STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165597	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDGEWATER, A WESLEYLIFE COMMUNITY	**9225 CASCADE AVENUE WEST DES MOINES, IA 50266**

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 observation, staff interviews, and record review, the facility failed to ensure staff implemented infection control practices to prevent the spread of infection such as proper use and disposal of personal protective equipment (PPE) for 1 of 5 staff members (Staff H) who entered a room without recommended PPE for a resident (Resident # 1) who was on isolation precautions. The facility reported a census of 37 residents. Findings include: 1. Facility documents include the following: a. Policy # NS-PO- , titled, Infection Control COVID-19 defined isolation as a means to separate an individual who is reasonably known to be infected with a communicable disease and potentially infectious from those who are not infected to prevent the spread of infection. The policy also defined PPE as protective items or garments worn to protect the body or clothing from hazards that can cause injury, which included gowns. The policy indicated that for residents who are suspected or confirmed to have COVID-19, staff members will use PPE appropriately including donning of PPE upon room entry and properly discarding before exiting the resident room in order to contain pathogens. The policy specified the donning of a clean isolation gown upon entry into the resident room or care area, and removing and discarding the gown in a dedicated container for waste or linen before leaving the resident's room or care area. b. The facility's Resident Matrix, indicated that Resident # 1 received antibiotics and had current [MEDICAL CONDITIONS] infection. 2. Interviews and observations on 6/10/2020 showed the following: a. At 10:19 AM, Staff N (Registered Nurse) identified no COVID-19 positive cases at the Aster Unit but facility protocol was that residents that left the facility for any reason required placement on transmission-based precautions and 14-day quarantine upon return. Staff N also identified the reasons for Resident # 1's isolation placement as his going out for a doctor's appointment on 6/9/2020, and also found positive for [MEDICAL CONDITION]. b. At 10:23 AM, Staff H wore a mask, and pushed the housekeeping cart in the hallway where he ended up parking in front of Resident # 1's room. Resident # 1's door had 2 warning posters that directed anybody entering the room to wear gown, mask, and face shield. However, Staff H only donned a pair of black gloves, took cleaning supplies from the cart, and then entered Resident # 1's room, without wearing a face shield and a gown. b. At 10:26 AM, Staff H stepped out from Resident # 1's room, took a blue gown which hung from the housekeeping cart, put it on, and then went back inside Resident # 1's room. c. At 10:28 AM, Staff H stepped out from Resident # 1's room, still wearing the same gown, removed gloves only and then pushed the housekeeping cart about 10 feet away from Resident # 1's door. Staff H stated a therapy staff was inside the room so he was just going to wait after Resident # 1's therapy before going back to finish cleaning. When asked if they have to wear PPE inside Resident # 1's room, Staff H replied in the affirmative, adding that Resident # 1 must left the facility. Staff H acknowledged that he forgot to wear gown when he first entered the Resident # 1's room. Staff H remained standing in the hallway until he went back inside Resident # 1's room at 10:35 AM. d. At 10:38 AM, Staff H came out from Resident # 1's room, took off his gown and hung it on the housekeeping cart. Staff H pushed the housekeeping cart down the hallway where he parked, and entered another room. e. At 10:53 AM, the Director of Nursing (DON) who was also around at the Aster Unit, verified the presence of the used gown hanging on the housekeeping cart being around by Staff H. The DON acknowledged that the dirty gown should not be going anywhere and should have been discarded inside Resident # 1's room. The DON also stated expectations that all staff should observe practices to prevent the spread of infection. \

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