STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265733	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOHNS PLACE	3333 BROWN ROAD SAINT LOUIS, MO 63114

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection control program during a Coronavirus disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2). Common symptoms include fever, cough, fatigue, shortness of breath, and loss of smell and taste.) pandemic, to provide a safe and sanitary environment for all residents. The facility failed to ensure staff wore masks appropriately in accordance with Center for Disease Control (CDC) guidelines, and to ensure proper hand-washing and food handling was followed in the kitchen and gloves were appropriately changed (Residents #1, #2, #3, #4, and #5). The census was 60. Review of CDC guidance, updated 5/19/20, showed the following: -Healthcare Providers (HCP) should wear a facemask at all times while they are in the facility. When available, facemasks are generally 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. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if personal protective equipment (PPE) is required. -Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. -Visitors, if permitted into the facility, should wear a cloth face covering while in the facility. Review of the facility's undated policy, entitled Outbreak Management, showed the following: -Policy: Nursing staff plays an essential role in the prevention of transmission of infectious diseases. If an outbreak is identified, nursing personnel will be responsible to: -Use meticulous infection control practices. 1. Review of Resident #1's face sheet, showed [DIAGNOSES REDACTED]. Review of Resident #2's face sheet, showed [DIAGNOSES REDACTED]. Observation on 5/28/20 at 11:20 A.M., showed Certified Nurse Aide (CNA) A on a resident hallway, wearing a cloth mask below his/her nose, covering his/her mouth only. Resident #1 and Resident #2 sat in wheelchairs on opposite sides of the hallway. CNA A walked past both residents, while his/her mask was below the nose. 2. Observation and interview on 5/28/20 at 11:31 A.M., showed CNA C and Housekeeper D entered the residents' dining room from outside. Both staff walked across the dining room with no masks on. CNA C coughed into his/her elbow. Both exited the dining room onto 500 hall and donned masks. Housekeeper D went to the nurse's station and washed his/her hands. CNA C did not wash his/her hands before he/she propelled a resident to a room. Housekeeper D said they were returning from a smoking break. 3. Observation on 5/28/20 at 11:44 A.M., showed Dietary Aide (DA) E, in the kitchen without a mask or gloves on. Without washing his/her hands, DA E put gloves on. Using utensils, DA E moved a large roast from the cooking pan to a cutting board. DA E then poured the meat's broth from the larger pan into a smaller pan. He/she then put a face mask on, and pushed the face mask up with the back of his/her gloved hand. He/she removed the gloves and put new gloves on, without washing his/her hands. At 11:47 A.M., DA E's mask was observed below his/her nose. DA E removed the gloves and washed his/her hands, exited the kitchen and went outside to the break area. During an interview on 5/28/20 at 11:50 A.M., the Dietary Supervisor said he/she told DA E to wear the mask up over his/her nose. DA E should have washed his/her hands when changing gloves. 4. Review of Resident #3's face sheet, showed [DIAGNOSES REDACTED]. Review of Resident #4's face sheet, showed [DIAGNOSES REDACTED]. Observation on 5/28/20 at 11:45 A.M., showed the assistant Director of Nurses (ADON) obtained two masks and then approached both residents, placing a mask on their faces. He/she did not wash his/her hands or apply hand gel between each resident. 5. Review of Resident #5's face sheet, showed [DIAGNOSES REDACTED]. Observation on 5/28/20 at 11:46 A.M., showed the resident approach the ADON with a skin tear to his/her left arm. The ADON removed supplies from the treatment cart, washed his/her hands in the sink, put on gloves and cleansed the resident's wound. With the same gloved hands, he/she opened the treatment cart drawer and pulled out a package of steri strips, opened the package and with the same gloved hands, placed the steri strips on the resident's wound. 6. Observation on 5/28/20 at 12:05 P.M., showed two housekeeping staff talking outside a resident's room, not social distancing, with one wearing a mask and the other without a mask. During an interview on 5/28/20 at 12:06 P.M., the Director of Nursing (DON) said she expected staff to wear a mask properly covering the nose and mouth. Staff have received in-servicing to include the proper way to put on, wear and take off a mask. Masks should be worn at all times by staff during resident care, when in a resident's room, when in a resident care area and when walking down any resident hallways where doors are open. 7. Observation on 5/28/20 at 12:20 P.M., showed eight residents in the dining room. Laundry Aide B entered the residents' dining room from outside while on his/her cell phone talking, with no mask on. He/she exited the dining room and walked down the 500 hall towards the nurse's station. He/she was approached by another staff member, then turned around walked back down 500 hall and exited the resident care area. Approximately two minutes later, he/she re-entered the 500 hall, wearing a mask.

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