STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265318	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, MARYLAND HEIGHTS	2920 FEE FEE ROAD MARYLAND HEIGHTS, MO 63043

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, interview, and record review, the facility failed to maintain an infection control program during a Coronavirus disease 2019 (COVID-19) pandemic, by not following current infection control standards and facility policies. The facility failed to ensure hand hygiene was performed appropriately, failed to clean multi-use dressing equipment (scissors and pen) and placed clean dressing supplies on and in unclean surfaces during a dressing change for one resident (Resident #3), failed to clean multiple resident use equipment after use, failed to remove personal protective equipment (PPE) prior to leaving a resident room, and failed to wear appropriate PPE while preparing silverware for resident use. The sample size was 3. The census was 151. Review of the facility's COVID-19 Patient While in the Center policy, dated 3/19/20, showed the following: -Healthcare personnel should perform hand hygiene using alcohol based hand sanitizer (ABHS) before and after all patient contact, contact with potentially infectious material, and before putting on and removing PPE, including gloves. Hand hygiene in healthcare settings also can be performed by washing with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS; -Use dedicated or disposable noncritical patient care equipment. If equipment must be used for more than one resident, clean and disinfect the equipment prior to using on another resident. Review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID 19 in Nursing Homes guidelines, updated 6/25/20, showed the following: -Healthcare Providers (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process; -HCP should perform hand hygiene by using ABHS with 60-95 percent alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS; -HCP should wear a facemask at all times while they are in the facility; -Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room. 1. Review of Resident #3's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/13/20, showed the following: -Severe cognitive impairment; -Dependent on staff for all mobility and personal care; -[DIAGNOSES REDACTED]. Observation on 8/3/20 at 9:45 A.M., showed the resident lay in bed on his/her left side with his/her legs drawn up to his/her abdominal area. Registered Nurse (RN) B, without washing hands or donning gloves, wheeled the treatment cart to the room door, unlocked the cart, retrieved a bottle of wound cleanser and two packaged kling wraps (an absorbent gauze roll, which stretches and clings to itself as it is wrapped) and laid them on top of the uncleaned treatment cart. He/She then stepped to the medication cart and retrieved a tube of Santyl ointment ([MEDICATION NAME] agent) which he/she laid on the treatment cart along with a pair of scissors and a box of gloves. RN B then left the cart to assist another resident, returned and washed his/her hands. He/She opened two small plastic bags and laid them on the foot of the resident's bed, returned to the treatment cart, placed the gathered supplies in a small plastic bag along with a 200 count package of 4 by 4 inch gauze, one package of ABD (thick gauze dressing) and three pieces of tape. He/She entered the room and laid the bag of clean supplies on the foot of the bed next to the two empty bags. RN B washed his/her hands, donned (put on) gloves, and removed the resident's top bed covers to expose both heels covered with dressings. He/She reached in the clean bag of supplies, retrieved the scissors and cut and removed the dressing from the right heel. He/She laid the scissors on the corner of the bag that held the clean supplies, changed gloves, did not wash his/her hands and using the same scissors, opened the ABD package and cut the ABD in half. He/She reached in the package of 4 by 4's, obtained three, sprayed wound cleanser on the gauze and cleansed the wound. He/She then again reached into the package of 4 by 4's, obtained two and dried the wound. He/She changed gloves, did not wash hands, reached in the package of 4 by 4's, obtained one, applied Santyl ointment to the gauze and reached into the bag of clean supplies and removed a kling. He/She placed the 4 by 4 on the wound, covered it with one half of the ABD and wrapped with a kling. He/She secured the kling with tape, removed his/her gloves, reached in his/her pocket, removed a pen, dated the tape and returned the pen to his/her pocket. He/She washed his/her hands, donned gloves, cut and removed the dressing from the resident's left heel and placed the scissors inside the corner of the bag of soiled supplies. He/She changed gloves without washing hands, reached in the package of 4 by 4's, removed two, sprayed wound cleanser on the 4 by 4 gauze, cleansed the wound and then removed two more 4 by 4 gauze pads from the package and dried the wound. He/She changed gloves, did not wash hands, applied Santyl ointment directly on the wound, laid the tube of Santyl in the bag with the soiled supplies, reached in the package of 4 by 4's removed one and laid it on the wound over the Santyl ointment. He/She covered the gauze with a half piece of ABD dressing and wrapped the heel with a kling and secured the kling with tape. He/She removed his/her gloves, reached in his/her pocket, removed a pen, dated the dressing and returned the pen to his/her pocket. After returning the tube of Santyl to the clean supply bag, he/she secured the bag of soiled supplies and placed it in the trash. With the scissors in his/her hand, he/she washed his/her hands and dried the scissors with the same towel he/she dried his/her hands. With the scissors in his/her hands, he/she removed the full bag of trash from the can under the sink, secured it and placed it in the trash can on the treatment cart, placed the scissors and remaining package of 4 by 4's in the drawer and returned the tube of Santyl to the medication cart. During an interview on 8/3/20 at approximately 10:35 A.M., RN B said the scissors should have been cleaned with a bleach wipe after cutting off the dressings and before cutting the ABD, and hands should always be washed whenever going from dirty to clean and after removing gloves. 2. Observation on 8/3/20 at 9:43 A.M., showed RN B in a resident room with a blood pressure (BP) machine. He/She exited the room with the BP machine. He/She wheeled the machine to the medication cart and recorded information in the computer, then wheeled the machine to the wall and plugged it in without cleaning the machine or the cuff. During an interview on 8/3/20 at approximately 10:35 A.M., RN B said the BP machine should be wiped down after each use as well as the cuff, but he/she had another chore to take care of first. He/She intended to return and clean the machine. When asked if another staff member wanted to use it, would they assume it was clean, the RN did not respond. He/She did not clean the machine after the conversation. 3. Observation on 8/3/20 at 10:48 A.M., showed Certified Nurse Aide (CNA) C exited a resident room and wore an isolation gown. He/She disposed an item in the laundry hamper then walked down the hallway past five occupied resident rooms, entered the soiled utility room, removed the gown and washed his/her hands. During an interview on 8/3/20 at approximately 10:50 A.M., CNA C said there was normally a hamper outside of the room to dispose of PPE, but he/she did not know where it was today. 4. During an interview on 8/3/20 at 11:50 A.M., the Administrator, Director of Nursing, Infection Preventionist and Nurse Practitioner said when staff perform a dressing change, the following should be done: -The scissors should be cleaned before and after use and should be dried with a clean paper towel; -Scissors should not be placed in a bag with soiled dressings; -Hands should be washed after touching anything dirty/soiled; -The top of the treatment cart should have been cleaned before placing any supplies on top of it; -Separate 4 by 4's should have been carried into the room and not the whole package; -Santyl should not have been placed in the bag with dirty supplies and the pen should not have been kept in the nurse's pocket; -The BP machine should always be cleaned

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) with bleach wipes before and after use along with the blood pressure cuff; -All of these are infection control issues, as well as staff wearing an isolation gown out of a resident room, which should never be done. The gown should have been removed and discarded in the resident's room. 5. Observation on 8/3/20 at 10:23 A.M., showed Dietary Aide (DA) A sitting in the dining room at a table rolling silverware into napkins. DA A was not wearing a facemask. Upon being alerted by another staff member, DA A donned a face mask. During an interview on 8/3/20 at 10:40 A.M., DA A said he/she has been educated to always wear a mask. He/She took the mask off because he/she was sweating and was letting the mask dry. No one else was around. During an interview on 8/3/20 at 11:11 A.M., the Dietary Manager said staff should always wear a facemask to keep germs from spreading. Staff have been educated on wearing a mask. During an interview on 8/3/20 at 11:45 A.M., the Administrator said staff should wear a mask while in the building and while rolling silverware.