| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **455560** | A. BUILDING _____ B. WING _____ | **09/30/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **MCALLEN NURSING CENTER** | **600 N CYNTHIA ST MCALLEN, TX 78501** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0552<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure that residents are fully informed and understand their health status, care and treatments.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure a resident or resident's representative was fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition, for one Resident (R#1) of one resident reviewed for resident rights, in that: The facility failed to inform R#1 and R#1's RP of R#1's positive test results for COVID-19 (Coronavirus) test on 09/01/20. This failure placed residents and their representatives at risk of not being fully informed of medical status changes. Findings included:<br>Record review of R#1's September Medication Review Report (Physician's orders) revealed R#1 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's quarterly MDS assessment, dated<br>08/21/20, revealed R#1: -had minimal difficulty hearing, -had clear speech, -was able to make himself understood, -was able to understand others, -was cognitively intact, Record review of R#1's Comprehensive Care Plan, initiated on 08/15/20, revealed R#1 was at risk for infections/sign and symptoms of COVID-19. Goal: R#1 would not exhibit signs/symptoms of COVID-19. Intervention: Educate staff, resident, family, visitors of COVID-19 signs and symptoms and precautions. In an interview on 09/24/20 at 8:10 a.m., during the entrance conference with the Administrator and DON present, a list of residents who had tested positive for COVID-19 in the months of August and September 2020, including the test dates and result dates was requested. The Administrator said the last COVID-19 positive test for a resident was on 09/05/20 and the last time residents were tested for COVID-19 was 09/03/20. In an interview on 09/24/20 at 1:10 p.m., the ADON/LVN located R#1's lab result indicating COVID positive test for a physician's order dated 08/31/20. The lab was drawn on 09/01/20 and a positive result received on 09/02/20. The ADON/LVN said R#1's positive lab result for COVID-19 was on their lab account site. The ADON/LVN said the lab results should have been in R#1's medical chart. ADON/LVN said R#1 should have been placed on isolation, but she did not see an isolation order or notification of the results to R#1 or R#1's Physician. ADON/LVN said, I was not aware he (R#1) tested positive for COVID. Record review of R#1's lab results on Results Viewer, dated 09/24/20, revealed: Order date 09/02/20 at 11:01 p.m. Draw date 09/01/20 at 11:20 a.m. Test: Name [DIAGNOSES REDACTED]-CoV-2 . Result: Positive Positive results are indicative of the presence of [DIAGNOSES REDACTED]-CoV-2 . .All testing performed at (name of lab) . Record review of R#1 electronic medical record revealed no documented evidence that R#1 and the responsible party was notified of Resident #1's positive COVID-19 test on 9/01/20. Record review of R#1's nurses notes, dated 09/03/20 at 2:10 p.m., revealed: Nurse spoke to (R#1's) responsible party in regard to COVID 19 testing. Nurse informed and educated responsible party on new CDC guidelines and need for resident to be tested . RP authorized the testing and will be notified of the results as soon as results are ready since it's in house; results will be ready in within 15 minutes of swab. Record review of R#1's nurses notes, dated 09/03/20 at 6:04 p.m., revealed: Nurse notified responsible party results were negative for COVID test performed inhouse. In an interview on 09/24/20 at 9:35 a.m., R#1 said he had been tested for COVID-19 twice, a day apart. R#1 said he thought it was due to him complaining of a headache to the nursing staff. R#1 said he had never tested positive and had never been in quarantine. In an interview on 09/24/20 at 12:51 p.m., the Administrator said 09/05/20 was the latest COVID positive result in the facility and she was not aware R#1 had a positive result for COVID. In an interview on 09/24/20 at 1:12 p.m., IP/ADON said R#1's positive test should have been in R#1's medical chart, under labs. I believe (R#1) is his own responsible party. In an interview on 09/24/20 at 1:41 p.m., the DON said an order was needed to do a COVID-19 test. The DON said, R#1 was never positive for COVID. In an interview on 09/24/20 at 1:53 p.m., the DON said he did not know why R#1, his physician, and his RP were not notified of R#1's positive lab result on 09/01/20. In an interview on 09/24/20 at 2:28 p.m., IP/ADON said no one was notified regarding R#1's positive COVID-19 result from 09/01/20. In an interview on 09/24/20 at 3:44 p.m., ADON/LVN said she was not aware of R#1's positive COVID-19 result from 09/01/20. Record review of the facility policy titled, Texas Department of Human Services Figure: 40 Tac 19.401 (b), dated 12/2002, revealed: Statement of Resident Rights You, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights . You have a right to: .9 . have a physician explain to you . your complete medical condition . 483.10 Resident Rights .(c) .The resident has the right to be informed of, and participate in, his or her treatment, including:<br>(1) The right to be fully informed in a language he or she can understand of his or her total health status, including but not limited to, his or her medical . Record review of facility policy titled, Laboratory Services, dated 10/11/08, revealed: Policy It is the policy of this facility to obtain all laboratory tests ordered by the attending physician to ensure that prompt appropriate action is taken . Fundamental Information Procedure 1. The physician will provide an order . 5. Lab results will be collected from the lab by the DON or designee every tour of duty before daily start-up. 6. DON or designee will review all lab results . 7. Lab results will be faxed to the facility by the lab vendor . 8. Charge nurse will notify attending physician . 9. Charge nursed will call the attending physician with any abnormal lab results . .the lab results will then be placed in the clinical record. Facility did not provide a list of residents with COVID-19 testing dates and/or positive result dates, by the time of exit. |
| F 0842<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to maintain medical records on each resident that were complete and accurately documented, for one Resident (R#1) of one resident reviewed for medical records, in that: Nursing staff did not document R#1's 09/01/20 COVID-19 positive lab results in the clinical record. This failure could affect residents that receive laboratory testing and put residents at risk for inadequate care. Findings included: Record review of R#1's September Medication Review Report (Physicians orders) revealed R#1 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's quarterly MDS assessment, dated 08/21/20, revealed<br>R#1: -had minimal difficulty hearing, -had clear speech, -was able to make himself understood, -was able to understand others, -was cognitively intact, Record review of R#1's Comprehensive Care Plan, initiated on 08/15/20, revealed R#1 was at risk for infections/sign and symptoms of COVID-19. Goal: R#1 would not exhibit signs/symptoms of COVID-19. Intervention: Educate staff, resident, family, visitors of COVID-19 signs and symptoms and precautions. In an interview on 09/24/20 at 8:10 a.m., during the entrance conference with the Administrator and DON present, a list of residents who had tested positive for COVID-19 in the months of August and September 2020, including the test dates and result dates was requested. The Administrator said the last COVID-19 positive test for a resident was on 09/05/20 and the last time |

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

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| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>residents were tested for COVID-19 was 09/03/20. Record review of R#1's lab results on Results Viewer, dated 09/24/20, revealed: Order date 09/02/20 at 11:01 p.m. Draw date 09/01/20 at 11:20 a.m. Test: Name [DIAGNOSES REDACTED]-CoV-2 INTE<br>Result: Positive Positive results are indicative of the presence of [DIAGNOSES REDACTED]-CoV-2 RNA . .All testing performed at clinical pathology laboratories, inc . In an interview on 09/24/20 at 9:35 a.m., R#1 said he had been tested for COVID-19 twice, a day apart. R#1 said he thought it was due to him complaining of a headache to the nursing staff. R#1 said he had never tested positive and had never been in quarantine. In an interview on 09/24/20 at 12:51 p.m., the Administrator said 09/05/20 was the latest COVID positive result in the facility and she was not aware R#1 had a positive result for COVID. In an interview on 09/24/20 at 1:10 p.m., the ADON/LVN located R#1's lab result, in the lab viewer of the lab center, indicating COVID positive test for a physician's orders [REDACTED]. The ADON/LVN said R#1's positive lab result for COVID-19 was on their lab account site. The ADON/LVN said the lab results should have been in R#1's medical chart. ADON/LVN said, I was not aware he (R#1) tested positive for COVID. In an interview on 09/24/20 at 1:12 p.m., IP/ADON said I don't know why (R#1) was tested on both September 1st and 3rd. When asked about the nurses note indicating R#1's RP was notified on 09/03/20 of testing and a negative result, IP/ADON said Okay, I do not see a positive result anywhere in the electronic or the paper medical chart. I was not made aware that R#1 was ever positive for COVID-19. In an interview on 09/24/20 at 1:41 p.m., The DON said, R#1 was never positive for COVID. In an interview on 09/24/20 at 2:28 p.m., IP/ADON said no one was notified regarding R#1's positive COVID-19 result. Record review of facility policy titled, Laboratory Services, dated 10/11/08, revealed: Policy It is the policy of this facility to obtain all laboratory tests ordered by the attending physician to ensure that prompt appropriate action is taken . Fundamental Information Procedure 1. The physician will provide an order . 5. Lab results will be collected from the lab by the DON or designee every tour of duty before daily start-up. 6. DON or designee will review all lab results . 7. Lab results will be faxed to the facility by the lab vendor . 8. Charge nurse will notify attending physician . 9. Charge nursed will call the attending physician with any abnormal lab results . .the lab results will then be placed in the clinical record. Facility did not provide a policy on documentation of medical charts, by the time of exit. Facility did not provide a list of residents with COVID-19 testing dates and/or positive result dates, by the time of exit. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program, designed to provide a safe, sanitary and comfortable environment, and to prevent the development and transmission of communicable disease and infections for two Residents (R#1 and R#3) of three residents observed for infection control procedures. 1) Linen and trash barrels were in the hall with lids ajar and not stored in closet when not in use. 2 ) There was one overflowing box of biohazard trash in the biohazard storage room. The Treatment nurse had a red biohazard bag taped to her treatment cart. 3) CNA B touched dirty linen with ungloved hand, DON did have N95 properly placed over mouth and nose, ADMIN and IP/ADON touched front of N95 with ungloved hands. 4) Handwashing was not performed to prevent the spread of infection. 5) Monitoring through surveillance for possible outbreaks was not conducted for the month of September 2020. These failures could affect residents dependent upon care and place them at risk for healthcare associated cross contamination, infections, and Coronavirus . Findings included: 1) Observation on 09/24/20 at 9:07 a.m. revealed two empty barrels with lids ajar, one labeled Trash, and the other labeled Dirty Linen, in Hall A across from room [ROOM NUMBER]. In an interview on 09/24/20 at 9:09 a.m., the RN said the trash barrel and linen barrel were empty and had not been used today. The RN said, I know they are for the hallway. When my aide comes from Hall B she brings Hall B barrels for the trash and dirty linen. But this hall is put in biohazard bag. They have them in the rooms. The biohazard bags are then placed into a box. I am not sure where the boxes are or where they are placed after they are filled. There are four residents in Hall A for droplet precautions, and there are two residents in this hall that are not on isolation. The two residents not on isolation are in room [ROOM NUMBER]. In an interview on 09/24/20 at 9:14 a.m., CNA A said she brought the trash barrel and dirty linen barrel from Hall B to Hall A to pick up the trash and dirty linen. Hall A barrels labeled trash and dirty linen had been used in the past, just not today. In an interview on 09/24/20 at 10:26 a.m., the DON said dirty linen and trash barrel lids had to be tightly sealed on the barrels. The DON said barrels were to be stored in a closest specifically for them when not being used, and they were not to be in the halls. In an interview on 09/29/20 at 10:31 a.m., the DON said the facility did not have a policy on dirty linen and trash, the facility utilized the infection control policy. In an interview on 09/29/20 at 2:17 p.m., the DON said the infection control policy titled, Surveillance Plan: Infection control Surveillance COVID-19 revision date 03/24/20, was the only policy for infection control. Record review of facility policy titled Surveillance Plan: Infection control Surveillance COVID-19 revision dated 03/24/20 revealed: .Cleaning Procedures 3. Management of laundry should also be performed in accordance with routine procedures. . Record review of the facility policy titled Infection Control Guidelines subtitled Clinical Practice Guidelines Infection Control revision date 02/13/20 revealed: Anticipated Outcome The purpose of this policy is to reduce and to prevent the spread of infections by the use of evidenced based techniques established infection control policies and procedures. .3. Staff: .d. Staff are trained on Infection Control practices during orientation, annually and as indicated. 7. Supplies Protocol: .h. soiled linen collected at bedside and placed in a plastic bag and placed in linen bags. When the bag is full, it shall be closed securely and placed in the soiled utility room. 2) Observation on 09/24/20 at 9:18 a.m. revealed a biohazard storage room located in Hall C had five sealed boxes and one overflowing biohazard box. ADON C said the open biohazard box was too full to close properly. ADON C said the red bag should be tied, the box closed, and a new box opened. ADON C said the top red bag should be placed in the new biohazard box. In an interview on 09/24/20 at 10:18 a.m., the DON said the biohazard boxes should not be left open when full. The biohazard bag should have been tightened up, the biohazard box sealed, and another biohazard box opened. Observation on 09/24/20 at 11:28 a.m. revealed a treatment cart in Hall C, between the door leading to the laundry room and resident room [ROOM NUMBER]. The treatment cart had a three fourths full open large red biohazard bag taped to the end of the treatment cart, containing smaller red biohazard bags. In an interview on 09/24/20 at 11:34 a.m., the Treatment Nurse said the treatment cart was hers, and she had taped the large biohazard bag to the end of the treatment cart. The Treatment Nurse said she did not take the treatment cart into any of the residents' rooms, she left the cart unattended in the hallway. The Treatment Nurse said the large biohazard bag contained the dirty dressings of different residents that she had changed. The Treatment Nurse said, I tape the small bag on my setup table, I place the dressings I remove from the resident into the small biohazard bag. After I complete my dressing change, I take the small biohazard bag and place it in the large biohazard bag taped to my cart. Then at the end of my shift I remove the large biohazard bag and dispose of it in the biohazard room. I have always left the large biohazard bag taped to the cart and open. It is okay to have a large bag since the other bags are individual bags in there. It is just dressing supplies, gloves and stuff that came from (removed resident dressing) or was used during the resident dressing change. In an interview on 09/24/20 at 11:39 a.m., the DON said biohazard bags were to be disposed of in the biohazard waste room. The DON said the biohazard bags were not to be left open or unattended in the hallways. The DON said biohazard bags were not to be taped to any surface. The DON said dressing changes were to be placed in a biohazard bag at the time of dressing change. After the dressing change was completed, the biohazard bag was to be immediately placed in the biohazard waste room. In an interview on 09/24/20 at 11:41 a.m., the DON said the facility did not have a policy on biohazardous waste. Record review of facility policy titled Surveillance Plan: Infection control Surveillance COVID-19 revision dated 03/24/20 revealed: No documented evidence of biohazard waste. 3) Observation on 09/24/20 at 9:51 a.m. revealed CNA B was pushing a barrel labeled F Hall into Hall C. The lid was not secured. The barrel had clear bags of what appeared to be linen. In an interview on 09/24/20 at 9:53 a.m., CNA B said she was taking dirty linen from F hall into C hall to the laundry. CNA B said the lid was supposed to be closed. In an observation on 09/24/20 at 9:54 a.m., CNA B attempted to close the lid on a F Hall dirty linen barrel. CNA B, with ungloved hands, proceeded to remove the resting lid and attempted to push the dirty linen further down into the barrel in attempt to close and seal the lid. In an interview on 09/24/20 at 10:26 a.m., the DON said the dirty linen lid had to be tightly sealed on the barrel of dirty linen. The dirty linen was only to be handled while wearing gloves. The DON said staff should not use bare hands to push the bagged linen down into the dirty linen barrel. The DON said the infection control policy was what they used for PPE guidance. In an interview on 09/29/20 at 10:31 a.m., the DON confirmed the facility did not have a policy on dirty linen barrels, the facility utilized the infection control policy. Observation on 09/24/20 at 2:05 p.m., revealed the DON was in his office, with ADON C to his right and IP/ADON D across the desk, directly in front of him. The DON's N-96 mask was not covering his mouth and nose. The N-95 was below his chin. The DON touched the front of the N-95 mask with an ungloved hand to raise the mask over his nose and mouth. Observation on 09/24/20 at 2:11 |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>p.m. revealed the Administrator touched the front of her N-95 mask with an ungloved hand when explaining to surveyor how the mask was to be worn. The Administrator said all staff were to wear a N-95 mask covering their mouth and nose while in the building. The Administrator said staff should not touch the N-95 mask without gloves. The Administrator said all staff were to practice social distancing and be no less than six feet apart. In an interview on 09/24/20 at 2:30 p.m., IP/ADON said the DON was not wearing his N-95 mask properly when the surveyor entered the DON's office and the DON grabbed the front of the N-95 mask with his bare hand to put it over his mouth and nose. IP/ADON said, since the DON had touched the N-95 mask barehanded, he should have washed his hands and changed the N-95 mask at that time. IP/ADON said she was not six feet apart from ADON/LVN and/or the DON. IP/ADON said ADON/LVN and the DON were standing side by side, less than a foot apart, and she (IP/ADON) was standing across the desk less than 4 feet from both ADON/LVN and the DON. IP/ADON said staff should have gloves on when touching the N-95 mask. The N-95 mask should only be touched when donning and doffing the mask. Observation on 09/24/20 at 2:31 p.m. revealed IP/ADON touched and adjusted her N-95 mask with her bare hand. Observation on 09/24/20 at 2:46 p.m., revealed IP/ADON touched and adjusted her N-95 mask with her bare hand. Observation on 09/24/20 at 2:51 p.m. revealed IP/ADON touched and adjusted her N-95 mask with her bare hand. Record review of facility policy titled Surveillance Plan: Infection control Surveillance COVID-19 revision dated 03/24/20 revealed: .Cleaning Procedures 3. Management of laundry .should also be performed in accordance with routine procedures. . The policy did not include the need for staff to don gloves when touching dirty linen, and/or bagged dirty linen. Record review of the facility policy titled Infection Control Guidelines subtitled Clinical Practice Guidelines Infection Control revision date 02/13/20 revealed: e. Staff shall use Personal Protective Equipment (PPE) according to established facility policy governing the use of PPE. 4. Hand Hygiene Protocol: .d. Hands shall be washed in accordance with our facility's established hand washing procedure. 7. Supplies Protocol: .h. soiled linen collected at bedside and placed in a plastic bag and placed in linen bags. When the bag is full, it shall be closed securely and placed in the soiled utility room. Record review of facility policy titled Conservation of Personal Protective Equipment dated 03/18/20 revealed: Policy did not address donning or doffing. Policy did not address touching N-95 mask with bare hands and/or gloved hands. 4) Observation on 09/24/20 at 9:52 a.m. revealed a Housekeeper coming out of resident room [ROOM NUMBER] in Hall C. The Housekeeper's hands were double gloved with [MEDICATION NAME] blue gloves and on top vinyl clear gloves. The Housekeeper removed the vinyl gloves, placed them in the trash, and utilized hand sanitizer while still wearing her [MEDICATION NAME] gloves. In an interview on 09/24/20 at 9:55 a.m., the Housekeeper said she had an allergy to the vinyl gloves. The Housekeeper said that, in an all staff in-service conducted by the DON, the DON said staff who were allergic to vinyl gloves were to place the [MEDICATION NAME] gloves on their hands. Staff would then use hand sanitizer on the blue gloves then don the vinyl gloves over the [MEDICATION NAME] gloves. Housekeeper said she was instructed to keep the [MEDICATION NAME] gloves on until she took her lunch break or if she took a restroom break. The Housekeeper said this was new to her, and she had always been told to change gloves and wash hands after every room. The Housekeeper said, I cleaned the DON's office and then went to Hall C. I am still wearing the same [MEDICATION NAME] gloves. I will not change them until my lunch break. The Housekeeper said she had sanitized the [MEDICATION NAME] gloves with hand sanitizer more than six times. In an interview on 09/24/20 at 10:00 a.m., the Housekeeping Supervisor said the Housekeeper cleaned both Halls C and D. The Housekeeping Supervisor said the Housekeeper had cleaned isolation rooms but had not cleaned any COVID-19 rooms. The Housekeeping Supervisor said, according to the training the DON conducted on gloves, since the housekeeper was allergic to the vinyl gloves, she would put on the blues gloves. The Housekeeper would then sanitize the blue gloves with hand sanitizer and then place the vinyl gloves over them. The Housekeeping Supervisor said the Housekeeper was to remove the vinyl gloves before leaving the room she cleaned and sanitize the blue gloves as if the gloves were her skin. The Housekeeper was to enter the next room, sanitize the blue gloves, and place the vinyl gloves over them. The Housekeeping Supervisor said the Housekeeper was to keep the blue gloves on until she went to lunch and when she went home for the day. The Housekeeping Supervisor said this was something new, and it had always been that they removed gloves and washed hands after each room. The Housekeeping Supervisor said she did not receive a copy of the in-service the DON conducted on gloves. The Housekeeping Supervisor said she was not sure of the date the in-service was conducted. The Housekeeping Supervisor said the practice of double gloving and donning the same pair of [MEDICATION NAME] gloves for the shift for the staff with allergies [REDACTED]. The Housekeeping Supervisor said the facility provided the Housekeeping department with gloves, but the Housekeeper was only able to obtain the [MEDICATION NAME] gloves directly from the DON. The Housekeeping Supervisor said the Administrator informed her yesterday (09/23/20) that [MEDICATION NAME] gloves were all back ordered. In an interview on 09/24/20 at 10:26 a.m., the DON said he conducted the in-service for all staff including housekeeping staff regarding double gloving. The DON said, I am not sure when the glove in-service was given. CDC said you can double glove and sanitize between glove changes. The DON said the facility supplied the Housekeeping department with gloves. The DON said the Housekeeper with the allergy to the vinyl gloves, who required [MEDICATION NAME] gloves, obtained the gloves from the DON. Observation on 09/24/20 at 12:15 p.m. revealed the Central Supply office with supplies storage had 12 cases of [MEDICATION NAME] gloves, each case containing 10 individual boxes of [MEDICATION NAME] gloves. [MEDICATION NAME] gloves sizes and quantity observed were two boxes of extra-large, five boxes of large and five boxes of medium. In an interview on 09/24/20 at 12:16 p.m., Central Supply said, All different types of [MEDICATION NAME] gloves are on back order, so I order five to ten cases each time I place an order. I received a case on 09/23/20 of [MEDICATION NAME] gloves. I usually receive one or two cases of [MEDICATION NAME] gloves with the order. The facility has less than 10 staff members that require the [MEDICATION NAME] gloves. The facility has not ever run out of [MEDICATION NAME] gloves. I probably have on hand 11 or 12 cases of [MEDICATION NAME] gloves. I keep them in my office. Record review of in-service titled Purpose Infection Control dated 06/22/20 revealed: In-service/Training Objectives: At completion of this program the recipient should be able to: In-serviced staff on Policy and Procedure of Infection Control: Wash hands before and after all care for 20-30 seconds . All linen is to be separated in bags clean and dirty Assure Isolation precautions are maintained at all times such as gowns, masks . Type of Presentation: Staff in-serviced on procedures of handwashing, donning of gloves, donning/doffing of double gloves procedures. Return demonstration done with staff. Inservice did not document when double gloving after removal of one pair of gloves hand sanitizer being utilized on the remaining pair of gloves. Inservice did not include when to change double gloves. Inservice did not include gloves to be utilized when touching dirty linen bags. Inservice did not include need to wear gloves when touch the front of an N95. Inservice did not include need for handwashing/hand sanitizer after touching front of N95. Inservice did not document signatures of attendance for: ADON/IP, ADMIN, and DON. Record review of facility policy titled Surveillance Plan: Infection control Surveillance COVID-19 revision dated 03/24/20 revealed: .Gloves Perform hand hygiene then put on clean, non-sterile gloves upon entry into the patient's room or care area Remove and discard gloves when leaving the patient room . .Cleaning Procedures 3. Management of laundry .should also be performed in accordance with routine procedures. . Policy failed to mention double-gloving. Record review of the facility policy titled Infection Control Guidelines subtitled Clinical Practice Guidelines Infection Control revision date 02/13/20 revealed: 4. Hand Hygiene Protocol: .d. Hands shall be washed in accordance with our facility's established hand washing procedure. Record review of facility policy titled Hand Hygiene dated 11/12/17 revealed: Policy: .will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Policy Explanation and Compliance Guidelines: 1. Hand hygiene is a general term that applies to either handwashing or the use of antiseptic hand rub, also known as alcohol-based hand rub (ABHR). 2. Staff will perform hand hygiene when indicated, using proper techniques consistent with accepted standards of practice . Record review of facility policy titled Conservation of Personal Protective Equipment dated 03/18/20 revealed: Policy did not address gloves. Center for Disease Control and Prevention cdc 24/7: Saving Lives Protecting People titled Coronavirus Disease 2019 (COVID-19) Strategies for Optimizing the Supply of Disposable Medical Gloves updated 04/30/20 revealed: .Methods for performing hand hygiene of gloved hands for extended use of disposable medical gloves. CDC does not recommend disinfection of disposable medical gloves as standard practice Alcohol-based hand sanitizers Alcohol-based hand sanitizers is the preferred method for performing hand hygiene of gloved hands in the healthcare settings . Disposable medical gloves can be disinfected for up to six applications of alcohol-based hand sanitizers . https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/gloves.html page five 5) In an interview on 09/24/20 at 2:28 p.m., IP/ADON said she had not started the mapping surveillance of resident infections for September 2020. IP/ADON said she had not had the time to start the mapping for September. In an interview on 09/24/20 at 4:00 p.m., the DON said IP/ADON had the surveillance mapping for the month of September 2020. Record review of facility policy titled Surveillance Plan: Infection control Surveillance COVID-19 revision dated 03/24/20 revealed: Policy To minimize exposure to and exposure to respiratory pathogens including 2019- nCoV Fundamental Information .Isolation precautions are implemented |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>for residents with known or suspected for COVID -19 in a private room . Patient Placement .2) The facility can adhere to the rest of the infection prevention and control practices . The resident should be placed in a private room with the door closed, implement respiratory isolation precautions. .Immediately notify the physician for an undiagnosed respiratory infection, suspected or confirmed cases of COVID-19. . Record review of the facility policy titled Infection Control Guidelines subtitled Clinical Practice Guidelines Infection Control revision date 02/13/20 revealed: Anticipated Outcome .11. Surveillance: There is on-going monitoring of for infections among residents and personnel and subsequent documentation of infections that occur . 12 Outbreak: a. Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks. 13. Monitoring: a. The system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases is reviewed and evaluated . b. .Infection prevention rounds are made to assess the level of quality provided and actions for improvement are taken as needed. c. Infection control outcomes are reviewed monthly .recommendations are made to sustain compliance with reducing and prevention the spread of infections. Policy failed to include daily surveillance of infections. Policy failed to include mapping for surveillance of infections, outbreaks, and clusters. |
| F 0881<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Implement a program that monitors antibiotic use.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to establish an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use, for one of one facility reviewed for antibiotic use. The facility's infection prevention and control program did not implement a facility-wide system to monitor the use of antibiotics and did not implement protocols to optimize the treatment of [REDACTED]. This failure could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections. Findings included: In an interview on 09/24/20 at 8:17 a.m., the DON said the facility had not been tracking and trending antibiotic use. The DON said he completed the Infection Preventionist training course. The DON said the facility had an infection control committee . In an interview on 08/24/20 at 2:28 p.m., IP/ADON said she was responsible for the facility's Infection Control Program and had not completed the Nursing Home Infection Preventionist training course. IP/ADON said she did not track and trend the physicians who ordered antibiotics in the facility. IP/ADON was unable to state which physician's were ordering the most antibiotics. IP/ADON said labs were not always performed before or after antibiotic use; not all physicians would order labs. IP/ADON said the facility had no infection control committee. In an interview on 09/27/20, at 3:00 p.m., the Administrator said the facility's Pharmacist and the facility's Medical Director were not present for infection control meetings. The Administrator said there was not an infection control committee and there were no infection control meeting minutes. The Administrator said the facility had not been tracking and trending antibiotic use in the facility. The Administrator said the DON had completed the Infection Preventionist course. Record review of the DON's certificate titled, Infection Preventionist Specialized Training, dated 09/18/18, revealed completion of Infection Preventionist Specialized Training 23 hours of Continuing Nursing Education jointly provided by American Health Care Association. Record review of the facility's policy titled, Antibiotic Stewardship Policy, review date 02/12/20, revealed: It is the policy of this facility to follow an Antibiotic Stewardship process that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. Fundamental Information Commitment- Facility leadership (Administrator, Director of Nursing {Infection Preventionist}, and Medical Director) and consultant Pharmacist are committed to safe and appropriate antibiotic use that includes; Accountability - Appropriate facility staff accountable for promoting and overseeing antibiotic stewardship Drug Expertise - Accessing pharmacist and others with experience or training in antibiotic stewardship Action - Implement policy(ies) or practice to improve antibiotic stewardship Tracking - Track measures of antibiotic use in the facility (such as process and outcome measures) Reporting - Regular reporting of antibiotic use and resistance to relevant staff such as prescribing physicians and nursing staff. Education - Educate staff and residents about antibiotic stewardship Process a. Antibiotic Stewardship is part of our Infection Control Program b. The facility will track outcome measures of antibiotic usage such as pharmacy data, lab data c. Antibiotic use will be calculated . f. The Director of Nurses will communicate antibiotic use/trends with physicians prescribing antibiotics . Policy did not reveal documented evidence of an infection control committee meeting. |
| F 0882<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | Based on interview and record review, the facility failed to designate an Infection Preventionist that was qualified by education, training, experience or certification, and who completed specialized training in infection prevention and control, for one of two Infection Preventionists reviewed. The designated Infection Preventionist (IP/ADON) had not completed specialized training reviewed. This failure could affect residents by placing them at risk of cross contamination and infection . Findings included: During an interview on 09/24/20 at 8:17 a.m., the DON said he was the Infection Preventionist for the facility and was certified. During an interview on 09/24/20 at 2:18 p.m., IP/ADON said she had not completed the training for Infection Preventionist. IP/ADON said she kept the logs for infection control, completed the mapping of surveillance for the facility infections to monitor for outbreaks and/or clusters. IP/ADON said she was responsible for the logs of the Antibiotic Stewardship. IP/ADON said she was just starting to learn about the antibiotic stewardship process. During an interview on 09/24/20 at 3:00 p.m., the Administrator said IP/ADON was the Infection Preventionist for the facility and she was almost done with her training. The Administrator stated IP/ADON was responsible and completed the infection control surveillance and logs. During an interview on 09/24/20 at 3:44 p.m., ADON/LVN said she assisted with infection control, but IP/ADON was the Infection Preventionist and completed all the surveillance and logs for infection control. During a telephone interview on 09/29/20 at 11:23 a.m., when asked in regard to IP/ADON not being certified, the DON said, I am the Infection Preventionist, I oversee the program. In an email on 09/29/20 at 2:37 p.m., the DON wrote, I do have an Infection Preventionist that has been coming in and doing directed in-service. Was here in September and is due in October. Employee records indicated IP/ADON was hired on 12/17/10. Employee records indicated the DON was hired on 01/02/06. Record review of facility policy titled, Infection Preventionist, dated 02/20/20, revealed: The facility will employee one or more individuals with responsibility for implementing the facility's infection prevention and control program. Definitions: 'Infection Preventionist' is defined as the individual designated by the facility to be responsible to facilitate and coordinate the infection prevention and control program. Policy Explanation and Compliance Guidelines: 1. The facility will designate a qualified individual as the Infection Preventionist (IP) whose role is to coordinate and be actively accountable for the facility's infection prevention and control program. 2. The facility will ensure the Infection Preventionist . is adequately qualified and meets eligibility requirements; .c. Education, training, experience or certification in infection control and prevention; d. Completed specialized training in infection prevention and control . 3. Responsibilities of the Infection Preventionist . a. Implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections . b. Establish facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases . c. Implement written policies and procedures in accordance with current standards of practice . d. Oversight of the facility's antibiotic stewardship program . |
| F 0884<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interview, the facility failed to report complete information about COVID-19 to the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) during a seven-day period, for one of one facility. The facility failed to document and notify the CDC regarding R#1's positive test results for COVID-19 (Coronavirus). This failure placed residents and staff at risk for exposure to COVID-19. The findings were: Record review of R#1's September Medication Review Report (physician's orders [REDACTED]. R#1's [DIAGNOSES REDACTED]. Record review of<br>R#1's quarterly MDS assessment, dated 08/21/20, revealed R#1: -had minimal difficulty hearing, -had clear speech, -was able to make himself understood, -was able to understand others. Record review of R#1's Comprehensive Care plan, initiated on 08/15/20, revealed R#1 was at risk for infections/sign and symptoms of COVID-19. Goal: R#1 would not exhibit signs/symptoms of COVID-19. Intervention: Educate staff, Resident, family, visitors of COVID-19 signs and symptoms and precautions. In an interview on 09/24/20 at 8:10 a.m., during the entrance conference with the Administrator and DON present, a list of residents who had tested positive for COVID-19 in the months of August and September 2020, including the test dates and result dates was requested . The Administrator said the last COVID-19 positive test for a resident was on 09/05/20 and the last time residents were tested for COVID-19 was 09/03/20. In an interview on 09/24/20 at 1:10 p.m., the ADON/LVN located R#1's lab result indicating COVID positive test for a physician's orders [REDACTED]. The ADON/LVN said R#1's positive lab |

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| F 0884<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>result for COVID-19 was on their lab account site. The ADON/LVN said the lab results should have been in R#1's medical chart. ADON/LVN said, I was not aware he (R#1) tested positive for COVID. Record review of R#1's lab results on Results Viewer, dated 09/24/20, revealed: Order date 09/02/20 at 11:01 p.m. Draw date 09/01/20 at 11:20 a.m. Test: Name [DIAGNOSES REDACTED]-CoV-2 INTE Result: Positive Positive results are indicative of the presence of [DIAGNOSES REDACTED]-CoV-2 RNA .<br>.All testing performed at (name of lab) . Record review of R#1's nurses notes, dated 09/03/20 at 6:04 p.m., revealed: Nurse notified responsible party results were negative for COVID test performed inhouse. Record review of R#1 electronic medical record failed to document R#1 positive COVID lab result for 09/01/20. Failed to document notification to R#1 and R#1 RP. In an interview on 09/24/20 at 12:51 p.m., the Administrator said 09/05/20 was the latest COVID positive result in the facility and she was not aware R#1 had a positive result for COVID. In an interview on 09/24/20 at 1:12 p.m., IP/ADON said Okay, I do not see a positive result anywhere in the electronic or the paper medical chart. IP/ADON said, for a positive COVID-19 result, they routinely placed the positive resident on droplet precautions and transferred to the unit designated for COVID-19 (at that time it was A hall now it is E hall). IP/ADON said the family, the doctor, the Administrator, and the DON would be notified. IP/ADON said I was not made aware that R#1 was ever positive for COVID-19. In an interview on 09/24/20 at 1:41 p.m., The DON said, R#1 was never positive for COVID. In an interview on 09/24/20 at 1:53 p.m., The DON said, I reported the positive COVID result to the County Health Department and to the state. In an interview on 09/24/20 at 2:28 p.m., IP/ADON said no one was notified regarding R#1's positive COVID-19 result. Record review of R#1's Infectious Disease Report, dated 09/10/20, revealed: Reportable Disease/Condition COVID-19 Positive Results Date: 09/01/20 specimen Collection 09/02/20 positive results 09/04/20 retest with negative results In an interview on 09/24/20 at 3:05 p.m., the Administrator said the facility does not retest COVID-19 positive residents until the third day after the positive result. In an interview on 09/24/20 at 3:44 p.m., ADON/LVN said she and IP/ADON conducted the COVID-19 testing rounds. If a resident's COVID-19 test returned with a positive result, the facility waited 48 hours to repeat the test. ADON/LVN said the repeat COVID-19 test was performed from the time of the positive result, not the time of the actual test. ADON/LVN said she was not aware of R#1's positive COVID-19 result. ADON/LVN said if they had been aware of the positive result, R#1 would not have been retested on [DATE]. On 09/24/20 at 3:00 p.m., a policy on COVID-19 reporting of residents and/or staff positive results was requested from both the DON and ADMIN. In a telephone interview on 09/29/20 at 11:24 a.m., the DON said, We test and report our staff and residents' results per CDC guidelines . We do not have a policy. |
| F 0885<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based interview and record review, the facility failed to notify residents and/or the residents' Responsible Party /families by 5:00 p.m. the following day, after a resident of the facility tested positive for COVID-19, reviewed for one of one residents . The facility failed to inform residents and/or the residents' RPs/family of a confirmed infection of COVID-19 in the facility. This failure placed residents at risk of not receiving proper medical attention. Findings included: Record review of R#1's September Medication Review Report (Physicians orders) revealed R#1 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's quarterly MDS assessment, dated 08/21/20, revealed R#1: -had minimal difficulty hearing, -had clear speech, -was able to make himself understood, -was able to understand others Record review of R#1's Comprehensive Care plan, initiated on 08/15/20, revealed R#1 was at risk for infections/sign and symptoms of COVID-19. Goal: R#1 would not exhibit signs/symptoms of COVID-19. Intervention: Educate staff, Resident, family, visitors of COVID-19 signs and symptoms and precautions. In an interview on 09/24/20 at 8:10 a.m., during the entrance conference with the Administrator and DON present, surveyor requested a list of residents who had tested positive for COVID-19 in the months of August and September 2020, including the test dates and result dates. The Administrator said the last COVID-19 positive test for a resident was on 09/05/20 and the last time residents were tested for COVID-19 was 09/03/20. Record review of R#1's lab results on Results Viewer, dated 09/24/20, revealed: Order date 09/02/20 at 11:01 p.m. Draw date 09/01/20 at 11:20 a.m. Test: Name [DIAGNOSES REDACTED]-CoV-2 INTE Result: Positive Positive results are indicative of the presence of [DIAGNOSES REDACTED]-CoV-2 RNA . .All testing performed at clinical pathology laboratories, inc . Record review of R#1's nurses notes, dated 09/03/20 at 2:10 p.m., revealed: Nurse spoke to (R#1's) responsible party in regard to COVID 19 testing. Nurse informed and educated responsible party on new CDC guidelines and need for resident to be tested . RP authorized the testing and will be notified of the results as soon as results are ready since it's in house; results will be ready in within 15 minutes of swab Record review of R#1's nurses notes, dated 09/03/20 at 6:04 p.m., revealed: Nurse notified responsible party results were negative for COVID test performed inhouse. In an interview on 09/24/20 at 12:51 p.m., the Administrator said 09/05/20 was the latest COVID positive result in the facility and she was not aware R#1 had a positive result for COVID. In an interview on 09/24/20 at 1:10 p.m., the ADON/LVN located R#1's lab result indicating COVID positive test for a physician's order dated 08/31/20. The lab was drawn on 09/01/20 and a positive result received on 09/02/20. When asked why R#1 was tested again on 09/03/20, the ADON/LVN shook her head and said, To be honest I'm not sure, I would have to look to see. The ADON/LVN said R#1's positive lab result for COVID-19 was on their lab account site. The ADON/LVN said the lab results should have been in R#1's medical chart. The ADON/LVN said R#1 was one of the residents they tested who was negative in the past, so it was time to test R#1 again. ADON/LVN said, I am not sure why he was tested on the 1st and then again on the 3rd by us (ADON/LVN and IP/ADON). ADON/LVN said R#1 should have been placed on isolation, but she did not see an isolation order or notification of the results to R#1 or R#1's Physician. ADON/LVN said, I was not aware he (R#1) tested positive for COVID. In an interview on 09/24/20 at 1:12 p.m., IP/ADON said We (IP/ADON and ADON/LVN) started using the Veritor machine (COVID-19 testing machine) and the results for the tests came right then. IP/ADON said there had to be an order for [REDACTED]. IP/ADON said ADON/LVN and IP/ADON did a training on 09/02/20 and tested everyone who had been negative in the past on 09/03/20. IP/ADON said, I don't know why (R#1) was tested on both September 1st and 3rd. I believe (R#1) is his own responsible party. When asked about the nurses note indicating R#1's RP was notified on 09/03/20 of testing and a negative result, IP/ADON said Okay, I do not see a positive result anywhere in the electronic or the paper medical chart. IP/ADON said, for a positive COVID-19 result, they routinely placed the positive resident on droplet precautions and transferred to the unit designated for COVID-19 (at that time it was A hall now it is E hall). IP/ADON said the family, the doctor, the Administrator, and the DON would be notified. IP/ADON said, We would need from the physician an isolation order and we would have needed an order for [REDACTED].#1 was ever positive for COVID-19. In an interview on 09/24/20 at 1:41 p.m., the DON said an order was needed to do a COVID-19 test. The DON said, for a positive test, both the Physician and RP were notified, the resident was placed in isolation, and all measures for PPE were put in place. The DON said, R#1 was never positive for COVID. In an interview on 09/24/20 at 2:28 p.m., IP/ADON said no one was notified regarding R#1's positive COVID-19 result. In a telephone interview on 09/29/20 at 11:23 a.m., the DON said there was not a facility policy to inform residents, and/or Resident Representatives of positive COVD-19 results. Record review of the facility policy titled, Condition Change, of the Resident (Observing, Recording and Reporting) undated revealed: Responsibility: 'Licensed Nurse' Purpose: To observe, record and report any condition change to the attending physician so proper treatment will be implemented. .2 . charge nurse is calling the attending physician . 4. Notify Resident's responsible party . Recognition of Change of Condition 1. Criteria: resident .Complains of not feeling well, fever or pain .4. Contact the attending physician or designee . 5. Receive orders from attending physician or designee 6. Implement orders 7. Provide nursing care . Record review of the facility policy titled Infection Control Guidelines subtitled Clinical Practice Guidelines Infection Control revision date 02/13/20 revealed: Anticipated Outcome The purpose of this policy is to reduce and to prevent the spread of infections by the use of evidenced based techniques established infection control policies and procedures. .9. Resident/Family/Visitor Education a. Patients, family members and visitors are provided information as it relates to them on the rationale of infection control, isolation precautions, and staff notification. |
| F 0886<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to conduct testing in a manner that was consistent with current standards of practice for conducting COVID-19 tests, reviewed for one of one facility for COVID-19 testing. The facility failed to document in the R#1's medical record the COVID-19 testing that was completed on 09/01/20, and the facility failed to wait the recommended timeframe between testing for COVID-19 per CDC guidelines. This failure placed residents and staff at risk for exposure to COVID-19 (Coronavirus). Findings included: Record review of R#1's September Medication Review Report (Physicians orders) revealed R#1 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's quarterly MDS assessment, dated 08/21/20, revealed R#1: -had minimal difficulty hearing, -had clear speech, -was able to make himself understood, -was able to understand others, Record review of R#1's Comprehensive Care plan, initiated on 08/15/20, revealed R#1 was at risk for infections/sign and symptoms of |

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| F 0886<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 5)<br>COVID-19. Goal: R#1 would not exhibit signs/symptoms of COVID-19. Intervention: Educate staff, Resident, family, visitors of COVID-19 signs and symptoms and precautions. In an interview on 09/24/20 at 8:10 a.m., during the entrance conference with the Administrator and DON present, a list of residents who had tested positive for COVID-19 in the months of August and September 2020, including the test dates and result dates was requested . The Administrator said the last COVID-19 positive test for a resident was on 09/05/20 and the last time residents were tested for COVID-19 was 09/03/20. Record review of R#1's lab results on Results Viewer, dated 09/24/20, revealed: Order date 09/02/20 at 11:01 p.m. Draw date 09/01/20 at 11:20 a.m. Test: Name [DIAGNOSES REDACTED]-CoV-2 INTE Result: Positive Positive results are indicative of the presence of [DIAGNOSES REDACTED]-CoV-2 RNA . .All testing performed at clinical pathology laboratories, inc . Record review of R#1's nurses notes, dated 09/03/20 at 2:10 p.m., revealed: Nurse spoke to (R#1's) responsible party in regard to COVID 19 testing. Nurse informed and educated responsible party on new CDC guidelines and need for resident to be tested . RP authorized the testing and will be notified of the results as soon as results are ready since it's in house; results will be ready in within 15 minutes of swab Record review of R#1's nurses notes, dated 09/03/20 at 6:04 p.m., revealed: Nurse notified responsible party results were negative for COVID test performed inhouse. In an interview on 09/24/20 at 12:51 p.m., the Administrator said 09/05/20 was the latest COVID positive result in the facility and she was not aware R#1 had a positive result for COVID. In an interview on 09/24/20 at 1:10 p.m., the ADON/LVN located R#1's lab result indicating COVID positive test for a physician's orders [REDACTED]. When asked why R#1 was tested again on 09/03/20, the ADON/LVN shook her head and said, To be honest I'm not sure, I would have to look to see. The ADON/LVN said R#1's positive lab result for COVID-19 was on their contracted lab account site. The ADON/LVN said the lab results should have been in R#1's medical chart. The ADON/LVN said R#1 was one of the residents they tested who was negative in the past, so it was time to test R#1 again. ADON/LVN said, I am not sure why he was tested on the 1st and then again on the 3rd by us (ADON/LVN and IP/ADON). ADON/LVN said, I was not aware he (R#1) tested positive for COVID. In an interview on 09/24/20 at 1:12 p.m., IP/ADON said, I was not made aware that R#1 was ever positive for COVID-19. In an interview on 09/24/20 at 1:51 p.m., the Administrator said that Halls B and E were the designated COVID-19 unit and Hall A was the presumptive area. The Administrator said Hall C was never a COVID-19 unit. The Administrator confirmed R#1 resided in Hall C and had only ever resided in Hall C. In an interview on 09/24/20 at 1:53 p.m., the DON said, I reported the positive COVID result to the County Health Department and to the state. (R#1) was retested right away and his result was negative. When there is a negative (R#1) does not have to be retested . We follow CDC guidelines for COVID-19 testing. In an interview on 09/24/20 at 2:28 p.m., IP/ADON said no one was notified regarding R#1's positive COVID-19 result. IP/ADON said when a resident had a positive COVID-19 result, the resident was retested for COVID-19 within 48 hours after receiving the positive result. In an interview on 09/24/20 at 3:05 p.m., the Administrator said the facility did not retest COVID-19 positive residents until the third day after the positive result. Review of the Centers for Disease Control and Prevention's Testing Guidelines for Nursing Homes, updated 07/17/20, revealed: Testing the same resident more than once in a 24-hour period is not recommended. Accessed on 10/05/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html Facility DON and ADMIN did not provide a policy on COVID-19 testing of residents and/or staff as requested on 09/24/20 at 8:30 a.m., 1:00 p.m., 2:00 p.m., and 3:00 p.m. In a telephone interview on 09/29/20 at 11:24 a.m., the DON said, We test our staff and residents per CDC guidelines. We do not have a policy. |
| F 0921<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**<br><br>Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. A housekeeping cart had two bottles of hand sanitizer left unattended. This failure could place residents at risk for accidental ingestion of a chemical substance. The findings included: Observation on 09/24/20 at 9:41 a.m. revealed a Housekeeping cart left unattended outside of the DON's office. Located on top of the cart were a partially full bottle labeled Germx hand sanitizer and a full bottle labeled Antiseptic hand rub. In an interview on 09/24/20 at 9:55 a.m., the Housekeeper said, I cleaned the DON's office. I always keep the hand sanitizer bottles on top of the cart. My Supervisor had told me to store the hand sanitizer on my cart. They never said the hand sanitizer could not be left alone, so I leave it on top of the cart and I leave my cart in the hall, when I clean the DON's office. It is not within my sight the entire time. I have my back to the cart while I am cleaning. In an interview on 09/24/20 at 9:56 a.m., the DON said, Housekeeping staff is not to leave hand sanitizer on top of the carts unattended, the hand sanitizer is to be stored inside the cart. In an interview on 09/24/20 at 10:02 a.m., the Housekeeping Supervisor said the housekeeping staff could leave hand sanitizer on their cart. When the housekeeper was in a room, the hand sanitizer was to be locked in the cart. The Housekeeping Supervisor said there had not been an in-service on where to store hand sanitizer. In an interview 09/24/20 at 10:00 a.m., the DON said he did not have an in-service for the storing of hand sanitizer. DON said the facility did not have a policy on the storage of hand sanitizer. Record review of four ounce Medline Antiseptic Hand rub label revealed: Topical solution with 80% v/v ethyl alcohol. Record review of Medline Antiseptic Hand Rub Safety Data Sheet revealed: Section two: Hazards Identification Classification FLAMMABLE LIQUIDS - Category 3 SERIOUS EYE DAMAGE /EYE IRRITATION - Category 2A Signal Word Warning . Hazard Statements Causes serious eye irritation Flammable liquid and vapor . Section 7. Handling and Storage General Handling Information: Take necessary action to avoid static electricity discharge (which might cause ignition of organic vapors). Keep away from fire, sparks and heated surfaces. Precautionary Measures: Do not get in eyes. Do not taste or swallow. Do not breathe vapor or fumes. Wash thoroughly after handling. Keep out of the reach of children. Conditions for safe storage: Keep away from heat and sources of ignition. Keep in a cool, well-ventilated place. Keep away from oxidizing agents . Container Warnings: Container is not designed to contain pressure. Do not use pressure to empty container or it may rupture with explosive force. Empty containers retain product residue (solid, liquid, and/or vapor) and can be dangerous. Do not pressurize, cut, weld, braze, solder, drill, grind, or expose such containers to heat, flame, sparks, static electricity, or other sources of ignition. They may explode and cause injury or death. Empty containers should be completely drained, properly closed, and disposed of properly. Record review of eight ounce germx moisturizing original hand sanitizer revealed: Drug Facts Active Ingredient: Ethyl alcohol 63%. Purpose: Antiseptic .Warnings for external use only: hands Flammable keep away from fire or flame When using this product keep out of eyes . avoid contact with broken skin. do not inhale or ingest. .if swallowed . call Poison Control Center right away |