| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **165291** | A. BUILDING _____ B. WING _____ | **06/09/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **FRIENDSHIP HAVEN, INC** | **420 SOUTH KENYON ROAD FORT DODGE, IA 50501** |

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 0689<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, staff interviews, and record review, the facility failed to provide adequate supervision for a resident who required staff assistance for one of four residents reviewed (Resident #3). On 6/2/20, a nurse aide took the resident outside for approximately 25 minutes, coming back in to retrieve a pendant (5 minutes or less) and back outside at 1:37 PM. Staff then left Resident #3 outside unsupervised on an enclosed secure patio, wearing a long-sleeved thick pink ribbed shirt. The temperature at that time per State Climatologist in Fort Dodge was 96 degrees Fahrenheit (F) with a relative humidity of 35%, which resulted in a heat index of 98 F. At 2:16 PM, staff returned the resident inside. Following heat exposure, the resident experienced a condition change. The resident appeared lethargic, confused and weak. The resident's temperature was 102.2 F (average temperature is 98.6) with a pulse of 105 (an average pulse is 80-100). The resident's ability to stand and transfer declined and she required increased staff assistance. Due to the lack of adequate supervision, the facility's actions caused the resident's health and safety to be in Immediate Jeopardy. The facility reported a census of 97 residents. Findings include: A Minimum Data Set (MDS) completed with an Assessment Reference Date of [DATE] showed a Brief Interview for Mental Status score of 14, indicating intact cognition. The resident had [DIAGNOSES REDACTED]. The MDS showed the resident required limited assistance of one staff member with ambulation and locomotion in the seven day lookback period. The resident experienced two falls with no injury since the last assessment. The resident record did not contain Occupational Therapy (OT) screening or nurse screening for safety when outside on the secured patio. The Interdisciplinary Note for Resident #3, written by Staff G (RN) dated 6/2/20 at 4:19 PM revealed a caregiver assisted the resident outside onto the patio at approximately 1:40 PM. The resident sat outside for 30 minutes in the area shaded by the building. The nurse checked on the resident at 2:15 PM, and the resident stated she was ready to come inside. The resident appeared weak and confused. The nurse assisted the resident in the recliner with an extensive assist of one. The resident's vital signs were: temperature of 102.2, pulse of 105, respirations 24, blood pressure of 126/80, and [MED]gen saturation of 94%. The resident received cold fluids, staff assisted with removing layers of clothing, and applied cold cloths to the neck and forehead. At 3:00 PM, the resident's temperature was 100.2. The resident appeared more alert and responded to questions appropriately. The resident reported she did not know what happened to her. The resident denied chest pain, nausea, or vomiting. The resident spoke with her family. The nurse notified the family of heat exposure. At 3:30 PM, the resident's temperature was 98.7. The resident denied concerns. The nurse informed the physician and family of the incident via the phone. A care plan intervention dated 1/24/20 identified the resident as an assist of one staff with ambulation with the four-wheeled walker due to increased falls. One staff assisted the resident with showers and when walking outside of the neighborhood. The care plan identified the resident planned to use the call light as needed. The resident did not use a gait belt per the resident's request and staff educated the resident regarding gait belt use. The resident verbalized she understood the risks of not using the gait belt. A care plan problem dated 1/24/20 identified the resident at risk for falls related to increased weakness and recent falls. The care plan identified the resident with poor safety awareness, and impulsivity which increased the risk of falls. Staff educated the resident at length regarding the use of [MEDICATION NAME] and the risks involved in the case of a fall occurred. The resident used a walker to assist with mobility. On 6/4/20 at 1:21 PM, the resident stated she insists on sitting outside every day. The resident said she sat outside every day except today (6/4/20). The resident stated she was not ill but couldn't see well. The resident reported that someone sits outside with her and approximately two to three other residents that also sit outside. During a follow-up interview on 6/4/20 at 3:33 PM, the resident stated she only remembered feeling better after cooling down. The resident stated she knew better but said identified herself as a sun freak for years. The resident denied having a pendant call light because it felt too heavy for her. The resident stated if the pendant call light was half the size, she would wear it, but it didn't matter because someone is always outside with her. On 6/8/20 at 8:53 AM, the surveyor examined the sweater the resident wore on 6/2/20. Observation revealed the sweater as a thick pink ribbed long-sleeved turtle neck.<br>Staff Interviews: On 6/4/20 at 1:34 PM, Staff B, Registered Nurse (RN), stated one resident got too warm on 6/2/20, and nurses monitored the resident. She noted staff should sit with residents when they are outside, as they can not be outside alone. Staff B denied any other issues with residents having problems with being outside. The nurse reported that six other residents sit outside with one staff, with no more than four residents at a time. On 6/4/20 at 1:51 PM, Staff E, Caregiver, stated a lot of the residents like to go out together when the weather is nice. The caregiver reported taking the resident for a walk on 6/2/20. The resident and the caregiver had a glass of water together while sitting outside. When Staff E needed to come inside, the resident didn't want to go inside. Staff E took the resident inside and put on her pendant call light then took the resident out to the enclosed patio to sit at around 1:37 PM. Staff E indicated she informed the oncoming shift that the resident was out on the patio during the 2:00 PM huddle. Staff E stated the protocol for residents to be outside alone included the resident having a pendant call light or a cellphone to contact someone. On 6/8/29 at 11:54 AM, Staff E stated the time the resident and Staff E was outside before the resident sitting out on the patio alone was between 15-25 minutes max. They came back in to get the pendant call light and then Staff E returned the resident outside to the secured patio at 1:37 p.m. In a follow up interview on 6/10/20 at 9:29 AM, Staff E stated while Resident #3 and herself sat outside and had a glass of water, they sat between the apartment buildings. Staff E reported that after this time sitting outside, the resident and herself went into the facility at approximately 1:35 PM to get the resident's pendant. Staff E said that they were only in the building for around 5 minutes. After getting the pendant, Staff E assisted the resident to the enclosed patio, not the same patio where she and the resident previously sat. On 6/4/20 at 2:35 PM, Staff G, RN, stated she became aware around 2:00 PM that the resident was outside. Staff G made rounds and wasn't sure how long the resident was out. Staff G stated she only knew of one resident that was allowed to be independent outside, and it wasn't Resident #3. Staff G said she has worked for the facility for approximately four years and did not recall the previous year's standards. Staff G denied knowing any other residents that had issues with being outside. Staff G did not know of any policies regarding residents being on the patio independently. Staff G stated staff received verbal education and communication regarding residents left outside unsupervised, especially if the resident was a fall risk. She stated Resident #3 should receive staff supervision while outside due to the resident's history of many falls and inferior vision. During a follow-up interview on 6/4/20 at 3:20 PM, Staff G stated the resident was very lethargic but was alert when returned into the facility. The resident's usual transfer status was a stand by assist to limited assistance. However, following the incident on 6/2/20, the resident required extensive assistance to get into the recliner. The resident did not know where she was or what was going on. Staff G said she didn't remember the resident using her pendant in the past but the resident occasionally utilized a touchpad call light when in the her room. Staff G identified the resident as forgetful |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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 0689<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>and made self transfers in the past without activating a call light. Staff G reported the resident wore the pendant while outside on 6/2/20. The pendant rested on the outside of the resident's sweater and the resident would know it was there. Staff G believed the temperature was in the mid to upper 90s F on the day of the incident. On 6/4/20 at 2:27 PM, Staff F, Caregiver, said the protocol last year was that, if the resident was independent, they could go outside alone. Staff F stated that Staff E did report the resident as out on the patio during the huddle. She said she did not see the resident outside on the East patio as she needed to assist someone in the west part of the neighborhood. On 6/8/20 at 10:23 AM, Staff J, Caregiver, reported offgoing staff identified the resident as outside during shift report. After receiving the report, Staff J answered a call light. Staff J said the next thing she knew, the nurse brought Resident #3 inside. Staff J stated someone needed to sit with the resident while outside, and she did not know of any residents that could sit out alone. On 6/4/20 at 1:36 PM Staff C, Household Coordinator stated the resident did sit outside alone. Staff C worked at home when the incident occurred. Staff C met with the caregiver who assisted the resident outside 6/4/20. On 6/4/20 at 1:39 PM, Staff D, Caregiver, stated she just returned from maternity leave and only worked certain days. Staff D denied hearing about any issues with the resident sitting on the patio. Staff D reported that a few residents sit outside but never alone. On 6/4/20 at 4:16 PM, Staff N, Skilled Care Coordinator, said a nurse contacted her about Resident #3 sitting outside.<br>Staff N identified the protocol as obtaining an OT screening to determine a resident's ability to sit out on the patio alone. When returned inside, Staff N stated the resident felt warm to the touch but refused to have the sweater removed. A nurse convinced the resident to remove it. After removal of the sweater, the nurse applied cold washcloths and assessed the patient. Staff N stated caregivers knew of the rule not to leave a resident outside alone. Staff N identified Staff E as a very good aide who mentors new staff. Staff N said Staff G started to call staff to determine who left the resident outside alone after assessing the resident. Staff N said Staff G did not know who left the resident, but Staff F knew. Staff N stated at the time, Staff F assisted another resident in their room. Staff N reported she did not know if the facility had a written policy regarding residents outside on the patio but would look into it. Staff N stated the expectation is for staff to supervise residents outside unless care planned otherwise. During a follow-up interview on 6/8/20 at 8:40 AM, Staff N reported no policy due to the decision of whether residents sit outside unsupervised as individualized based on OT screening for safety. Observations: Observation of 6/2/20 surveillance video (the day of the incident) at 1:37 p.m. showed Staff E CNA (certified nurse aide) assist the resident via wheelchair to Catalyst's east secured patio. Staff E returned to the building one minute later and opened blinds to the patio door. At time stamp 1:42 PM, Staff G walked up to the nurses station and then walked away from the desk one minute later. At timestamp 1:49 PM, note an unidentified person, seated at the computer with their back away from the patio doors. At time stamp 1:58 PM, an unidentified person arose from the computer station and walked away from the nurses station. At 29 minutes into the video, Staff N walked over to the cupboard of the nurses station, removed an item and walked away from the area. Thirty-three minutes into the video, Staff G arrived at the nurses station and used the phone with her back to the patio doors. Staff G finished the call and walked away from the area. At thirty-seven minutes and 52 seconds into the video, a staff member walked up to the patio window, looked out, and walked away. At thirty-eight minutes and forty seconds into the video, two staff members exited the door onto the patio. At thirty-nine minutes and fifteen seconds (2:16 p.m.), the two staff members return the resident inside via wheelchair. At thirty-nine minutes and forty-three seconds, the video ended with the two staff pushing the resident into the facility away from the camera's view. The resident returned the resident inside at 2:16 p.m. Observation on 6/4/20 at 1:14 PM showed the patio as bright and sunny. Observation on 6/8/20 at 8:53 AM seen the bright patio sunny with no shade and breezy. Physician Interview: On 6/8/20 at 9:28 AM, the resident's primary physician revealed the facility notified him of the incident. The physician identified the resident's ability to sit alone on the patio as hard to determine due to not seeing the resident in awhile. The physician revealed that ideally the all residents should not sit outside without staff. He stated the resident sitting outside unsupervised in 98 degree heat for approximately 35 minutes placed the resident in imminent danger and the resident should not sit outside that long. Following notification, the physician directed staff to supply the resident with cool washcloths and encourage fluids. He instructed the nurse to call if fever increased or continued or the resident's condition changed right away. On 6/8/20 at 9:44 AM, the Director of Nursing (DON) said Staff C conducted staff education. After the surveyor expressed concerns, staff placed the education on the screening table. All staff read the education before beginning their shift and signed it, stating they read it. The caregiver received a counseling session from her supervisor. During a follow-up interview on 6/8/20 at 9:53 AM, the DON stated that each situation is individualized regarding a resident's ability to sit independently on the patio. The DON reported nurses or OT decided if the resident could sit on the patio alone. The DON said therapy is usually involved for residents with cognition concerns. The DON felt each neighborhood could make the decisions. During an observation on 6/8/20 at 10:56 AM, noted the patio area with shade on the south side and breezy. The door to the east patio covered contained a sign with the following printed on the sign: a. Everyone must wear a mask while outside. b. Four residents per staff member. The sign included in black handwriting that residents must have a staff member outside with them. No sign observed to the west patio. During a follow-up interview on 6/8/20 at 11:43 AM, Staff G stated the resident was sitting to the north of the door. Due to where the resident was sitting, the resident was not able to be seen from the nurses' station. The nurse stated the area had slightly more shade than at present, but it was covering the resident. During a follow-up interview on 6/8/20 at 12:08 PM, Staff N stated that she texted the Catalyst neighborhood staff to ensure the team knew about the new policy. During an interview on 6/8/20 at 12:11 PM, the Administrator reported that education on new policies went out to everyone who had worked from 6/6/20 afternoon. The Administrator stated outside of the staff who received individual education in the Catalyst neighborhood, she did not know of any other education provided to the team. Follow Up Regarding Surveillance Camera footage: During a follow-up interview on 6/8/20 at 1:40 PM, the Administrator stated the facility did have a camera for the east patio. The Administrator noted the video did not show the resident on the patio. However, the footage showed when staff took the resident onto the patio and back in from the facility. On 6/9/20 at 12:50 PM, Staff O, Transitions Coordinator, assisted this surveyor by sitting in a chair in the approximate location Staff G described where the resident sat when the incident occurred. While Staff O sat in the chair, this surveyor went into the facility and looked out the window. Staff N and Staff P observed from the door to see if Staff O was visible. During this observation, the only part of Staff O visible from the nurses' station was Staff O's feet and the leg of the chair. Staff N opened the door and stated you could see almost the entire patio from the doorway. While doing this, Staff P looked out and said she was surprised to see Staff O outside as she did not know she was out there. During an interview on 6/9/20 at 1:49 PM, Staff H stated she did see the resident on the patio but reported not knowing the resident was outside until she received the report in the huddle. Staff H stated she and Staff G went straight out after the huddle to bring the resident in from the patio. An Employee Counseling Report dated 6/4/20 indicated Staff E received counseling related to the incident. The counseling report identified the reason for disciplinary action as: on 6/2/20, Staff E took a resident outside. Staff E left the resident alone and then went to the 2:00 PM huddle. At 2:15 PM, the nurse noticed the resident outside. By that time, the resident appeared weak and overheated. Employee comments revealed Staff E took the resident outside around 1:40 PM and informed the second shift the resident sat on the secured patio with a pendant. The area what must be done to correct the violation contained the following information: Staff must stay outside with resident or call for another staff member to come out. Bring resident inside if staff unable to go outside with resident. Weather: On 6/8/20 at 10:17 a.m. the State Climatologist identified the temperature as 96 degrees with relative humidity 35% making the heat index 98 degrees. Abatement: In addition to the employee counseling on 6/4/20, the facility abated the immediate jeopardy on 6/6/20 during the investigation by issuing a memo to all employees and residents dated 6/6/20 that contained reminders to be aware of temperature and heat index-stay inside if too hot. Avoid peak times. Plan activities in the early morning or when the sun starts to set. Dress appropriately-wear loose light colored clothing. Apply adequate sunscreen SPF above 15. Stay hydrated by drinking plenty of cool water. Avoid caffeine and alcohol. Spend as much time as possible in air conditioned spaces. If outside stay in shady area if possible. If escorting a resident to the patio and/or outside, please verify care plan of resident to see if they require supervision while outside. Warning signs of heat related illness may include but are not limited to: increased body temperature, weakness, headache, muscle cramps, dizziness, confusion, nausea/vomiting and weak pulse. If you have signs of heat related illness or observe someone else who is, come in from the outside immediately and notify a team member and/or supervisor. Immediate interventions may include: giving water, applying a cold wash cloth to wrists, ankles, armpits and neck to lower the temperature, check vital signs. The facility was informed of the immediate jeopardy situation on 6/9/20. |
| F 0690<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide appropriate care for residents who are continent or incontinent of bowel/bladder,** |

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| F 0690<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>**appropriate catheter care, and appropriate care to prevent urinary tract infections.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record reviews, the facility failed to provide adequate perineal care for one of two residents reviewed (Resident #4). The facility reported a census of 97 residents. Findings include: The Minimum Data Set completed with an Assessment Reference Date of 5/14/20 showed a Brief Interview for Mental Status score of 5, indicating severe cognitive impairment. The resident had [DIAGNOSES REDACTED]. During an observation on 6/8/20 at 12:27 PM, Staff K, Caregiver, assisted the resident in the bathroom. After the resident sat on the toilet, Staff K entered into the resident's room and removed her gloves. Staff K moved the garbage can and closed the bathroom door. Staff K then sanitized her hands while waiting for the resident to finish in the bathroom. When the resident finished, Staff K entered the bathroom and prepared the supplies. Staff K placed a wax paper onto the sink and opened the wipes. Staff K put some wipes onto the wax paper on the counter. The resident's adult pull up appeared clean and dry. Staff K wiped the resident, starting on the backside of the resident cleaning the buttocks. After running out of wipes from the wax paper barrier, Staff K picked up the wipe package and removed new wipes from the package and continued to clean the resident's backside. After cleaning the backside of the resident, Staff K moved to clean the front of the resident without hand hygiene, continuing to pull new wipes from the package. Once done with the perineal cares, Staff K removed her gloves and pulled up the resident's clothes. Staff K then washed her hands with soap and water before shutting off the sink with a clean, dry paper towel. Staff K then placed the used cleansing wipes into the cupboard before checking if the resident felt comfortable. On 6/9/20 at 1:35 PM, Staff L, Unit Manager, identified the correct way to complete perineal care as washing the front perineal area then wash the backside. Staff L stated the aide should not take wipes with dirty hands out of the package, and if necessary, throw the container away. On 6/9/20 at 1:40 PM, the Director of Nursing stated staff needed to complete perineal care by washing front to back. The policy labeled Perineal Care with a review date of 3/19 indicated the facility's policy is to provide perineal care to residents to maintain good hygiene, prevent skin breakdown, and promote a sense of personal well-being. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interviews, and record review, the facility failed to follow proper infection control standards for three of three residents reviewed (Residents #1, #4, and #7). The facility reported a census of 97 residents. Findings include: 1. A Minimum Data Set (MDS) completed for Resident #4 with an Assessment Reference Date (ARD) of 5/14/20 showed a Brief Interview for Mental Status (BIMS) score of 5, indicating severe cognitive impairment. The resident had [DIAGNOSES REDACTED]. During an observation on 6/8/20 at 12:27 PM, Staff K, Caregiver, assisted the resident into the bathroom. After the resident sat on the toilet, Staff K walked into the resident's room and removed gloves. Staff K moved the garbage can and closed the bathroom door. Staff K then sanitized her hands while waiting for the resident to finish in the bathroom. When the resident finished, Staff K entered the bathroom and prepared the supplies. Staff K placed wax paper onto the sink for barrier and opened the wipes. Staff K put some wipes on the wax paper on the counter. The resident's adult pull up appeared clean and dry. Staff K wiped the resident, starting on the backside of the resident cleaning the buttocks. After running out of wipes from the wax paper barrier, Staff K picked up the wipe package and removed new wipes from the package to complete cleaning the resident's backside. After cleaning the backside of the resident, Staff K clean the front periarea of the resident without hand hygiene and continued to pull new wipes from the package. Once done with the perineal cares, Staff K removed her gloves and pulled up the resident's clothes. Staff K then washed her hands with soap and water before shutting off the sink with a clean, dry paper towel. Staff K then placed the used cleansing wipes into the cupboard before checking if the resident felt comfortable. On 6/9/20 at 1:35 PM, Staff L, Unit Manager, identified the correct way to complete perineal care as washing the front perineal area then wash the backside. Staff L stated the aide should not take wipes with dirty hands out of the package, and if necessary, throw the container away. 2. The MDS completed for Resident #1 with an ARD of 5/8/20 showed a BIMS score of 10, indicating moderate cognitive impairment. The resident had [DIAGNOSES REDACTED]. observation on 6/4/20 at 3:00 PM, revealed Staff H, Registered Nurse (RN), collected supplies in the nurses' station. Staff H picked up the stethoscope from the shelf and placed it onto the neck. She then retrieved the pulse oximeter from a bag and put it into Staff H's pocket of her scrub top. Staff H then entered the resident's room and washed her hands while Staff B, RN, assisted the resident to adjust their legs. Staff B then went into the bathroom and washed her hands. Once Staff B finished washing her hands, she came out, threw away the paper towels, and noticed something on the floor. Staff B picked an item up off the floor and threw the item into the garbage. Without completing hand hygiene again, Staff B went over to the resident, assisted the resident with a drink, and then arranged the resident's bedside table. Staff H prepared the medications and then applied gloves. After helping the resident with medications, Staff H removed her gloves and sanitized her hands. Staff H then assessed the resident's lungs and [MED]gen saturation. After listening to the resident's lungs without disinfecting the items, Staff H placed the stethoscope onto her neck and the pulse oximeter into her top scrub pocket. Staff H prepared the resident's nebulizer treatment, then applied the treatment mask to the resident. Staff H and Staff B washed their hands and exited the room. On 6/8/20 at 1:40 PM, the Director of Nursing (DON) said Staff needed to clean items shared between each resident use. If a resident is in isolation, the resident should get a set specifically for that room. 3. The MDS completed for Resident #7 with an ARD of 3/19/20, showed a BIMS score of 5, indicating severe cognitive impairment. The resident had [DIAGNOSES REDACTED]. During an observation on 6/4/20 at 12:33 PM, Staff A, Caregiver, entered the resident's room and offered to assist the resident in the bathroom. Staff A assisted the resident to stand up with the standing mechanical lift and moved it into the restroom. Staff A pulled the resident's pants down and sat the resident on the toilet. After confirming the resident was clean and dry, Staff A prepared a wax paper barrier to complete perineal care. Once the resident finished, Staff A stood the resident with the standing mechanical lift, applied gloves without hand hygiene, and wiped the resident from between the legs starting at the front then moving to the backside. Staff A removed gloves and stood the resident up with the standing mechanical lift and moved the resident to the recliner. Staff assisted the resident with comfort and went in the bathroom and washed hands. Staff A then left the resident room and placed the standing mechanical lift into the alcove without disinfecting. Staff A walked away from the stand lift without cleaning the machine. On 6/8/20 at 1:18 PM, Staff M, Household Coordinator, reported five residents on the east side and three on the west side that used a standing mechanical lift. Staff M identified 3 machines for the two neighborhoods. Staff M said staff should disinfect the machines after every use, and there was no specific area for cleaning. The expectation was to bring the device out and disinfect it every time. Facility policy labeled Infection Control Precautions/Guidelines with a review date of 8/18 revealed it was facility policy to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in the facility. |