STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465020	A. BUILDING _____ B. WING _____	06/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER CARE CENTER	815 SOUTH 200 WEST BRIGHAM CITY, UT 84302

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 -** Many	**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 properly prevent and/or contain COVID-19. A focused COVID-19 Infection Control survey was completed on 6/29/2020. The facility was found to not be in compliance with 42 CFR 483.80 infection control regulations. The facility did not ensure staff implemented policy and procedures to prevent the transmission of the COVID-19 virus. Specifically, staff did not don appropriate personal protective equipment (PPE) prior to entering a resident room that was on droplet precautions pending the results of COVID-19 testing, placed a water mug from a room where the resident was on droplet precautions pending the results of a COVID-19 test on top of a hydration cart, filled the mug with water, replaced the lid then delivered the water mug back to the resident on droplet precautions. Additionally, multiple staff members were observed in a resident room who was on droplet precautions pending the results of a COVID-19 test, without wearing the appropriate PPE. No hand hygiene was observed when the staff members exited the resident room who was on droplet precautions pending the results of a COVID-19 test. These findings placed all the residents at risk for exposure to COVID-19. Resident identifier 1, 2 and 3. Findings include: An on-site focused COVID-19 infection control survey was conducted on 6/29/2020 between 9:30 AM and 11:30 AM. On 6/29/2020 at approximately 9:45 AM, an entrance interview was conducted with the facility Administrator (ADM). The ADM was asked if there were any current resident's who had been tested for COVID-19. The ADM stated that there were three current residents who had COVID-19 testing that was pending. The ADM identified that residents 1, 2, and 3 who had been tested on Friday, June 26, 2020 and June 27, 2020. On 6/29/2020 at approximately 9:50 AM, a tour of the south hall was conducted. There was personal protective equipment (PPE's) in plastic bins that were observed outside of rooms for resident 2 and 3. The plastic bin outside of resident 2's room was within close proximity to resident 1's room. There were red signs posted on resident 1, 2 and 3's room doors which directed staff and visitors to check with the charge nurse prior to entering the room. On 6/29/2020 at approximately 9:55 AM, certified nurse assistant (CNA) 1 was observed while exiting resident 1's room. Resident 1's door was in the open position. CNA 1 was wearing a face shield and mask and was not observed to remove a gown or gloves. CNA 1 was holding a water mug with a lid and a washable plastic straw. CNA 1 took the water mug to the hydration cart. CNA 1 removed the lid and straw from the mug and placed them on top of the stainless steel hydration cart upside down with the straw touching the top of the cart. CNA 1 grabbed the ice scoop out of the ice chest, filled the scoop with ice then placed the ice scoop against the rim of the mug to fill the mug with ice. CNA 1 then dispensed water from the water dispenser on top of the hydration cart. CNA 1 replaced the lid and straw on the ice mug and entered resident 1's room without performing hand hygiene, donning gloves or a gown. CNA 1 exited resident 1's room, entered another resident room to retrieve another water mug. CNA 1 did not perform hand hygiene prior to entering another resident room. During the same observation, CNA 2 was observed in resident 1's room. CNA 2 was not wearing gloves or a gown. CNA 2 retrieved a clear trash bag where linen had been placed. CNA 2 exited resident 1's room and proceeded to ambulate down the hallway. Multiple other staff members were observed refilling other residents' water mugs with the now contaminated ice scoop, water dispenser and hydration cart. An interview was conducted with the registered nurse (RN) 1 on 6/29/2020 at 10:05 AM. RN 1 was assigned to care for the residents that resided on the south hallway. RN 1 was asked what infection control precautions had been implemented for resident 1. RN 1 stated resident 1 had episodes of diarrhea on 6/28/2020. RN 1 stated that resident 1 was placed on droplet precautions pending the results of a COVID-19 test. RN 1 stated that droplet precautions included donning a mask, face shield, gown and gloves. Additionally, RN 1 was asked how infection control requirements were communicated with staff. RN 1 stated that the nurse's conducted a shift report to let the CNA's know which resident's were on isolation precautions. A conference was held with the ADM, the director of nursing (DON) and the infection preventionist (IP) on 6/29/2020 at 10:09 AM to notify them of the observations and potential spread of COVID-19. The DON and IP stated that employees were to don PPE which included a mask, face shield, gloves, and a gown prior to entering a room when droplet precautions had been implemented. Immediate intervention which included inserving all staff related isolation precautions including the use of PPEs and hand hygiene. Additionally, CNA 1 and CNA 2 were sent home to change their clothing. CNA 2 did not return to the facility. The ADM further stated that all the water mugs that were in resident rooms had been removed to be washed in the dishwasher and that the hydration cart, ice chest, and water dispenser were being disinfected to prevent any potential contamination. A telephone interview was conducted with CNA 1 on 6/29/2020 at 1:48 PM. CNA 1 stated that he had been trained on the importance of social distancing and the use of PPE's. CNA 1 stated that he was not aware that resident 1 had been placed on droplet because because the door was wide open. CNA 1 stated that resident 1's door should have been closed. CNA 1 stated that water mugs from resident's on droplet precautions should not have been removed from the room to prevent cross contamination. A telephone interview was conducted with CNA 2 on 6/29/2020 at 2:00 PM. CNA 2 stated that she had been trained related to COVID-19 precautions. CNA 2 stated that a face mask, face shield, gown, gloves and shoe protectors were to be worn. CNA 2 stated that she was not aware that resident 1 had been placed on droplet precautions. CNA 2 stated that soiled linens should have been labeled as on precautions prior to being removed from resident 1's room. Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 6/28/2020, resident 1 complained of diarrhea. Resident 1's primary care physician was notified and an order to obtain a COVID-19 test was given. There were no orders for isolation precautions during the testing of COVID-19 nor documentation that resident 1 had been put on droplet precautions (meaning that staff and visitors were required to wear gloves, masks, face shields and gowns). The COVID-19 test was obtained on 6/28/2020. The results of the testing was not available at the time of the survey. Resident 2's medical record was reviewed. Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] after a being hosptalized on [DATE] for a fractured humerus. A psychiatric evaluation was completed and resident 2 was diagnosed with [REDACTED]. On 6/28/2020 resident 2 complained of diarrhea. Resident 2's primary care physician was notified and an order to obtain a COVID-19 test was given. There were no orders for isolation precautions during the testing of COVID-19 nor documentation that resident 2 had been put on droplet precautions (meaning that staff and visitors were required to wear gloves, masks, face shields and gowns). The COVID-19 test was obtained on 6/28/2020. The results of the testing was not available at the time of the survey. Resident 3's medical record was reviewed. Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. There was no documentation that resident 3 had diarrhea or a high temperature. Additionally, there was no documentation that resident 3's physician ordered a COVID-19 test or that the testing had been completed. The facility staff did not document that resident 3 had been placed on droplet precautions. The results of the testing was not available at the time of the survey. A review of the facility COVID-19 policy related to prevention, surveillance, education, suspected cases and new admissions was conducted. The policy had the following under SUSPECTED CASE OF COVID 19 . 4. Personal Protective Equipment should be implemented when symptoms are identified. a. For suspected cases of COVID-19, CDC (Centers for Disease Control and Prevention) is recommending wearing a gown, gloves, facemask and goggles or a face shield and N95 masks. . The IP was re-interviewed on 6/20/2020 at 10:40 AM. The IP stated, I had not considered water mugs coming out of resident rooms. The IP stated that

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 -** Many	(continued... from page 1) water mugs would not be refilled from the hydration cart and that the facility would implement a new procedure for refilling them. The IP stated employees would continue to be educated daily on COVID-19 precautions, the implementation of PPE and refilling water mugs.