STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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, clinical record review, staff interview and facility document review, it was determined that facility staff failed to implement infection control practices to prevent the spread of communicable disease for five of 27 residents in the survey sample, Residents #1, #2, #3, #4, and #5, all of whom were identified as being under contact precautions. The facility staff failed ensure appropriate PPE (personal protective equipment), donning of gloves prior to entering the rooms and providing feeding assistance to, Resident(s) #1, #2, #3, #4, and #5, all of whom were under contact precautions. The findings include: 1. Resident #1 was admitted to the facility with the [DIAGNOSES REDACTED]. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/23/20. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and extensive assistance for all other areas of activities of daily living, including eating. On 08/25/2020 at 9:12 a.m., an observation revealed Resident # 1 in their bed having breakfast. Further observation revealed CNA (certified nursing assistant) # 2 was seated at Resident # 1's bedside feeding the resident. Observation of CNA # 2's PPE (personal protective equipment) revealed they were wearing a face mask goggles and gown. Further observation failed to evidence CNA # 2 wearing gloves. Observation of the entrance to Resident # 1's room revealed a sign posted next to the door that documented, STOP. CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. A review of the comprehensive care plan revealed one dated 7/16/20 for Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits. This care plan included the following interventions: Contact Isolation dated 8/24/20. Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance dated 7/16/20. A review of the clinical record revealed a laboratory result dated 7/22/20 which documented the resident had tested negative for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). A review of the clinical record revealed a physician's orders [REDACTED]. Review of the nurse's notes in Resident #1's clinical record from 8/18/20 to 8/24/20, revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested , etc.) A review of the COVID-19/Coronavirus Daily Evaluation form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the Comments section on many of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:52 a.m., an Interview was conducted with CNA # 2. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions, with a sign posted outside of their room, CNA # 2 stated, A gown mask face shield or goggles and gloves When asked if they assisted Resident # 1 with their breakfast, CNA # 2 stated, Yes. I was wearing a mask and gown. I did not have gloves. When asked why it was important to wear all of the correct PPE, CNA # 2 stated, Because of [MEDICAL CONDITION] that's going on gloves protect the patient and myself. When asked to describe what was on the sign outside the door of Resident # 1's room, CNA # 2 stated, To wear gloves a gown a mask and wear the goggles or a face shield. When asked if they should have been wearing gloves if a resident is under contact precautions, CNA # 2 stated yes. On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions, LPN # 2 stated goggles, gown and mask and gloves. When asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions, LPN # 2 stated, To prevent the spread of infection. When informed of the above observation, LPN # 2 stated, They (CNA #2) should've followed the sign and wore gloves. On 08/25/2020 at 11:10 a.m., an interview was conducted with RN (registered nurse) # 1, ADON (assistant director of nursing) and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, We are debating between resident dignity and what the sign says. When asked why staff and residents were maintaining social distancing, RN # 1 stated, To prevent contact with droplets. When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, To prevent the spread of infection. When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership. When informed of the above observation, RN # 1 stated that the staff (CNA #2) should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #2. The facility's IN-SERVICEATTENDANCE FORM dated 7/13/20 documented, Topic: Residents face mask and social distancing & (and) PPE. Under Print Name and Signature it documented CNA #2's name. On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON (assistant director of nursing) and infection control coordinator. When asked why Resident # 1 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, (name of unit), had tested positive for COVID-19. The facility's policy Contact Precautions documented in part, Policy: Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, spread by direct or indirect contact with the resident or the resident's environment. In addition to Standard Precautions use Contact Precautions to prevent nosocomial spread of organisms that can be transmitted by direct resident contact (touching) with environmental surfaces or contaminated resident care equipment. Procedures for Contact Precautions: Glove Use for Contact Precautions. 1. In addition to wearing gloves as outlined under Standard Precautions, clean, non-sterile gloves are worn when providing direct care (changing, clothing, toileting, bathing, dressing changes, etc.) to residents on Contact Precautions. 2. Wear gloves whenever touching the resident's intact skin or surfaces and articles near the resident (e.g. medical equipment, bed rails). Don gloves upon entry into the room or cubicle. 3. Gloves should also be worn when handling items potentially contaminated by MDROs (multi-drug resistant organisms). This includes items such as bedside tables, over-bed tables, bed rails, bathroom fixtures, television and bed controls, suctions and oxygen tubing. 4. During providing care for residents, gloves will be changed after having contact with infective material that may contain high concentrations of microorganisms (fecal material or wound drainage). 5. Wearing gloves is not a substitute for hand antisepsis. Gloves will be removed and discarded before leaving the resident's room, hands will be washed with soap and water or waterless hand antiseptic will be used. After glove removal and hand hygiene, staff should ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room to avoid transfer of microorganisms to other residents or environments. On 08/25/2020 at 11:23 a.m., ASM (administrative staff member) # 1, administrator, was informed of the above findings. No further information was provided prior to exit.

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html. (2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html. 2. Resident #2 was admitted to the facility with the [DIAGNOSES REDACTED]. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/21/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for dressing and total care for all other areas of activities of daily living, including eating. On 08/25/2020 at 9:16 a.m., observation revealed Resident # 2 in bed with their breakfast tray on the over the bed table. Further observation revealed CNA (certified nursing assistant) # 3 was seated at Resident # 2's bed side offering/ holding a cup of orange juice in front of Resident # 2. After several attempts Resident # 2 refused the juice, CNA # 3 placed the cup on the breakfast tray and got up from their chair. Observation of CNA # 3's PPE (personal protective equipment) revealed they were wearing a face mask, face shield, and gown. Further observation failed to evidence CNA # 3 wearing gloves. Observation of the entrance to Resident # 2's room revealed a sign posted next to the door that documented, STOP. CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. A review of Resident #2's comprehensive care plan revealed one dated 7/16/20 for Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits. This care plan included the following interventions: Contact Isolation dated 8/24/20. Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance dated 7/16/20. A review of the clinical record revealed a laboratory result dated 7/22/20 which documented the resident had tested negative for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). A review of the clinical record revealed a physician's orders [REDACTED]. Review of nurse's notes in Resident #2's clinical record from 8/18/20 to 8/24/20 revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested , etc.) A review of the COVID-19/Coronavirus Daily Evaluation form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the comments section on many of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:56 a.m., an Interview was conducted with CNA # 3. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions with a sign posted outside of their room, CNA # 3 stated, A gown, 95 mask, face shield or goggles and gloves When asked if they assisted Resident # 2 with their breakfast, CNA # 2 stated yes. When asked if they should have been wearing gloves when they were in Resident # 2's room, CNA # 3 stated yes. When asked why it was important to wear all of the correct PPE CNA # 3 stated, To protect the patient and myself. On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions LPN # 2 stated goggles, gown and mask and gloves. When asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions, LPN # 2 stated, To prevent the spread of infection. When informed of the above observation, LPN # 2 stated, They (CNA#3) should've followed the sign and wore gloves. On 08/25/2020 at 11:10 a.m., an interview was conducted with RN (registered nurse) # 1, ADON (assistant director of nursing) and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, We are debating between resident dignity and what the sign says. When asked why staff and residents were maintaining social distancing, RN # 1 stated, To prevent contact with droplets. When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, To prevent the spread of infection. When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership. When informed of the above observation RN # 1 stated that the staff should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #3. The facility's IN-SERVICEATTENDANCE FORM dated 7/13/20 documented, Topic: Residents face mask and social distancing & (and) PPE. Under Print Name and Signature it documented CNA #3's name. On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON (assistant director of nursing) and infection control coordinator. When asked why Resident # 2 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, (name of unit), had tested positive for COVID-19. On 08/25/2020 at 11:23 a.m., ASM (administrative staff member) # 1, administrator, was informed of the above findings. No further information was provided prior to exit. References: (1) A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html. (2) The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called [MEDICAL CONDITION]. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 3. Resident # 3 was admitted to the facility with the [DIAGNOSES REDACTED]. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/2/20. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living, with eating requiring limited assistance. A review of the comprehensive care plan revealed one dated 7/16/20 for Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits. This care plan included the following intervention: Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance dated 7/16/20. A care plan for (Resident) demonstrates the need for ADL assistance dated 12/23/19, included the intervention, dated 8/3/20 for Contact Precaution - COVID-19 precaution. On 08/25/2020 at 9:24 a.m., observation revealed Resident # 3 in bed having breakfast. Further observation revealed CNA (certified nursing assistant) # 2 was seated at Resident # 3's bedside feeding the resident. Observation of CNA # 2's PPE (personal protective equipment) revealed they were wearing a face mask, goggles and gown. Further observation failed to evidence CNA # 2 wearing gloves. Observation of the entrance to Resident # 3's room revealed a sign posted next to the door that documented, STOP. CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. A review of the clinical record revealed a laboratory result dated 8/4/20 which documented the resident had tested negative for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). A review of the clinical record revealed a physician's orders [REDACTED]. Review of nurse's notes in Resident #3's clinical record from 8/18/20 to 8/24/20 revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested , etc.) A review of the COVID-19/Coronavirus Daily Evaluation form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the comments section on many of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:52 a.m., an Interview was conducted with CNA # 2. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions with a sign posted outside of their room, CNA # 2 stated, A gown mask face shield or goggles and gloves When asked if they assisted Resident # 3 with their breakfast, CNA # 2 stated, Yes. I was wearing a mask and gown. I did not have gloves. When asked why it was important to wear all of the correct PPE, CNA # 2 stated, Because of [MEDICAL CONDITION] that's going on gloves protect the patient and myself. When asked to describe what was on the sign outside the door of Resident # 1's room, CNA # 2 stated, To wear gloves a gown a mask and wear the goggles or a face shield. When asked if they should have been wearing gloves if the resident is under contact precautions CNA # 2 stated yes. On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe what PPE should be worn by staff when entering a residence room that

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F 0880

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 2)
is under contact precautions LPN # 2 stated goggles, gown and mask and gloves. When I asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions LPN # 2 stated, To prevent the spread of infection. When informed of the above observation LPN # 2 stated, They (CNA #2) should've followed the sign and wore gloves. On 08/25/2020 at 11:10 a.m., an interview was conducted with RN (registered nurse) # 1, ADON (assistant director of nursing) and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, We are debating between resident dignity and what the sign says. When asked why staff and residents were maintaining social distancing, RN # 1 stated, To prevent contact with droplets. When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, To prevent the spread of infection. When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership. When informed of the above observation RN # 1 stated that the staff should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #2. The facility's IN-SERVICEATTENDANCE FORM dated 7/13/20 documented, Topic: Residents face mask and social distancing & (and) PPE. Under Print Name and Signature it documented CNA #2's name. On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON (assistant director of nursing) and infection control coordinator. When asked why Resident # 3 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, (name of unit), had tested positive for COVID-19. On 08/25/2020 at 11:23 a.m., ASM (administrative staff member) # 1, administrator, was informed of the above findings. No further information was provided prior to exit. References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/ 9.htm. (2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/[MEDICAL CONDITION].html. (3) A brain disorder that causes people to have recurring [MEDICAL CONDITION]. The [MEDICAL CONDITION] happen when clusters of
nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/[MEDICAL CONDITION].html. 4. Resident # 4 was admitted to the facility with [DIAGNOSES REDACTED]. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/3/20. The
resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living, including eating which required total care. On 08/25/2020 at 9:28 a.m., observation revealed Resident # 4 in bed having breakfast. Further observation revealed CNA (certified nursing assistant) # 3 was seated at Resident # 4's bedside feeding the resident. Observation of CNA # 3's PPE (personal protective equipment) revealed they were wearing a face mask, faceshield, and gown. Further observation failed to evidence CNA # 3 wearing gloves. Observation of the entrance to Resident # 4's room revealed a sign posted next to the door that documented, STOP. CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before
room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. A review of Resident #4's comprehensive care plan revealed one dated 7/16/20 for Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits. This care plan included the following interventions: Contact Isolation dated 8/24/20. Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance dated 7/16/20. A review of the clinical record revealed a laboratory result dated 7/22/20 which documented the resident had tested negative for [DIAGNOSES REDACTED]-CoV-2 (COVID-19). A review of the clinical record revealed a physician's orders [REDACTED]. Review of nurse's notes in Resident #4's clinical record from 8/18/20 to 8/24/20, revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested , etc.) A review of the COVID-19/Coronavirus Daily Evaluation form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the comments section on some of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:56 a.m., an interview was conducted with CNA # 3. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions with a sign posted outside of their room, CNA # 3 stated, A gown, 95 mask, face shield or goggles and gloves When asked if they assisted Resident # 4 with their breakfast,
CNA # 3 stated yes. When asked if they should have been wearing gloves when they were in Resident # 4's room CNA # 3 stated yes. When asked why it was important to wear all of the correct PPE CNA # 3 stated, To protect the patient and myself. On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN (licensed practical nurse) # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions LPN # 2 stated goggles, gown and mask and gloves. When I asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions LPN # 2 stated, To prevent the spread of infection. When informed of the above observation LPN # 2 stated, They (CNA #3) should've followed the sign and wore gloves. On 08/25/2020 at 11:10 a.m., an interview was conducted with RN (registered nurse) # 1, ADON (assistant director of nursing) and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, We are debating between resident dignity and what the sign says. When asked why staff and residents were maintaining social distancing, RN # 1 stated, To prevent contact with droplets. When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, To prevent the spread of infection. When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership. When informed of the above observation RN # 1 stated that the staff should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #3. The facility's IN-SERVICEATTENDANCE FORM dated 7/13/20 documented, Topic: Residents face mask and
social distancing & (and) PPE. Under Print Name and Signature it documented CNA #3's name. On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON (assistant director of nursing) and infection control coordinator. When asked why Resident # 4 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, (name of unit), had tested positive for COVID-19. On 08/25/2020 at 11:23 a.m., ASM (administrative staff member) # 1, administrator, was informed of the above findings. No further information was provided prior to exit. References: (1) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. (2) [MEDICAL CONDITION] occurs when a person loses contact with reality. The person may have false beliefs about what is taking place, or who one is (delusions), see or hear things that are not there (hallucinations). This information was obtained from the website: https://medlineplus.gov/ency/article/ 3.htm. (3) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/[MEDICAL CONDITION]-disorder/index.shtml. 5. Resident # 5 was admitted to the facility with [DIAGNOSES REDACTED]. The most recent
MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/16/20. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living, with eating requiring extensive care. On 08/25/2020 at 9:35 a.m., an observation of Resident # 5 revealed they were in their bed having breakfast. Further observation revealed CNA (certified nursing assistant) # 2 was seated at Resident # 5's bedside feeding the resident. Observation of CNA # 2's PPE (personal protective equipment) revealed they were wearing goggles, face mask and gown. Further observation failed to evidence CNA # 2 wearing gloves. Observation of the entrance to Resident # 5's room revealed a sign posted next to the door that documented, STOP. CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before

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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	(continued... from page 3) room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention. A review of the comprehensive care plan revealed one dated 7/16/20 for Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches