STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265610	A. BUILDING _____ B. WING _____	05/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF ST LOUIS	3520 CHOUTEAU AVE SAINT LOUIS, MO 63103

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 -** Immediate jeopardy **Residents Affected -** Many	**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 implement Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) recommended infection control practices in order to control and prevent the potential spread of COVID-19 amongst the facility residents and staff. The facility allowed staff to work and provide care to residents after reporting COVID-19 symptoms and/or fevers, failed to thoroughly screen staff for COVID-19 prior to caring for residents in the facility, and failed to ensure staff providing care to residents and working in resident areas wore appropriate PPE. A determination was made that the facility's noncompliance with one or more of the requirements of participation placed all residents in the facility in immediate jeopardy. On [DATE] at 2:30pm, the Administrator was informed of the immediate jeopardy at F880, Infection Prevention and Control. The IJ was found to have started on [DATE] with the failures to appropriately screen staff for signs and symptoms of COVID-19 and prevent staff who were ill and/or COVID-19 positive from caring for the residents. Findings include: On [DATE] at 10:27am, the Administrator and Director of Nursing (DON) indicated that the facility experienced an outbreak of COVID-19, beginning in late March. The facility experienced 41 positive cases, of which seven residents died . The Administrator and DON indicated that during the outbreak, any positive residents were quarantined on the 4th floor. The Administrator and the DON indicated that the facility did not have any active cases of COVID-19 at the time of survey, and transferred the residents after they were asymptomatic from the 4th floor to the 2nd or 3rd floors. Following the outbreak, the 2nd floor of the facility was the clean floor, and that the 3rd floor was the unknown, or under observation for COVID-19, floor. The Administrator and the DON indicated that on the 2nd floor, staff were expected to appropriately wear a facemask when providing care to residents. On the 3rd floor, staff were expected to wear full PPE, consisting of an N95 respirator mask, disposable shoe covers, a gown, hairnet, gloves, and eye protection when assisting residents. Staff may wear an appropriately applied disposable surgical mask when in common areas, not providing resident care. The Administrator and DON indicated that a Physical Therapy Assistant (PTA1) recently tested positive for COVID-19. On [DATE] at 8:40am, Licensed Practical Nurse (LPN1), who stood at the medication cart on the second floor, pulled her N95 respirator mask down, exposing her mouth and nose. LPN1 indicated that the facility had an outbreak of COVID-19 about one to two months ago. LPN1 indicated that maybe 20 residents contracted the disease, and that they were quarantined on the 4th floor of the facility for 14 days. LPN1 indicated that over the weekend, all of the residents on the 4th floor were moved back downstairs because the quarantine was over. LPN1 indicated that staff must wear full PPE when entering resident rooms. LPN1 indicated that she knew pulling her facemask down to expose her mouth and nose was not proper mask usage, and could expose herself and/or other residents to possible contagions. On [DATE] at 9:00am, Maintenance staff (M1) left resident room [ROOM NUMBER] after cleaning the room. M1 wore a disposable gown, gloves, and a disposable surgical mask. M1 failed to change her gloves and sanitize her hands after leaving the room. M1 then entered resident room [ROOM NUMBER] and began cleaning, continuing to wear the same gloves. M1 cleaned the bathroom of room [ROOM NUMBER]. M1 indicated that she failed to change her gloves and sanitize her hands after cleaning room [ROOM NUMBER], indicating that normally, she only would change her gloves. M1 also indicated that the facility provided her with an N95 respirator, but that she chose to wear disposable surgical masks, because the N95 was uncomfortable, and that she had hot flashes and couldn't wear them. On [DATE] at 9:05am, Occupational Therapy Assistant (OTA1) indicated that the facility had an outbreak of COVID-19 in March and April. All residents who were positive were moved to the 4th floor. OTA1 indicated that approximately 30 residents required quarantine because of COVID-19. OTA1 indicated that facility staff must wear PPE with all residents, due to the recent outbreak. OTA1 indicated that a Physical Therapy Assistant(PTA1) tested positive for COVID-19 last week, and had been working with residents prior to her test. On [DATE] at 9:10am, the Central Supply (CS) supervisor stepped out of the elevator onto the 2nd floor. The CS supervisor wore only a disposable surgical mask, and failed to wear any other PPE. The CS supervisor indicated that the expectation of facility staff was that all staff were to wear gowns and facemasks while on the 2nd and 3rd floors, because of the COVID-19 outbreak. On [DATE] at 9:15am, Nurse Aide (NA1) exited the elevator onto the 3rd floor. NA1 walked from the elevator, past the nursing station, and to an empty office area. NA1 wore a disposable surgical mask, but failed to wear any other PPE. At 9:20am, NA1 indicated that she escorted a resident downstairs to the transportation van, disposed of her other PPE, and had failed to don more before entering the 3rd floor. On [DATE] at 9:25am, the Administrator and the CS supervisor exited the elevator onto the 3rd floor. Both wore disposable surgical masks, and failed to wear any other PPE. On [DATE] at 9:27am, LPN2 wore a disposable surgical facemask. LPN2 indicated that the facility provided her with an N95 respirator, but chose not to wear it because it was uncomfortable. Two boxes of N95 respirators sat on the counter of the nursing station. On [DATE] at 9:35am, LPN2 stood at the medication cart and finished preparing medications for a resident. LPN2 then took the prepared medications and entered resident room [ROOM NUMBER], wearing eye protection, a gown, an N95 respirator, and disposable shoe covers. LPN2 failed to wear gloves while giving the resident their medications. On [DATE] at 9:40am, LPN1 sat at the computer at the nursing station. LPN1 wore a facemask, however, the mask was pulled beneath her chin, leaving her mouth and nose exposed. On [DATE] at 10:25am, the CS supervisor indicated that the facility had not experienced a shortage or low levels of PPE. The CS supervisor indicated that the facility had a sufficient supply of PPE and had five or six days of backup PPE. On [DATE] at 11:48am, the Administrator and DON indicated that the expectation of facility staff was to wear PPE appropriately and perform hand hygiene after leaving resident rooms. - Review of staff screening sheets documented that the facility permitted staff to work while feverish or reporting signs or symptoms of COVID-19: 1. On [DATE], the facility failed to thoroughly screen 17 staff, one of which reported body aches, two reported sore throats, and one reported shortness of breath. None of the 17 staff had documented temperatures. 2. On [DATE], the facility failed to thoroughly screen two staff, who had temperatures taken, but failed to answer any screening questions. 3. On [DATE], a staff person documented a temperature of 100.3F on the screening sheet. The staff person documented no other signs or symptoms of COVID-19. Review of the staff person's time clock records documented that they worked from 6:35am to 2:42pm that day. 4. On [DATE], the facility failed to thoroughly screen six staff reporting for work, when the staff failed to answer screening questions. Additionally, the DON reported a temperature of 100.3F, and failed to answer any screening questions. Time clock records documented that the DON worked her scheduled shift that day. 5. On [DATE], the facility failed to thoroughly screen five staff reporting for work, when the staff failed to answer screening questions. 6. On [DATE], the facility failed to thoroughly screen four staff reporting for work, when the staff failed to answer screening questions. 7. On [DATE], the facility failed to thoroughly screen three staff, when the staff failed to answer screening questions. 8. On [DATE], the facility failed to thoroughly screen four staff, when the facility failed to ensure that two staff had their temperature taken before working and all four failed to answer screening questions. 9. On [DATE], the facility failed to thoroughly screen all staff when a staff person had an elevated temperature of 99.4F, reported that they had signs and symptoms of COVID-19, and that they had close personal contact with a person with a confirmed case of COVID-19. Review of the staff person's time clock records for [DATE] revealed that the staff person worked from 6:28am to

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

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) 3:02pm that day. On [DATE] at 10:27am, the Administrator and DON indicated that the expectation of staff would be that all facility staff would be thoroughly screened prior to beginning a shift. Staff with a fever or who answered affirmatively to screening questions would be sent home, or would be more thoroughly screened by administrative staff. The DON indicated that she was not aware of any current issues with the screening process.