STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165110	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREAT RIVER KLEIN CENTER	**1221 S GEAR STREET WEST BURLINGTON, IA 52655**

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to ensure proper use of Personal Protective Equipment (PPE) in accordance with Centers for Medicare and Medicaid Services and Centers for Disease Control and Prevention. The facility reported a census of 107. Findings include: The facility policy # 34, titled, Post Acute Plans of Care: COVID-19 Pandemic, revised on 7/2020, directed asymptomatic staff to wear a surgical facemask and face shield during shift and remain on during consecutive encounters. The policy indicated that face covers may only be removed for break time and during downtime when not within 6 feet of a resident. The policy indicate that for the care for residents on droplet precautions, staff members are to wear gowns. Observations on 7/15/2020, showed the following: a. At 11:58 a.m., Staff M (Dietary Staff) facial mask failed to cover her nose while preparing food at the Appletree/Mississippi kitchen. Staff M's facial mask remained off her nose while handling and giving out food to other staff members to be served to residents at the dining area until 12:08 p.m., when surveyor left the Appletree dining area. b. At 12:31 p.m., Staff A (Registered Nurse) donned PPE while standing near a medication cart on the(NAME)hallway. Staff A stated going to care for Resident # 12, who was on droplet precaution. As Staff A walked down the hallway towards room [ROOM NUMBER], a closer observation showed Staff A's back exposed or the gown did not protect her scrub suit on the back side as it was not tied on the waist part. Staff A placed her clipboard on Resident # 12's unmade bed. Staff A assisted Resident # 12 to the restroom, assessed and applied cream on Resident # 12's coccyx area. Staff A helped Resident #12 back to the recliner, in close contact with Resident # 12 and moving around with the loose gown. Staff A sat down on Resident # 12's unmade bed. Staff A's body exposed from the gown touched the unmade bed. Staff A moved to assess Resident # 12's feet, and her gown hung loose on her front touching the floor and at times, touching Resident # 12's feet. Staff A with her gown still on, stepped out from room [ROOM NUMBER], to the hallway or room [ROOM NUMBER]'s entryway, opened and closed a mini-cabinet where clean supplies were stocked, and then left her clipboard secured by a hand bar attached to the wall on the hallway. Staff A re-entered room [ROOM NUMBER] to remove and leave her gown. c. At 1:06 p.m., 4 residents sat at the dining area on Heritage Hill. Staff B (Nurse Aide) and Staff Q (Dietary Staff), with face masks not covering their noses, worked in the dining area and cleaned the countertops in the kitchenette close to the same dining area. d. At 1:13 p.m., Staff G sat in a chair while talking in close proximity (approximately 2 feet) to Resident # 21 in room [ROOM NUMBER]. Staff G failed to utilize a facemask and a face shield. Staff G stood up and turned her back from the door (Clinical Manager and surveyor observed through the open door). Staff G then put face mask on. c. At 1:31 p.m., Staff Q (Dietary Staff) stood in the Cascade Falls/Heritage(NAME)kitchen doing dishes. Staff Q failed to cover her nose and mouth with a mask. Staff Q had the mask position on her chin. The Clinical Manager approached Staff Q and reminded her to wear the face mask properly, covering mouth and nose. On 7/15/20 at 1:30 p.m., Staff G (Nurse Aide) verified that she did not wear face mask while in room [ROOM NUMBER] and talking to Resident # 21 at a close distance. Staff G stated that her face mask fell and stated that she tried to quickly fix it. Staff G also added that her face mask was hurting behind her ears. Staff G stated understanding the importance of wearing face covering while interacting with residents, and acknowledged she should have worn her face mask while with Resident #21. On 7/15/20 at 3:00 p.m., the Director of Nursing (DON) stated an expectation of staff to properly utilize PPE at all times.

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