-19 Unit showed: -Collecting linens - only pick up at the door. They will pass the dirty clothes barrel with lid attached through the opening. -Everything is to be in a gray tied bag, then placed in a clear bag in the linen cart. -Apply PPE correctly. -Place all linen in washer. -The procedure did not show when the staff should discard PPE. 1. Observation and interview on 6/25/20 at 11:45 A.M., showed Laundry Aide A walked to the laundry room wearing full PPE (gown, gloves, facemask and face shield) from the COVID unit, while pushing the laundry barrel and deposited it in the laundry room. He/She came back out of the laundry room wearing a gown, gloves, face shield and facemask. He/She walked around in the hallway, on the non-COVID unit, performing no specific activity. Upon entry to the laundry room, there was a blue disposable gown turned inside out, laying on top of one of the laundry bins across from the trash bin. There was an uncovered face shield stored on a shelf (open to air) above the bins. Laundry Aide A said: -He/She collected and laundered the clothing and linen from all of the residents (on the COVID unit and non-COVID unit). -He/She normally wore a facemask and gloves to collect the laundry from the residents on the non-COVID unit. -When he/she collected the clothing and linen from the COVID unit, he/she had to wear a gown, facemask, face shield, and gloves. -He/She was not allowed to go onto the COVID unit, so the staff on the COVID unit would double bag the laundry from the unit and place the bags by the entrance to the unit. -He/She then reached his/her arm through the entrance to the COVID unit to get the bags and placed them in his/her laundry cart. -Once he/she gathered the laundry from the COVID unit, he/she took the laundry cart to the laundry room. -He/She doffed his/her PPE once he/she was in the laundry room, washed his/her hands, then washed the laundry. -He/She did not know whether he/she should have removed his/her PPE and discarded it at the site where he/she put on the PPE instead of removing it once he/she returned to the laundry room. -The gown laying on top of the bin was the gown he/she had just removed. -He/She then discarded his/her gown in the trash receptacle and said it was probably contaminated. During an interview on 6/25/20 at 1:00 P.M., the Housekeeping/Laundry Supervisor said: -They have had in-services on infection control, disinfecting equipment, cleaning and wearing PPE. -He/She has a monthly in-service with his/her staff to review infection control practices. -He/She expected the laundry staff to use gloves and their facemask on the non-COVID unit, but they are to use the full PPE (gown, gloves, facemask, and face shield) when they collect laundry from the COVID unit. -None of the laundry staff were allowed to go onto the COVID unit, but they were allowed to collect the soiled laundry that is double bagged and sat at the entry to the unit. -Laundry staff reach in through the entrance of the COVID unit to collect the laundry bag then put it in the laundry bin. -The PPE is at the entry to the COVID unit and staff were expected to put it on and remove it at the entry at the entry of the COVID unit before taking the laundry to the laundry room. -Once in the laundry room, they were supposed to put on new PPE (gown and gloves) prior to removing the laundry from the bin and placing it in the washer. -The face shields and facemasks were reused and they were to place them in a bag once their shift was over (labeled with the staff's name). During an interview on 6/25/20 at 3:00 P.M., with the Director of Nursing (DON) and Corporate Nurse, the Corporate Nurse said: -He/She saw Laundry Aide A walking around on the hall while wearing his/her full PPE (gown, gloves, facemask, and face shield) and informed Laundry Aide A that he/she could not walk around the facility with his/her PPE on after collecting the laundry from the COVID unit and instructed him/her to discard it. -The Laundry Aide A was not allowed to go onto the COVID unit to collect the laundry, so the staff on the unit placed the laundry in a double bag and sat it at the entry to the COVID unit. Laundry Aide A then was supposed to don full PPE (gown, gloves, facemask and face shield) and reach through the entry to get the bagged laundry and place it in his/her laundry bin. -Since his/her PPE was considered contaminated, he/she should immediately remove and discard his/her gown and gloves, then transport the laundry bin to the laundry room then put on a new gown and gloves to remove the laundry from the bin and put it into the washer. -The DON said he/she had spoken to Laundry Aide A and will re-educate him/her on maintaining infection control regarding the use of PPE and transporting the laundry. 2. Observation and interview on 6/25/20 at 2:06 P.M., on the dedicated COVID unit, showed Certified Nursing Assistant (CNA) A was in the hallway with a cart that had a container with ice. He/She was wearing a gown, gloves, facemask, and face shield. He/She was going room to room, brought the residents' cups out of their rooms to the cart (that was in the hallway) filled the cups with ice then went back into the resident's room to fill the cup with water at the sink (at the resident's request) before he/she left the room to go to the next resident's room. CNA A did not remove or discard his/her gloves and did not sanitize his/her hands before going into another resident's room. He/She continued to travel to four resident rooms bringing the resident cups out of the rooms to the cart and back without changing his/her gloves or washing/sanitizing his/her hands. CNA A said: - He/She had enough PPE to do his/her job and knew where to obtain additional supplies if he/she ran out. -He/She used a gown, gloves, facemask, and face shield on the unit and only reused his/her face shield and facemask. -When he/she was providing resident care, he/she changed his/her gloves and sanitized/washed his/her hands between every resident, but since he/she was passing ice he/she would only need to change his/her gloves and sanitize/wash his/her hands after he/she finished passing ice on the hall. -When he/she was finished passing ice, he/she would discard his/her gloves and wash his/her hands. -He/She thought it

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) was okay to bring the resident's cup outside of the room to fill it with ice. During an interview on 6/25/20 at 2:30 P.M., Licensed Practical Nurse (LPN) A said: -They have enough PPE supplies for the nursing staff to do their jobs and they did not have a shortage on gloves or handwashing supplies. -Staff should sanitize or wash their hands whenever they touch anything, especially if it belongs to a resident on the unit. -Nursing staff were expected to wash/sanitize their hands upon entering the residents room and put on gloves. -They should wash/sanitize their hands anytime they go from a clean to dirty process, anytime their hands/gloves are soiled, once they complete the resident interaction, and before leaving the resident's room. -When passing water/beverages, the staff should remove their gloves and sanitize their hands and put on a new pair of gloves after exiting each resident's room since he/she is handling the resident's beverage cup. During an interview on 6/25/20 at 3:00 P.M. with the DON and Corporate Nurse, the Corporate Nurse said: -Staff should sanitize/wash their hands and glove prior to entering a resident's room and after leaving a resident's room, especially after they handle a resident's belongings. -Staff who are passing ice and beverages should not bring the resident's cup out of the resident's room to fill it with ice, but they can use disposable cups to fill with ice and take into the resident's room on the COVID unit. 3. Record review of the facility's Cleaning and Disinfecting Blood Glucose Meters policy, dated 2019, showed: -Blood glucose monitors (glucometer) shared among residents must be cleaned and disinfected between each use. -Gloves were to be put on before performing a blood glucose test, administration of insulin, and any other procedures that involved potential exposure to blood or body fluids. -Dispose of used fingerstick devices and lancets at the point of use in an approved sharps container. Remove gloves and perform hand hygiene. Apply new gloves. -The glucometer was to be thoroughly cleaned of all visible soil or organic material (e.g., blood) before disinfection. -Hand hygiene was to be performed immediately after removal of gloves and before touching other medical supplies intended for use on another resident. -All nursing staff was to be trained in the proper procedure, protective equipment required (if any), and safety precautions. Record review of Resident #3's Significant Change Minimum Data Set (MDS - a federally mandated assessment tool required to be completed by facility staff), dated 4/6/20, showed he/she: -Was re-admitted to the facility on [DATE]. -Had a [DIAGNOSES REDACTED].M., showed LPN B: -Obtained the necessary equipment to obtain the resident's blood sugar. -Sanitized his/her hands, donned clean gloves and obtained the resident's blood sugar. -Discarded the used supplies in the room along with his/her contaminated right glove. No hand hygiene was performed. -Exited the resident's room with the contaminated glucometer in his/her left hand which remained covered with a contaminated glove. -Removed a clean glove from the box of gloves on top of the medication cart using his/her contaminated right hand. LPN B continued to wear the contaminated glove and held the contaminated glucometer in his/her left hand as he/she put the clean glove on his/her right hand. -Obtained a disinfecting wipe and wiped the glucometer with contaminated gloved hands. He/She placed the glucometer on a clean barrier to dry. -Discarded both gloves and sanitized his/her hands using alcohol-based hand rub (ABHR). Record review of Resident # 4's Quarterly MDS, dated [DATE], showed the resident: -Was re-admitted to the facility on [DATE]. -Had a [DIAGNOSES REDACTED]. Observation on 6/25/20 at 11:50 A.M., showed LPN B: -Obtained the necessary supplies for a blood sugar test. -Sanitized his/her hands, donned clean gloves and obtained the resident's blood sugar. -Discarded the used supplies in the room and removed his/her right glove. No hand hygiene was performed. -Exited the resident's room with the contaminated glucometer in his/her left hand which remained covered with a contaminated glove. -Removed a clean glove from the box of gloves on top of the medication cart using his/her contaminated right hand. LPN B continued to wear the contaminated glove and held the contaminated glucometer in his/her left hand as he/she put the clean glove on his/her right hand. -Obtained a disinfecting wipe and wiped the contaminated glucometer with contaminated gloved hands, placing it on a clean barrier to dry. -Discarded both gloves and sanitized his/her hands using ABHR. -Obtained the resident's insulin, donned gloves, then touched the contaminated computer keyboard. -Entered the resident's room without changing gloves. While wearing the same contaminated gloves, LPN B used the resident's contaminated television remote to lower the volume. -While wearing the same contaminated gloves, he/she administered the insulin in the resident's right upper arm. -He/She discarded the used supplies, removed his/her gloves, and washed his/her hands at the sink before exiting the resident's room. During an interview on 6/25/20 at 12:05 P.M., LPN B said: -Staff were to sanitize or wash their hands after removing gloves. -If gloves became contaminated before their intended use, i.e., by using the computer or touching items in a resident's room, staff should change them. -He/She should have removed both contaminated gloves and performed hand hygiene before putting on clean gloves and disinfecting the glucometer. -He/She acknowledged not doing so could result in cross-contamination. -He/She also acknowledged the gloves used during the insulin administration should have been changed as he/she had touched other surfaces prior to giving the insulin. -He/She could have put the contaminated glucometer on a barrier on top of the medication cart so he/she would have been able to remove both contaminated gloves, sanitize, then don clean gloves before disinfecting the machine. During an interview on 6/25/20 at 2:05 P.M., the DON said: -He/She expected staff to remove soiled gloves, sanitize their hands, and don clean gloves to clean a soiled glucometer. -Staff could not properly disinfect a glucometer if they continued to wear one soiled glove; staff would have to use the soiled glove to put the clean glove on the other hand thereby contaminating the clean glove. -He/She expected staff to change their gloves and perform hand hygiene if gloves had been contaminated before being used, i.e., if staff had touched the computer keyboard and/or used a resident's television remote before administering insulin. 4. Review of cdc.gov Preparing for COVID-19 in Nursing Homes showed: -Implement Social Distancing Measures --Implement aggressive social distancing measures (remaining at least 6 feet apart from others): ---Remind health care personnel (HCP) to practice social distancing and wear a facemask (for source control) when in break rooms or common areas. During an interview on 6/25/20 at 9:20 A.M., the acting Administrator said: -There were currently 37 residents on the COVID unit. -Housewide, 10 residents had passed away due to COVID-19. Seven of the ten had been receiving hospice care. -Additionally, five residents had been hospitalized . One hospitalization was not COVID-related. Three of the hospitalized residents had already been discharged . -16 residents who were negative for COVID-19 had been retested on [DATE] and they were waiting the results. --All staff wore N95 (KN95) masks at all times when in the building. -They had ample supply of personal protective equipment (PPE). -Meals were brought to the COVID Unit on separate carts. They were using paper or plastic dishware for all meals. Staff would transfer the meals from the carts outside the unit to carts inside the unit and then the carts outside the unit would be disinfected. -The same Housekeeping and Maintenance staff was assigned to the COVID unit to help prevent the possibility of cross-contamination. During an interview on 6/25/20 at 10:30 A.M., LPN B said: -Staff was supposed to wash their hands upon entering and exiting a resident's room; anytime gloves were removed; if hands were visibly soiled. Alcohol based hand rub (ABHR) could be used as long as hands were not visibly soiled. -If a resident was negative for COVID-19, staff was supposed to wear a N95 or equivalent mask and gloves when providing care. -If a resident was suspected of being positive for COVID-19, he/she would be placed in contact/droplet precautions and a cart containing PPE would be placed outside the resident's room for staff to use when entering the resident's room until their status was known. If positive, the resident would be transferred to the COVID unit. During an interview on 6/25/20 at 10:50 A.M., the DON said: -The first positive COVID result was an employee on 6/8/20. All residents and staff were tested on [DATE]. Ten residents showed positive results on 6/12/20. -They had an isolation unit where they placed symptomatic residents, residents who returned from the hospital, and/or new admits. They expanded this area to make the COVID unit. -The facility was doing weekly testing on the residents who tested negative. No retesting was done for the residents who tested positive. Observation on 6/25/20 at 12:30 P.M. showed: -A large and small cart containing resident meals were sitting outside the plastic sheets hanging in the hall separating the COVID unit from the rest of the facility. The food was in disposable foam containers. -Staff from inside the COVID unit (Certified Medication Technician (CMT) A and CNA C) reached through the split between the plastic sheets and retrieved the food from the carts placing it on a smaller cart that remained on the COVID unit. CMT A and CNA C were wearing PPE, including gowns, facemasks and shields, and gloves as they transferred beverages and food from the cart and/or adjusted the position of the carts to retrieve the containers. CNA C had the sleeves of his/her gown pushed up to his/her elbows as he/she retrieved the food from the cart outside the plastic. CMT A's wrists were exposed. During an interview on 6/25/20 at 1:40 P.M., CNA B said: -Hand hygiene was supposed to be done before entering a resident's room; after performing cares; before and after assisting a resident to eat; passing trays; handling soiled linens; and before putting on gloves and after taking gloves off. -When wearing protective gowns, the sleeves should come down to the wrists and the end of the sleeve should be covered by gloves. During an interview on 6/25/20 at 1:55 P.M., LPN B said: -Sleeves of a protective gown were supposed to stay down and gloves usually covered up the end of the sleeve. During an interview on 6/25/20 at 2:05 P.M., the DON said: -Protective gowns should not be worn with the sleeves pushed up on the staff's arms when staff wore them on the floor or back in the COVID unit. Staff wouldn't be protected if they wore them that way. -The staff in the COVID unit is dedicated to that unit. They do not work anywhere else at this time. Observation on 6/25/20 at 2:36 P.M. showed: -Four staff members

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) were outside the side door of the facility by a table that was under a canopy. Staff were clustered together, less than six feet apart talking, drinking beverages, and/or smoking. During a telephone interview on 7/1/20 at 9:00 A.M., the acting Administrator said: -Four residents (who previously tested negative) and three staff members (dedicated to the COVID unit) had tested positive for COVID-19 when tested [DATE] and 6/25/20. The residents now positive were spread out (not living on the same units); all were asymptomatic; and all had been moved to the COVID unit. -Staff should maintain social distancing. During a telephone interview on 7/2/20 at 1:00 P.M., the facility Medical Director said: -He/She contacted the facility weekly to monitor how things were going and staff would contact him as needed. This COVID situation was difficult. He/She felt the facility staff were doing the best they could to manage it. They were fortunate to be able to have a unit specifically for the COVID positive residents. -Staff should wear PPE as intended. He/She would expect staff to not push the sleeves of a protective gown up to their elbows; doing so defeated the purpose of the gown. The end of the sleeves should be down at the wrist so the gloves could cover the end of the sleeve. -He/She expected staff to follow appropriate infection control measures to prevent the spread of infection when dealing with residents not infected with COVID-19, i.e., hand hygiene should be completed after soiled gloves were removed, gloves should be changed if contaminated, and contaminated gloves should not be used when disinfecting equipment such as glucometers. -He/She wasn't sure it was practical to change gloves after each resident contact when passing fresh water to COVID-19 positive residents. While typical infection control measures for those in precautions usually included taking water/ice into a resident's room rather than taking the water receptacle out of the room to fill, all of the residents on the unit were COVID positive and those who were recovered should have some type of immunity so the potential for re-infection was limited. However, if there were other disease processes involved, such as multi-drug resistant bacterial infections, etc. then staff should definitely change their gloves between the residents. -Due to the practicality of the situation, he/she didn't believe the laundry staff would need to remove the PPE used to retrieve laundry from the COVID unit prior to delivering the laundry to the laundry room. The laundry staff should take off that PPE in the laundry area and they should wipe down surfaces touched, such as the door knob, etc.