STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265639	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LENOIR HEALTH CARE CENTER	3850 CARTWRIGHT LANE COLUMBIA, MO 65201

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 follow infection control protocols due to the ongoing COVID-19 pandemic, to help prevent the possible transmission of COVID-19, when facility staff failed to utilize facemasks appropriately, failed to maintain a social distance of at least six feet for residents and staff, and failed to wash or sanitize their hands per facility protocol. The facility census was 26. Review of the Centers for Disease Control and Prevention (CDC) recommendation dated 5/21/20, showed in order to prevent the spread of COVID-19, facility staff are to ensure all healthcare personnel (HCP) wear a facemask or cloth face covering for source control while in the facility. Additional review of the CDC recommendation titled How to Wear Face Coverings Correctly dated 5/22/20, showed staff are to place it over their nose and mouth and secure it under their chin. Further review of the CDC recommendation, titled Facemask Do's and Don'ts, dated 6/2/20, showed staff are not to touch or adjust their facemask without cleaning their hands before and after touching it. Review of the CDC's recommendation Strategies for Optimizing the Supply of Facemasks, dated 3/17/20, showed facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the contaminated outer surface during storage. The folded mask can be stored between uses in a clean, sealable paper bag or breathable container. Review of the CDC's recommendation titled, Preparing for Covid-19 in Nursing Homes, updated 6/5/20, showed the potential for asymptomatic Severe Acute Respiratory Syndrome, [MEDICAL CONDITION] 2 ([DIAGNOSES REDACTED]-CoV-2; [MEDICAL CONDITION] that causes COVID-19) transmission underscores the importance of applying prevention practices to all patients, including social distancing, hand hygiene, and surface decontamination. Review of the facility's policy CDC Implement Extended Use of Facemask, undated, showed staff were directed as follows: -HCP must take care not to touch their facemask. If they touch or adjust their facemask they should immediately perform hand hygiene; -HCP should leave the patient care area if they need to remove the facemask; -The facemask should be worn the entirety of the HCP shift. Review of the facility's policy Personal Protective Equipment (PPE), dated 3/10/20, showed staff were directed as follows: -Do not touch the part of the mask that will cover the face. Hold the mask by the strings only; -Avoid any unnecessary handling of the mask; -Never touch the mask while it is in use; -Handle mask only by the strings. 1. During an interview on 7/1/20 at 11:13 A.M., the Director of Nursing (DON) touched her facemask multiple times. She did not wash or sanitize her hands after she touched her facemask. Observation on 7/1/20 at 11:47 A.M., showed Certified Nursing Assistant (CNA) A and CNA B delivered meal trays to resident rooms. CNA A took a tray into a resident's room and placed it on the bedside table. The CNA did not wear gloves, and touched the resident's bedside table. He/she uncovered the resident's food, obtained silverware from the cart in the hallway, gave it to the resident, and pushed the food cart to the next resident's room. CNA A did not wash or sanitize his/her hands after he/she touched the resident's bedside table with his/her bare hands or before he/she left the resident's room. Furthermore, the observation showed CNA B took a meal tray to a resident room, touched his/her facemask, and then touched the food cart and meal tickets with his/her bare hands. CNA B did not wash or sanitize his/her hands after he/she touched his/her facemask or after he/she opened the resident's door. Further observation showed, CNA A took a meal tray into a different resident's room. The CNA set the tray on the resident's bedside table, uncovered the food, adjusted his/her facemask, exited the room, and pushed the food cart. CNA A did not wash or sanitize his/her hands after he/she touched his/her facemask or after he/she left the resident's room. Observation on 7/1/20 at 11:54 A.M., showed CNA B propelled a resident in a wheelchair. CNA B touched his/her facemask multiple times while he/she propelled the resident. The CNA did not wash or sanitize his/her hands after he/she touched his/her facemask. Additional observation, showed Restorative Aide (RA) C passed out surgical facemasks to residents that sat in the common area. He/She touched his/her cloth facemask multiple times, but he/she did not wash or sanitize his/her hands. Further observation, showed RA C squatted down to speak to a resident in a wheelchair, and touched his/her facemask. He/she then touched the resident's wheelchair, the resident's arm, and the surgical facemasks he/she was handing out. RA C did not wash or sanitize his/her hands after he/she touched his/her facemask. Observation on 7/1/20 at 12:00 P.M., showed Licensed Practical Nurse (LPN) E stood closer than six feet to a resident in a wheelchair. LPN E pulled down his/her facemask to speak to the resident, placed his/her facemask over his/her nose, and opened the door to the soiled utility room. LPN E did not wash or sanitize his/her hands after he/she touched his/her facemask. Observation on 7/1/20 at 12:02 P.M., showed RA C stood in the hallway closer than six feet to a resident. RA C pulled down his/her facemask to speak to LPN E. RA C replaced her facemask over his/her nose and touched the facility phone at the nurse's station. RA C did not wash or sanitize his/her hands after he/she touched his/her facemask. Observation on 7/1/20 at 12:06 P.M., showed RA C went in a resident's room. RA C did not wash his/her hands before he/she entered the resident room or when he/she exited the resident's room. Observation on 7/1/20 at 12:09 P.M., showed CNA A entered a resident's room and assisted a resident. CNA A wore a facemask, but it did not cover his/her nose and mouth. He/she touched the resident's bedside table, dishes, doorknob, and door, with his/her bare hands. He/She did not wash or sanitize his/her hands before he/she left the resident's room. Additional observation, showed CNA A and LPN F returned to the resident's room and transferred the resident. LPN F and CNA A washed their hands and touched the doorknob when they left the resident's room. CNA A did not wash or sanitize his/her hands after he/she touched the doorknob. Observation on 7/1/20 at 12:17 P.M., showed five staff members sat in the Den (a room located on the hallway, used by residents and staff) and ate lunch. The staff members did not wear masks and sat closer than six feet apart. The door to the Den was open, and residents were present outside the room. Observation on 7/1/20 at 12:24 P.M., showed three staff members sat in the dining room and ate lunch. Two of the staff members sat at the same table, without masks, and were closer than six feet apart. Observation on 7/1/20 at 12:33 P.M., showed Floor Technician (FT) H entered the facility and walked to the employee check-in station. FT H did not sanitize his/her hands when he/she entered the facility. FT H wore a facemask, but it did not cover his/her nose and mouth. FT H adjusted his/her facemask, but he/she did not wash or sanitize his/her hands after he/she touched his/her mask. Additional observation, showed Cook I entered the facility and walked to the employee check-in station. Cook I did not sanitize his/her hands when he/she entered the facility. Additional observation, showed Housekeeper J entered the facility from the smoking area, and touched keys and the doorknob to a storage room. Housekeeper J did not wash or sanitize his/her hands after he/she entered the facility. Further observation, showed an unidentified staff member entered the facility and touched the doorknob to the maintenance room. The unidentified staff member did not wash or sanitize his/her hands after entering the facility. Additional observation, showed three unidentified staff members walked out of the facility, removed their facemasks and face shields, and walked to the smoking areas. The staff members held their personal protective equipment (PPE) (face shields and facemasks) against their uniforms while they smoked in the smoking area. Observation on 7/1/20 at 12:44 P.M., showed Cook K entered the facility and did not wash or sanitize his/her hands. He/she wore a facemask, but it did not cover his/her nose and mouth. Observation on 7/1/20 at 12:54 P.M., showed Dishwasher L entered the facility and did not wash or sanitize his/her hands. During an interview on

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) 7/2/20 at 10:51 A.M. RA C said staff are expected to wash their hands when they enter and exit a resident's room. He/she said staff should put on gloves to deliver resident meal trays, and staff should remove the gloves and wash hands when exiting the resident's room. This should be done between each resident room. He/she said staff are to utilize face shields and facemasks at all times, and the face shield should cover the entire face. Additionally, he/she said the facemask should cover from the middle of the nose to under the chin. He/she said staff should wash or sanitize their hands whenever they touch their facemask, and should not pull their facemask down when speaking to a resident or staff member. He/she said the facility's social distancing policy says to maintain at least six feet of separation, and it applied to residents and staff members. He/she said the facility policy says staff are to eat their lunch in the staff break room, in the basement, and staff should maintain six feet distance while eating lunch. He/she said staff are not allowed to eat their lunch in resident care areas, which includes all areas of the building except the staff break room. Additionally, he/she said when going outside to smoke, staff are expected to maintain six feet of separation, and to sanitize their hands when re-entering the building. He/she said the staff cannot remove their face shield, and facemask until they are outside of the building. He/she said hand sanitizer and storage for PPE is not available outside of the building, and he/she holds his/her PPE while he/she is smoking. He/she said the staff must put their PPE back on before re-entering the building. During an interview on 7/2/20 at 11:15 A.M., LPN E said staff are expected to wash their hands when they enter and exit a resident's room. He/she said staff should wash or sanitize their hands after delivering a resident meal tray, and should do so between each resident's room. He/She said staff should wear the face shield so it covers all of their face, and staff should wear facemasks so they cover the nose and mouth and rests under the chin. He/she said staff are expected to wash or sanitize their hands whenever they touch their facemask. He/she said staff can remove their facemask to speak to residents who are hard of hearing. But some other options are to write on a white board or to move closer to the resident. He/she said staff have received training on facemasks, face shields, and hand washing. Furthermore, he/she said the facility policy on social distancing is to maintain at least six feet separation, and it applied to staff during meals and smoking. He/she said staff are allowed to eat meals in the Den on the Neighborhoods or in the employee break room in the basement, but the facility policy is to eat in the employee breakroom. He/she said nurses will eat in the Den in order to keep an eye on the residents, but it is expected that staff who eat in the Den, maintain six feet of separation, and close the door. Additionally, he/she said staff who go outside to smoke must exit the building before removing their facemask and face shield (PPE). He/she said staff must put on their PPE before re-entering the facility, and they must sanitize their hands when they get inside. Furthermore, he/she said hand sanitizer and storage for PPE is not available outside of the building, and he/she holds his/her PPE while smoking. During an interview on 7/2/20 at 11:37 P.M., the DON said it is expected that staff would wash their hands when exiting a resident room and sanitize their hands when they are in the hallway. He/she said this should occur between each resident room. He/she said staff should wash their hands and put on gloves before taking a meal tray into a resident room, and staff should remove the gloves and wash their hands when exiting the resident room. Additionally, he/she said facemasks should cover the nose and mouth and rest under the chin. He/She said cloth facemasks cannot be used on the Neighborhoods, and staff should wash or sanitize their hands whenever they touch their facemasks. He/She said face shields should be worn at the eyebrows so it is flush to the face, and should cover from the eyebrows to the chin. He/she said staff have been trained on handwashing/hand sanitizing, facemasks, and face shields. He/she said signs are posted throughout the facility, and the Infection Control Preventionist (ICP) conducts demonstrations and audits. He/she said he/she knows staff members pull down their facemask to speak to residents who have difficulty hearing. Additionally, he/she said staff could utilize a whiteboard. He/she said staff should not pull down their facemask to speak to staff or residents, and should maintain at least six feet of social distance, to include during meals and smoking. He/she said nursing staff will eat in the Den of their Neighborhood, but there should not be more than three staff in the Den so they can maintain six feet of distance. Furthermore, he/she said staff have been asked to close the door when eating in the Den. He/She said dietary staff can eat in the dining rooms of the Neighborhoods if there are no residents present, and should maintain at least six feet of separation in the dining room and should not sit more than one at a table. He/She said staff members who smoke are expected to exit the facility from the basement. He/she also said, the staff are expected to remove their facemask and face shield (PPE) once they are outside the building, and they must put on their facemask or shield before re-entering the building. Additionally, he/she said staff are expected to sanitize their hands when entering the building, and a dispenser is available inside the door. He/she said the expectation is for staff to put on their facemasks and then go into the bathroom to wash their hands. He/she said hand sanitizer is not available outside of the building, and he/she was not aware of the policy for PPE storage when going outside to smoke.