STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065267	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES - BOULDER	2800 PALO PKWY BOULDER, CO 80301

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 0622 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have an appropriate reason to issue an involuntary discharge to one (#1) out of three sample residents. Specifically, the facility failed to: -Ensure there was sufficient evidence for the reason for discharge after Resident #1 went to the hospital for emergent care; and, -Ensure the required physician documentation was provided for the resident's discharge. I. Facility policy The Admission Agreement, undated, was provided by the nursing home administrator (NHA) on 8/6/2020 at 1:45 p.m. It read in pertinent part: We may terminate this agreement and discharge you from the center by notifying you in writing. Where legally required, we will notify you at least 30 days prior to your transfer or discharge. In cases where the safety or health of you or other individuals in the center may be endangered, or if other legal reasons exist, we will notify you as soon as practicable before transfer or discharge. Residents have the right to be transferred or discharged on ly for medical reasons, his or her welfare or that of other residents, or for non-payment of his or her stay; and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by professional staff. II. Resident status Resident #1, age 81, was admitted on [DATE] and discharged on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 1/15/2020 minimum data set (MDS) assessment revealed the resident was slightly cognitively impaired with a brief interview for mental status score of 14 out of 15. She exhibited verbal and other disruptive behaviors. She required extensive assistance of two staff members with mobility and activities of daily living (ADLs). There were no plans for the resident to discharge indicated on the assessment. A discharge MDS assessment dated [DATE] indicated the resident's return to the facility was anticipated. The resident was discharged to the hospital. III. Record review Review of Resident #1's progress notes from 2/27/2020 to 4/12/2020 revealed the resident exhibited behaviors in the facility that included yelling, being disruptive and demanding care. The resident exhibited physical and verbal behaviors towards staff during care. The progress notes revealed multiple communications with the resident's family members related to the resident's behaviors. On 4/1/2020, a care plan meeting note revealed a meeting was held with the family via telephone. The meeting was attended by the interdisciplinary team, two of the resident's physicians, and the resident's three daughters. The note revealed the meeting attendees discussed the resident's behaviors and her [MEDICAL CONDITION] medications. The facility staff discussed with the family the facility would continue to provide care for the resident through medication changes and another care plan meeting would be scheduled for the near future. On 4/10/2020, a care plan progress note revealed the resident's medications had been changed and her behaviors seemed to be stabilizing. On 4/12/2020, a progress note read the resident was sent to the hospital at 9:24 p.m. The resident was unresponsive when a nurse was trying to administer medications. The resident only responded to painful stimuli. The resident was assessed and was found to have low oxygen saturations of 84% and the resident's physician gave orders for the resident to transfer to the hospital. The resident was alert and able to answer questions when leaving the facility with emergency personnel. Review of progress notes dated 4/13/2020, 4/14/2020, and 4/15/2020 after the resident's transfer to the hospital on [DATE] revealed the RDO spoke to the resident's family members and hospital staff stating the facility would not be readmitting the resident to the facility after hospitalization because the facility could not meet the resident's needs. Review of the resident's hospital case management notes revealed the resident was expected to return to the facility on ce she was medically stable, though on 4/14/2020 the facility called and stated they would not accept her back. The hospital case manager explained to the facility representative that it was the facility's responsibility to find the resident alternate placement. On 5/18/2020 the resident was discharged from the hospital to another long term care facility. Cross-reference F625 for the facility's bed hold policy and F626 for the facility not permitting the resident to return to the facility. Review of the resident's facility medical record did not include the required documentation from the facility staff or the resident's physician stating the specific reasons or circumstances of why the resident was being discharged from the facility or the specific needs the facility could not meet. The resident's medical record did not include a written notice of discharge issued to the family and the ombudsman at the time of the discharge. Cross-reference F623 for written notice to be provided before discharge. IV. Interviews A resident family member was interviewed on 7/28/2020 at 12:00 p.m. She stated the facility transferred the resident to the hospital on [DATE] for a medical emergency. She stated she received a call from the RDO on 4/14/2020 and was informed the facility was not going to accept the resident back to the facility due to her behaviors over the past two years. She stated she wanted the resident to return to the facility because the facility was her home, she had friends and a boyfriend at the facility. She stated the facility had discussed the behavior issues with her recently and had informed her of the possibility of finding other placement, though they had never issued a discharge notice or made any plans with them for transfer to another facility. A frequent visitor to the facility was interviewed on 7/28/2020 at 1:30 p.m. She stated she had been involved with the situation of the resident being discharged from the facility. She stated she spoke with the facility related to the resident not being properly discharged and the facility failing to issue a written notice of discharge and discharge appeal rights. She stated she knew the resident had exhibited behavior problems in the facility, though the way the resident was discharged from the facility did not follow guidelines or procedure for properly discharging a resident. The NHA was interviewed on 8/6/2020 at 2:00 p.m. She stated she was not employed at the facility at that time of the resident discharge, though upon reviewing the situation and the circumstances of the discharge, she stated the discharge was not appropriate and did not follow facility guidelines or procedures.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#1) of three sample residents received written notice of discharge before a facility-initiated transfer. Specifically, the facility failed to provide Resident #1 with written notice of discharge that included her appeal rights when the facility initiated a discharge from the facility once she was hospitalized . I. Facility policy and procedures The Admission Agreement, undated, was provided by the nursing home administrator (NHA) on 8/6/2020 at 1:45 p.m. It read, in pertinent part: We may terminate this agreement and discharge you from the center by notifying you in writing. Where legally required, we will notify you at least 30 days prior to your transfer or discharge. In cases where the safety or health of you or other individuals in the center may be endangered, or

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) if other legal reasons exist, we will notify you as soon as practicable before transfer or discharge. Residents have the right to be transferred or discharged on ly for medical reasons, his or her welfare or that of other residents, or for non-payment of his or her stay; and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by professional staff. The Care Transitions Checklist, revised September 2018, was provided by the regional director of operations (RDO) via email on 8/7/2020 at 6:21 p.m., it read in pertinent part: For transitions from skilled nursing facility to acute care the facility was required to notify patient, family, and representative. Issue written notification per state specific guidelines; consult a representative from the legal department with questions and notify the ombudsman. II. Resident status Resident #1, age 81, was admitted on [DATE] and discharged on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 1/15/2020 minimum data set (MDS) assessment revealed the resident was slightly cognitively impaired with a brief interview for mental status score of 14 out of 15. She exhibited verbal and other disruptive behaviors. She required extensive assistance of two staff members with mobility and activities of daily living (ADLs). There were no plans for the resident to discharge indicated on the assessment. A discharge MDS assessment dated [DATE] indicated the resident's return to the facility was anticipated. The resident was discharged to the hospital. The Notice of Discharge was provided by the NHA on 8/6/2020 at 2:00 p.m. The notice read the resident was being discharged from the facility due to the facility not being able to meet her needs and the safety of other individuals in the facility were endangered. The date of discharge was 4/12/2020 whenand the resident was discharged to the hospital. The notice read the resident had the right to appeal the discharge to the ombudsman. -The notice was issued on 5/1/2020, which was 20 days after the resident transferred to the hospital. The notice did not include a description of specific needs the facility could not meet for the resident or a physician signature. III. Record review On 4/12/2020, a progress note read the resident was sent to the hospital at 9:24 p.m. The resident was unresponsive when a nurse was trying to administer medications. The resident only responded to painful stimuli. The resident was assessed and was found to have low oxygen saturations of 84% and the resident's physician gave orders for the resident to transfer to the hospital. The resident was alert and able to answer questions when leaving the facility with emergency personnel. -Review of the resident's transfer paperwork did not include the facility bed hold policy. Cross-reference F625 for the facility's bed hold policy. Review of progress notes dated 4/13/2020, 4/14/2020, and 4/15/2020 after the resident's transfer to the hospital on [DATE] revealed the RDO spoke to the resident's family members and hospital staff stating the facility would not be readmitting the resident to the facility after hospitalization because the facility could not meet the resident's needs. Cross-reference F626 for permitting the resident to return to the facility after hospitalization . Review of the resident's hospital case management notes revealed the resident was expected to return to the facility on ce she was medically stable, though on 4/14/2020 the facility called and stated they would not accept her back. The case manager explained to the facility representative that it was the facility's responsibility to find the resident alternate placement. On 5/18/2020 the resident was discharged from the hospital to another long term care facility. Cross-reference F622 for transfer and discharge requirements. -Review of the resident's facility medical record did not include the required written notice of discharge being provided to the resident or her family member. IV. Interviews A resident family member was interviewed on 7/28/2020 at 12:00 p.m. She stated the facility transferred the resident to the hospital on [DATE] for a medical emergency. She stated she received a call from the RDO on 4/14/2020 and was informed the facility was not going to accept the resident back to the facility due to her behaviors over the past two years. She stated she wanted the resident to return to the facility because the facility was her home, she had friends and a boyfriend at the facility. She stated the facility had discussed the behavior issues of the resident with her recently and had informed her of the possibility of finding other placement, though they had never issued a discharge notice or made any plans with them for transfer to another facility. She stated after she and other family members asked the facility multiple times, a written discharge notice was emailed to her on 5/1/2020 provided by the RDO, that had informed the family the resident would not be accepted back to the facility. She stated the notice was provided two and a half weeks after the resident transferred to the hospital. She stated she and the family wanted the resident to return to the facility and would have appealed the discharge once they were notified, if they knew they could have. A frequent visitor to the facility was interviewed on 7/28/2020 at 1:30 p.m. She stated she had been involved with the situation of the resident not being readmitted to the facility. She stated she spoke with the facility related to the resident not being properly discharged and the facility failing to issue a written notice of discharge that included her discharge appeal rights. She stated she received the written notice of discharge electronically on 5/1/2020. She stated the discharge notice read the resident's needs could not be met in the facility due to the safety of other individuals in the facility being endangered with the date of discharge of 4/12/2020. She stated the discharge notice did not include a physician signature or a description of the resident needs that could not be met in the facility as required. The NHA was interviewed on 8/6/2020 at 2:00 p.m. She stated she was not employed at the facility at that time of the resident discharge, though the facility should have issued a written notice of discharge at the time the resident transferred to the hospital. She stated the reasons for the discharge should have been specified at the time the facility decided to discharge the resident. The RDO was interviewed on 8/6/2020 at 2:30 p.m. She stated once the resident was transferred to the hospital, the decision was made that the resident would not be returning to the facility. She stated the facility could not meet the resident's needs due to her past behaviors. She stated the written notice of discharge should have been provided to the family and the ombudsman at the time of the discharge. She stated she issued the written notice of discharge on 5/1/2020 to the family and the ombudsman by email.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to inform residents of the facility's bed hold policy for one (#1) of three sample residents. Specifically, the facility failed to ensure the resident or her responsibility party was informed in writing of the facility's bed hold policy prior to being transferred and discharged from the facility. I. Facility policy The Care Transitions Checklist, revised September 2018, was provided by the regional director of operations (RDO) via email on 8/7/2020 at 6:21 p.m., it read in pertinent part: For transitions from skilled nursing facility to acute care the facility was required to issue a copy of the facility bed hold policy to the resident or resident representative. II. Resident status Resident #1, age 81, was admitted on [DATE] and discharged on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 1/15/2020 minimum data set (MDS) assessment revealed the resident was slightly cognitively impaired with a brief interview for mental status score of 14 out of 15. She exhibited verbal and other disruptive behaviors. She required extensive assistance of two staff members with mobility and activities of daily living (ADLs). There were no plans for the resident to discharge and this was not indicated on the assessment. A discharge MDS assessment dated [DATE] indicated the resident's return to the facility was anticipated. The resident was discharged to the hospital. III. Record review A progress note on 4/12/2020 read the resident was sent to the hospital at 9:24 p.m. The resident was unresponsive when a nurse was trying to administer medications. The resident only responded to painful stimuli. The resident was assessed and was found to have low oxygen saturations of 84% and the resident's physician gave orders for her to be transferred to the hospital. The resident was alert and able to answer questions when leaving the facility with emergency personnel. Review of progress notes dated 4/13/2020, 4/14/2020, and 4/15/2020 after the resident's transfer on 4/12/2020 to the hospital revealed the RDO spoke to the resident's family members and hospital staff stating the facility would not be readmitting the resident to the facility after hospitalization because the facility could not meet the resident's needs. -Review of the resident's transfer paperwork did not include the facility bed hold policy. IV. Staff interviews The nursing home administrator (NHA) was interviewed on 8/6/2020 at 2:00 p.m. She stated she was not employed at the facility at the time of the resident's discharge, though all residents should receive the facility bed hold policy upon transfer to the hospital as it would be expected the resident would return to the facility. The RDO was interviewed on 8/6/2020 at 2:30 p.m. She stated the resident and her family were not issued a bed hold policy when she transferred to the hospital because the facility had decided they would not be accepting the resident back to the facility due to not being able to meet her needs due to her behaviors. Cross-reference to F622 for transfer and discharge requirements, F623 providing notice before discharge, and F626 permitting a resident to return to a facility.
F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Permit a resident to return to the nursing home after hospitalization or therapeutic**

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F 0626 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **leave that exceeds bed-hold policy.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to permit a resident to return to the facility after a leave of absence for one (#1) of three sample residents. Specifically, the facility failed to re-admit Resident #1 to the facility when the resident was ready for discharge from the hospital. I. Facility policy The Admission Agreement, undated, was provided by the nursing home administrator (NHA) on 8/6/2020 at 1:45 p.m. It read, in pertinent part: We may terminate this agreement and discharge you from the center by notifying you in writing. Where legally required, we will notify you at least 30 days prior to your transfer or discharge. In cases where the safety or health of you or other individuals in the center may be endangered, or if other legal reasons exist, we will notify you as soon as practicable before transfer or discharge. Residents have the right to be transferred or discharged on ly for medical reasons, his or her welfare or that of other residents, or for non-payment of his or her stay; and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by professional staff. II. Resident status Resident #1, age 81, was admitted on [DATE] and discharged on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The 1/15/2020 minimum data set (MDS) assessment revealed the resident was slightly cognitively impaired with a brief interview for mental status score of 14 out of 15. She exhibited verbal and other disruptive behaviors. She required extensive assistance of two staff members with mobility and activities of daily living (ADLs). There were no plans for the resident to discharge indicated on the assessment. A discharge MDS assessment dated [DATE] indicated the resident's return to the facility was anticipated. The resident was discharged to the hospital. III. Record review On 4/12/2020 a progress note read the resident was sent to the hospital at 9:24 p.m. The resident was unresponsive when a nurse was trying to administer medications. The resident only responded to painful stimuli. The resident was assessed and was found to have low oxygen saturations of 84% and the resident's physician gave orders for the resident to transfer to the hospital. The resident was alert and able to answer questions when leaving the facility with emergency personnel. Review of progress notes dated 4/13/2020, 4/14/2020, and 4/15/2020 after the resident's transfer to the hospital on [DATE] revealed the regional director of operations (RDO) spoke to the resident's family members and hospital staff stating the facility would not be readmitting the resident to the facility after hospitalization because the facility could not meet the resident's needs. Review of the resident's hospital case management notes revealed the resident was expected to return to the facility on ce she was medically stable, though on 4/14/2020 the facility called and stated they would not accept her back. The case manager explained to the facility representative that it was the facility's responsibility to find the resident an alternate placement. On 4/15/2020, a facility representative told the hospital case manager that due to a COVID-19 positive staff member, the facility was on an admission hold and could not accept the resident back until the facility was COVID-19 negative. On 4/20/2020, a facility representative told the hospital case manager the RDO would have the final decision whether to accept the resident back to the facility. On 4/24/2020, the RDO told the hospital case manager she would assess the resident to return to the facility on ce the admission hold had ended. On 4/30/2020, the case manager was informed by the RDO the facility would not readmit the resident to the facility. On 5/4/2020, a note read the resident had been denied by 11 facilities and the ombudsman had been contacted related to the facility not accepting the resident back. On 5/18/2020, the resident was discharged from the hospital to another long term care facility. Cross-reference F625 for the facility's bed hold policy. V. Staff interviews The resident's family member was interviewed on 7/28/2020 at 12:00 p.m. She stated the facility transferred the resident to the hospital on [DATE] for a medical emergency. She stated she received a call from the RDO on 4/14/2020 and was informed the facility was not going to accept the resident back to the facility due to her behaviors over the past two years. She stated she wanted the resident to return to the facility because the facility was her home, she had friends and a boyfriend at the facility. She stated the facility had discussed the behavior issues with her recently and had informed her of the possibility of finding other placement, though they had never issued a discharge notice or made any plans with them for transfer to another facility. She stated she felt the facility used the medical emergency on 4/12/2020 to get rid of the resident. A frequent visitor to the facility was interviewed on 7/28/2020 at 1:30 p.m. She stated she had been involved with the situation of the resident not being readmitted to the facility from the hospital. She stated she spoke with the facility related to the resident not being properly discharged and the facility had a responsibility to their long term resident to accept her back to the facility and properly discharge her with assistance to find a more appropriate facility. The NHA was interviewed on 8/6/2020 at 2:00 p.m. She stated she was not employed at the facility at that time, though the facility should have accepted the resident back to the facility on ce she was medically stable at the hospital. She stated the facility should have helped find more appropriate placement for the resident once she returned to the facility after the hospitalization . Cross-reference to F622 for transfer and discharge requirements and F623 providing notice before discharge. The RDO was interviewed on 8/6/2020 at 2:30 p.m. She stated once the resident was transferred to the hospital, the decision was made that the resident would not be returning to the facility. She stated the facility could not meet the resident's needs due to her past behaviors.
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 observations, record review and interviews, the facility failed to maintain an effective infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection such as COVID-19 in two of five units. Specifically, the facility failed to: -Ensure housekeeping staff practiced proper hand hygiene and cleaning procedures; and, -Ensure staff wore face masks correctly at all times in the facility. Findings include: I. Hand hygiene A. Reference The Center for Disease Control (CDC), Hand Hygiene in Healthcare Settings (1/31/2020) retrieved 8/11/2020 from:https://www.cdc.gov/handhygiene/providers/index.html. It read in pertinent part: When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. B. Facility policy The Hand Hygiene policy, undated, was provided by the nursing home administrator (NHA) on 8/6/2020 at 2:40 p.m. It read in pertinent part: When to wash hands or use an alcohol-based hand rub (ABHR): before applying and after removing gloves. C. Staff education Staff education provided in June 2020 related to infection control was provided by the NHA on 8/6/2020 at 2:40 p.m. It read in pertinent part: Wearing gloves is not a substitute for hand hygiene; if your task requires gloves, perform hand hygiene prior to donning gloves and perform hand hygiene immediately after removing gloves. D. Observations On 8/6/2020 at 11:15 a.m., housekeeper (HK) #1 was observed entering a resident room [ROOM NUMBER] to clean. She was observed to remove the trash bag from the trash can and she returned to the housekeeping cart to discard the trash. She removed her gloves and immediately donned new gloves. She did not perform hand hygiene before donning new gloves. She obtained two cleaning cloths from the cart, one blue and one yellow, and placed them in her pockets. She obtained a mop head from a bucket of cleaning solution, placed the mop head on the mop, then proceeded to clean the surfaces in the room with the blue cloth from her pocket. She wiped the bedside dresser, the over bed table, and the blinds on the window. She placed the blue cloth back in her pocket. She did not use any disinfectant when cleaning the surfaces in the resident room with the blue cloth. -At 11:19 a.m., HK #1 mopped the floor in the resident room. -At 11:21 a.m., she changed the mop head. She removed her gloves and immediately donned a new pair of gloves without performing hand hygiene and proceeded to obtain bathroom cleaning supplies from the cart. -At 11:23 a.m., she returned to the cart and replaced the bathroom supplies. She removed her gloves and immediately donned a new pair without performing hand hygiene. She proceeded to mop the bathroom floor. -At 11:27 a.m., she returned to the cart, discarded the yellow cloth in the laundry bag as well as the mop head used for the bathroom. She removed her gloves and used ABHR, rubbing her hands together for approximately five seconds. -At 11:28 a.m., HK #1 entered resident room [ROOM NUMBER] to clean. She donned a new pair of gloves and obtained the broom from the cart, she swept the room and returned the broom and dustpan to the cart. She took the trash bag out of the trash can and discarded it on the cart. She obtained a mop head out of the bucket of cleaning solution and placed it on the mop. She then took the blue cloth out of her pocket she used in the previous room and proceeded to wipe the surfaces in the room, the bedside dresser, the over bed table and the blinds. She placed the cloth back in her pocket. She did not use any disinfectant when cleaning the surfaces in the resident room with the blue cloth. -At 11:30 a.m., she mopped the room. She returned to the cart to change the mop head. After changing the mop head, she

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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 -** Few	(continued... from page 3) removed her gloves and performed hand hygiene with ABHR. She rubbed her hands together for approximately 10 seconds and then wiped her hands on the front of her scrubs to dry them. She did not use the ABHR appropriately by using it for 20 seconds and letting it dry completely. E. Staff interview HK #1 was interviewed on 8/6/2020 at 11:31 with a laundry aide (LA) #1 translating as HK #1 did not speak English. She stated she should have performed hand hygiene between each glove change. She stated she should change her gloves between each task when her gloves become contaminated. She stated she should not use the same cleaning cloth in multiple rooms. She did not know she should not carry cleaning cloths in her pocket and she did not know she should not dry her hands on her scrubs. II. Proper mask use A. Reference The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, last updated 7/15/2020, retrieved on 8/12/2020 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize. It read in pertinent part, Source control refers to use of cloth face coverings or facemasks to cover a person ' s mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19. HCP (healthcare personnel) should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. When available, facemasks are preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. B. Facility policy and procedure The Personal Protective Equipment Usage Guide, undated, was provided by the NHA on 8/6/2020 at 2:40 p.m. It read in pertinent part: Procedure masks or surgical masks are used for facility and community staff under universal masking criteria. As of 3/26/2020, all facilities are under universal masking criteria. Masks are donned at the beginning of the shift and only removed during scheduled breaks out of patient care areas. The Applying Personal Protective Equipment guide, revised in 2013, was provided by the NHA on 8/6/2020 at 2:40 p.m. It read in pertinent part: Mask: Place over nose, mouth and chin C. Observation On 8/6/2020 at 11:40 a.m., a licensed practical nurse (LPN) #1 was observed at the nurses station desk at the computer with her surgical mask pulled down below her chin. She pulled the mask back up over her nose and mouth when the surveyor approached the nurses station. D. Staff interview The business office manager (BOM) was interviewed on 8/6/2020 at 11:50 a.m. She stated she notified LPN #1 that her mask was below her chin. She stated she notified another nurse she observed with her mask not on correctly. III. Management interview The NHA was interviewed on 8/6/2020 at 1:00 p.m. She stated hand hygiene should be performed between each glove change and gloves should be changed in between each task when gloves were contaminated. She stated cleaning clothes should never be used in more than one room and should never be stored in a staff member ' s pocket. She stated hand hygiene with ABHR should be performed for 20 seconds and until the product dried on their hands. She stated all staff should be wearing their mask over their nose and mouth at all times unless they were on a break, not in resident areas. The NHA stated she provided corrective action for each of the staff members identified above. She stated the facility was taking breaks in infection control very seriously. IV. COVID-19 status The NHA was interviewed on 7/28/2020 at 9:30 a.m. She stated they had no COVID-19 positive residents or staff. She stated there were no presumptive positive or tests pending for residents or staff.