

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/27/2020
NAME OF PROVIDER OR SUPPLIER MAPLE LEAF HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 MAPLE CARE LANE STATESVILLE, NC 28625		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
F 000	INITIAL COMMENTS	F 000			
F 880 SS=F	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals</p>	F 880		8/26/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/17/2020

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 880	<p>Continued From page 1</p> <p>providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens.</p>	F 880			

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F 880	<p>Continued From page 2</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of the facility's Infection Control and COVID-19 protocol documents, the facility failed to implement protocols when staff did not don and doff Personal Protective Equipment (PPE) when they entered and exited the rooms of residents who were on Droplet Precautions for 2 of 2 nursing staff observed working on the facility's quarantine hallway. The facility failed develop a policy that addressed when laundry staff were to perform hand hygiene and what Personal Protective Equipment (PPE) they were to wear. Additionally, a laundry aide was observed not wearing any PPE while handling clean and dirty laundry nor perform hand hygiene after touching soiled linen laundry for 1 of 1 staff observed processing laundry. Staff disposed of isolation gowns, that were used on the facility's quarantine unit, in a bag that was attached to a blood pressure machine. Staff failed to disinfect a mattress that was removed from a resident's room (Resident #4), who was on droplet precautions, and failed to wear PPE, to prevent contact with skin and clothing, when the mattress was removed from the quarantine unit. These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through the transmission of COVID-19.</p>	F 880	<p>Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a mean to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. F880</p> <p>A Fish Bone Diagram/Root Cause Analysis was conducted on 8/12/20 to identify the root cause of 1) the failure of the facility to implement protocols when staff did not don and doff Personal Protective Equipment(PPE) upon entering and exiting the rooms of residents who were on droplet precautions on the quarantine hallway and 2) the failure of the facility to develop a policy that addressed when laundry staff are to perform hand hygiene and wear PPE and 3) the failure of laundry staff to wear PPE and perform hand hygiene when handling clean and dirty laundry and 4) failure of nursing staff who disposed of isolation gowns in a bag attached to a blood pressure machine and 5) failure of staff to disinfect a mattress from a resident's room who was on droplet precautions and</p>		

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F 880	Continued From page 3 Findings included: 1. According to the facility protocol documents titled "Tool Kit A-Section I and II: Center Preparedness Infection Prevention Strategies and Guidance for COVID-19" dated 07/15/20 read in part as of May 14, full PPE is recommended in admission units, observation units, and dedicated areas where residents with suspected and confirmed COVID-19 cases are located. Recommended PPE on these units include N-95 respirators, eye protection, gloves, and gowns. According to the facility protocol document titled "Tool Kit B- Section I and II: Managing COVID-19 in your Center" dated 07/01/19, all new admissions who are admitted with negative testing and asymptomatic shall be placed on droplet precautions for 14 days and re-tested on the 12th day of admission. It further indicated care considerations of residents in suspected care areas are positive until facility testing confirms otherwise and staff must be meticulous in hand hygiene and use of PPE. It reads in part that staff should ensure all needed supplies for the resident are available when entering the room. It further mentioned under frequently asked questions related to waste materials that surfaces should be wiped down with a disinfectant and that staff should follow OSHA (Occupational Safety & Health Administration) administrative controls, safe work practices, and PPE to prevent worker exposures. A continuous observation on 07/22/20 from 10:18 AM to 11:55 AM revealed Nurse Aide (NA) #1 was working on the facility's quarantine unit and the following observations were made:	F 880	failure to wear PPE during the mattress removal. The Root Cause Analysis was facilitated by the Administrator with input by the Vice President of Clinical Services, Vice President of Operations, Director of Nursing(DON), and the Environmental Services Director(ESD). The Results of the Root Cause Analysis were reviewed by the QAPI Committee on 8/14/20 and incorporated into the following facility plan of correction. The DPOC will be completed on 8/26/20 with Training conducted by the DON and/or Infection Preventionist. 1. Corrective action was accomplished for the alleged deficient practice by the DON providing re-education on 7/23/20 to Nurse Aide #1 on donning/doffing of Personal Protective Equipment(PPE) upon entering and exiting the rooms of residents on droplet precautions and on proper disposal of PPE. ESD provided individualized re-education on 8/7/20 to Laundry Worker #1 on wearing PPE and performing hand hygiene when handling clean and dirty laundry and on the location of the HSG Laundry Operations manual and the HSG COVID 19 Checklist. DON provided re-education on 7/23/20 to Medication Aide #1 on donning/doffing of Personal Protective Equipment(PPE) upon entering and exiting the rooms of residents on droplet precautions and on proper disposal of PPE. Admin provided re-education to the former Environmental Services Supervisor(EVS) on 7/23/20 regarding disinfecting furniture(mattresses) for a resident on droplet precautions and proper		

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F 880	Continued From page 4 On 07/22/20 at 10:18 AM, NA #1 was observed to exit Resident #5's room wearing full PPE which included gown, gloves, N-95 mask, and a face shield. Signage posted on the resident's door indicated Resident #5 was on Droplet Precautions. NA #1 was carrying two plastic bags which revealed soiled linen and trash. She approached the community trash and soiled linen carts located in the hallway. NA #1 used her soiled gloved hands to open the lid instead of using the installed foot pedal. She then proceeded to remove the glove on her right hand followed by her isolation gown and her left glove. She then used her bare hand to compress the items in a downward fashion in the trash receptacle and touch the lid of the soiled linen and trash receptacles to close them then washed her hands. On 07/22/20 at 10:20 AM Nurse Aide #1 was observed to don full PPE which included a gown, gloves, mask, and face shield and entered the soiled utility room. Immediately following, Nurse Aide #1 exited the soiled utility room, walked across the hallway and retrieved linens from the clean linen cart and entered Resident #6's room and closed the door to the room. Signage posted indicated Resident #6 was on Droplet Precautions. Nurse Aide #1 then opened Resident #6's door and retrieved an item from the clean linen cart that was in the hallway outside of Resident #6's room and went back in the room wearing the same gloves she had on when she exited the room and closed the door to the room. On 07/22/20 at 10:28 AM, Nurse Aide #1 exited Resident #6's room carrying two plastic bags. One bag included linens and the other contained	F 880	donning/doffing of PPE during the mattress removal. Corrective action was accomplished for the alleged deficient practice of absence of a policy related to laundry staff's use of PPE and hand hygiene by the Administrator re-educating the current ESD on 8/7/20. Re-education was provided to current ESD to ensure understanding that the Healthcare Services Group(HSG) Laundry Operations Manual and the Infection Prevention Manual for Long Term Care Laundry Services both contain policies that address the laundry staff's use of PPE and hand hygiene. 2. All residents have the potential to be affected by this alleged deficient practice. 3. The DON and/or Infection Preventionist will provide re-education and in-service training to all staff on hand hygiene, donning/doffing and proper disposal of PPE, transmission based precautions(TBP) and disinfecting furniture(mattresses) in residents' rooms. An Attestation statement by the DON verifying completion of in-service training to all staff will be completed on 8/26/20. The DON and/or Infection Preventionist/Designee will verify staff competency on hand hygiene, donning/doffing and proper disposal of PPE, transmission based precautions(TBP) and disinfecting furniture(mattresses) in residents' rooms requiring droplet precautions by making observations of five nursing staff per day for five days per week for twelve weeks. Opportunities will be immediately		

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F 880	<p>Continued From page 5</p> <p>trash. She was wearing full PPE of gown, gloves, mask, and face shield when she approached the linen and trash receptacles located in the hallway. She opened the lid to both the trash and soiled linen cart with her gloved hands. After throwing the trash in the receptacle, she opened the bag of soiled linens and began removing the items from the bag and dropping them directly into the soiled linen receptacle before throwing the bag away in the trash receptacle and removing her PPE. She then closed the contaminated lids with her bare hands and was not observed to sanitize the receptacle after touching it with her gloved hands. NA #1 was observed to don a mask, gown, gloves, and a face shield out of the isolation cart located in the hallway.</p> <p>On 07/22/20 at 10:30 AM, NA #1 entered the soiled utility room using the door handle then exited and proceeded down the hall to answer Resident #7's call light. She entered Resident #7's room and turned off the resident's call light then exited the room and disposed of her PPE in the trash receptacle. She reapplied a gown, retrieved linen and gloves from the clean linen cart then re-entered Resident #7's room to perform care. She was not observed to perform hand hygiene before she applied the new gloves and returned to Resident #7's room. Signage indicated Resident #7 to be on Droplet Precautions.</p> <p>An interview was conducted with Nurse Aide #1 on 07/22/20 at 11:13 AM which revealed she was unaware there was a foot pedal for use in opening the trash and soiled linen cart she had used. She identified she had touched the lid with both her gloved and ungloved hands as well as compress the trash compartment with her bare</p>	F 880	<p>corrected as identified. All newly hired staff will receive in-service education and training on hand hygiene, donning/doffing and proper disposal of PPE, TBP, and disinfecting furniture(mattresses) in residents' rooms requiring droplet precautions effective 8/26/20. Additionally to implement and monitor systemic change, the facility will implement an infection sign and symptom tracking log to monitor all residents and staff for communicable, respiratory infection including COVID-19 effective 8/26/20. The DON will educate the Infection Preventionist, the ADON, the Life Engagement Director, the RCMD and the MDS Coordinator on use of the log. The DON will sign an attestation statement verifying completion of this education by 8/26/20. The DON, ADON, and Infection Preventionist are all current SPICE certified Infection Control nurses. The DON and/or Infection Preventionist/ADON will document all resident and staff signs/symptoms of infections on the facility infection tracking log. Compliance and review of the infection control log will be completed by the Infection Preventionist and/or DON. Monitoring will include the DON and/or Infection Preventionist each day and more often as necessary, reviewing the infection prevention tracking and trending for twelve weeks. Any unexpected increases in infection will be communicated to the Medical Director and the Iredell County Health Department effective 8/26/20. The DON and/or Infection Preventionist will also conduct rounds throughout the facility</p>		

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F 880	<p>Continued From page 6</p> <p>hand followed by touching of the outside of the receptacle and did not use a disinfectant to clean it afterwards. She stated she should not have touched the outside of the cart with soiled gloves, the receptacle should have been emptied instead of compressing it with her hand, and the surface should have been disinfected if touched with a soiled glove. NA #1 also stated she should have removed her gloves and washed her hands before retrieving additional items from the clean linen cart. She acknowledged she should not exit the soiled utility room wearing PPE an enter Resident #6's room without washing her hands and changing PPE. She also revealed the reason she had been observed removing the laundry from the bags at the cart and placing the soiled linen directly in the soiled linen cart was because when carts were returned from laundry, they would include the bags linens had been in when sent to laundry and she must discard them in the trash. NA #1 stated she should have washed her face shield before she applied PPE and should not have worn the same PPE in Resident #7's room as she had worn in the soiled utility room. She also stated she should have washed her hands before applying clean PPE to return to Resident #7's room to provide care.</p> <p>On 07/22/20 at 11:55 AM, NA #1 was observed to don a gown and gloves from the isolation cart in the hallway and pick up a meal tray from the cart dietary had placed on the unit. She then noticed Resident #5's call light was on, so she sat the lunch tray back down on the cart and proceeded to the doorway of Resident #5's room to answer the call light. When she arrived at the door of Resident #5's room and placed her hand on the door frame, NA #1 spoke to Resident #5 and left and went into a room where Nurse #1's office</p>	F 880	<p>to ensure that staff is exercising appropriate use of PPE and to ensure infection control procedures are followed on each hall. Ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. Monitoring of ten staff per day for five days a week for twelve weeks will occur effective 8/26/20. The facility utilizes Healthcare Services Group(HSG) Laundry Operations Manual and the Infection Prevention Manual for Long Term Care Laundry Services that both contain policies about the laundry staff's proper use of PPE and hand hygiene. Hard copies of the HSG Laundry Operations Manual and the Infection Prevention Manual for Long Term Care Laundry Services policy were placed in the facility laundry area on 8/7/20. A copy of the HSG Laundry Operations Manual and the Infection Prevention Manual for Long Term Care Laundry Services policy were reviewed with the laundry staff on 8/13/20 by the current Environmental Services Director(ESD) . All laundry staff will receive in-service education and training on the HSG Laundry Operations Manual and the Infection Prevention Manual for Long Term Care Laundry Services policy upon hire and annually effective 8/13/20. Additionally, laundry staff also will receive in-service education on hand hygiene, donning/doffing and proper disposal of PPE, TBP and disinfecting furniture(mattresses) in residents' rooms requiring droplet precautions by the DON by 8/26/20. An attestation statement by the DON verifying</p>		

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F 880	<p>Continued From page 7</p> <p>was located to wash her hands. She removed one glove and discarded it, then turned on the faucet and washed the one ungloved hand, then reapplied a glove and exited the room. She returned to the meal cart and picked up another tray and entered another room that was on the quarantine unit.</p> <p>An interview with Nurse #1 was conducted on 07/22/20 at 12:20 PM revealed she was the nurse for the New Admission/Observation unit and was the supervisor for Nurse Aide #1. She stated NA #1 should not have touched the lids on the trash and soiled linen carts with gloves used in Resident #5 or 7's room. Nurse #1 revealed Resident #5, #6, and #7 were on Droplet Precautions. Nurse #1 further stated NA #1 should not have attempted to compress items in the trash receptacle with her hand. She indicated trash and linen receptacles should be emptied frequently by nurse aides and should not be allowed to overflow. She further revealed all contaminated surfaces should be immediately disinfected. Nurse #1 indicated linen should not be emptied from plastic bags and emptied directly into the soiled linen receptacle and was unaware that NA #1 had. Nurse #1 stated NA #1 should prepare all needed supplies before entering the room of Resident # 6; however, if additional items were needed, all PPE should be removed, hand hygiene performed, and clean PPE should be donned before NA #1 returned to Resident #6's room. Nurse #1 revealed she was unaware laundry was returning bags previously used to hold soiled linen back in the carts. Nurse #1 acknowledged NA #1 should have removed both gloves and performed hand hygiene before delivering additional trays after touching the door frame of Resident #5's room.</p>	F 880	<p>completion of in-service training for laundry staff will be completed by 8/26/20. The current ESD and/or DON/Designee will observe one laundry aide on 1st and 2nd shifts for five days a week for twelve weeks to verify staff competency in understanding of the location and policies of HSG Laundry Operations Manual and the Infection Prevention Manual for Long Term Care Laundry Services Policy. The DON and/or Infection Preventionist/Designee will conduct observations of 1 laundry staff team member five times per week for twelve weeks on 1st and 2nd shifts to verify competency of laundry staff on hand hygiene, donning/doffing and proper disposal of PPE, TBP and disinfecting furniture(mattresses) in residents' rooms requiring droplet precautions. Observations will continue for three months to ensure continued compliance. Opportunities will be immediately corrected as identified. The DON and/or Infection Preventionist will provide education to the current ESD on disinfecting furniture(mattresses) in residents' rooms requiring droplet precautions by 8/26/20. An attestation statement by the DON verifying completion of in-service training on disinfecting furniture(mattresses) for the current ESD will be completed by 8/26/20. The DON and/or Infection Preventionist will make observations of five staff per day for five days per week for twelve weeks on their disinfection of furniture(mattresses) in residents' rooms requiring droplet precautions.</p>		

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F 880	<p>Continued From page 8</p> <p>An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on 07/22/20 at 1:40 PM and revealed all staff had received in-service training on transmission-based precautions and donning and doffing of PPE including gowns. The IC Nurse/DON stated Nurse Aide #1 should not have touched the outside of the trash and soiled linen receptacles with her soiled gloves nor should she have attempted to compress the trash but should have instead emptied the trash receptacle before it became full. They said the outside of the receptacles should be sanitized if they become contaminated after contact with gloves used in Resident #5's or #7's room who was on Droplet transmission-based precautions. The IC Nurse and DON revealed NA #1 should have taken all supplies needed into the room, but PPE should have been removed when exiting the room. Hand hygiene should be performed, needed supplies gathered, and full PPE should be donned before re-entering Resident #6's room. They stated NA #1 should always remove gown and gloves and perform hand hygiene after touching the door frame of Resident #5's room and continued with meal delivery.</p> <p>An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions and proper use of PPE. She stated staff should properly remove PPE into waste receptacles without contacting the exterior of the container with soiled gloves nor attempt to compress the trash into the receptacle and should always remove contaminated PPE and perform hand hygiene before entering Resident's rooms housed on the New</p>	F 880	<p>Opportunities will be immediately corrected as identified.</p> <p>4. To monitor the effectiveness of the above plan, the DON and/or Infection Preventionist will report results of the weekly staff competency audits in the facility's weekly and monthly QAPI meetings. The ESD will report results of the weekly laundry staff competency audits in the weekly and monthly QAPI meetings. The DON and/or Infection Preventionist will report the results of the observations of disinfection of furniture(mattresses) in the facility's weekly and monthly QAPI meetings. The DON and/or Infection Preventionist will report the results of the tracking log and discuss any trends and notifications to the Medical Director and Iredell County Health Department during the facility's weekly and monthly QAPI meetings. The DON and/or Infection Preventionist will also report the results of the observations around the appropriate use of PPE and infection control practices in the facility's weekly and monthly QAPI meetings. The QAPI Committee will evaluate the effectiveness of the plan and make recommendations for changes in the plan as indicated. The completion date for the plan of correction is August 26, 2020.</p>		

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F 880	<p>Continued From page 9</p> <p>Admission/Observation quarantined unit. She acknowledged it was unsafe and posed an increased risk of infection through cross contamination.</p> <p>2. According to the facility protocol document titled "Tool Kit B- Section I and II: Managing COVID-19 in your Center" dated 07/01/20 read in part under frequently asked questions to waste materials that staff should follow OSHA administrative controls, safe work place practices, and wear PPE to prevent worker exposures.</p> <p>The undated facility document titled "The Laundry Process," it did not address processing laundry during the COVID-19 pandemic, laundry processing for residents on transmission-based precautions, nor did the document define appropriate PPE when the documented laundry workers must always wear proper PPE when handling soiled linens under the transferring and sorting headings. The document also did not address when hand hygiene should be performed at any point when staff processed laundry.</p> <p>A continuous observation of the laundry department on 07/22/20 beginning at 12:35 PM and ending at 12:45 PM revealed Laundry Worker #1 to be located on the dirty side of the laundry room. She was wearing a face mask at the time of the initial observation. Laundry Worker #1 was observed to open the washing machine door with her bare hand, then apply one standard surgical glove, retrieve a bag of soiled linen from the linen/trash receptacle and place the bag in the washing machine. The clothes placed in the washer contained both personal residential laundry and facility linens. She removed the bag from the washer using both her gloved and bare</p>	F 880			

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F 880	<p>Continued From page 10</p> <p>hand and placed the bag into the linen. Laundry Worker #1 then applied a second glove and continued retrieving linen from the soiled cart. When she was attempting to retrieve linen from the cart, Laundry Worker #1 was observed to have her entire uncovered arms in the soiled linen cart and her forehead and hair was touching the back portion of the cart and its lid. After Laundry Worker #1 had removed all linen from the cart, she closed the cart with her gloved hand, shut the washer door, and pushed the dirty cart into the adjacent room next to the sink. Laundry Worker #1 then removed her gloves and disposed of them in the trash. She then pushed a yellow flat cart of damp laundry to the dryer located on the clean side of the laundry room and began loading the damp linen into the dryer with her bare hands. Once all damp linen was loaded, she returned to the washer, applied one glove and repeated the above sequence of loading laundry in the dryer again. She was not observed to apply an apron, long thick gloves, or a face shield when emptying the linen carts nor perform hand hygiene during the continuous observation.</p> <p>An interview with Laundry Worker #1 on 07/22/20 at 12:45 PM revealed she had worked in the laundry department for the last 7 years and stated she had the apron, long gloves, and a face shield available, but never uses them to sort or load laundry into the washing machine. Laundry Worker #1 identified the apron, face shield, and long gloves were located on a shelf in the laundry department. Laundry Worker #1 acknowledged she should wear gloves on both hands to load the washer and agreed she should wash her hands after removing them.</p> <p>An interview with the Maintenance Director on</p>	F 880			

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F 880	<p>Continued From page 11</p> <p>07/22/20 at 12:48 PM revealed Laundry Worker #1 should have gloves on both hands and washed her hands after removing PPE. He stated he was unaware Laundry Worker #1 was not wearing full PPE when sorting and loading laundry and was also unaware she was not washing her hands between performing tasks requiring her to move from the dirty to clean side of the laundry room.</p> <p>An interview with the Environmental Services (EVS) Supervisor on 07/22/20 at 1:00 PM revealed the EVS Supervisor was unaware Laundry Worker #1 was not wearing the appropriate PPE when sorting and loading laundry on the dirty side of the laundry room. He further revealed he was also unaware Laundry Worker #1 was putting dirty bags back into the cart to be returned to the units after emptying soiled linen. He stated Laundry Worker #1 should have worn gloves on both hands when sorting and loading the washing machine. He also stated full PPE that included apron, long gloves, and a face shield should be worn when emptying some soiled linen carts, but he did not require it on others. He provided the undated document titled "The Laundry Process" that did not specify when it was acceptable for Laundry Worker #1 to not wear full PPE when loading or sorting linens in the laundry department. The EVS Supervisor verified the document provided did not include when and what type of PPE the laundry workers should wear during sorting and processing linens in the laundry room nor when laundry workers were to perform hand hygiene while processing soiled and clean linens.</p> <p>An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on</p>	F 880			

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F 880	<p>Continued From page 12</p> <p>07/22/20 at 1:40 PM. The IC nurse revealed all staff had received in-service training on hand hygiene, transmission-based precautions, and donning and doffing of PPE. The DON stated Laundry Worker #1 had been re-educated often about concerns in the laundry department without success of retention. The DON further stated since the pandemic began clothing had been returned to the inappropriate resident's room by Laundry Worker #1 and it require the item to be re-washed. The IC Nurse and DON indicated not wearing full PPE and not performing hand hygiene after removal posed risk of infection for Laundry Worker #1, all residents, and other laundry workers through cross-contamination.</p> <p>An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions, proper use of PPE, and hand hygiene. She stated Laundry Worker #1 should have worn full PPE and washed her hands after removal. She acknowledged Laundry Worker #1 not wearing full PPE and not washing her hands was unsafe practice and posed an increased risk of infection through cross contamination. The Administrator verified the laundry department is a contract company and had their own policies separate from the facility.</p> <p>3. An observation was made on 07/22/20 at 12:02 PM, revealed Medication Aide (MA) #1 wearing a mask and a face shield and was working the quarantine hallway. She applied a gown, picked up a tray from the meal delivery cart, and entered Resident #6's room without wearing gloves. Signage on the outside of the door of Resident #6's indicated she was on Droplet Precautions.</p>	F 880			

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F 880	<p>Continued From page 13</p> <p>She placed the meal tray on Resident #6's overbed table and used her bare hands to set up the resident's meal tray. MA #1 was not observed to wear gloves when she was in the room of Resident #6. On 07/22/20 at 12:05 PM, MA #1 exited Resident #6's room and returned to the meal delivery cart in the hallway of the quarantined unit. MA #1 was then observed to use her bare hands to obtain a meal tray from the cart, carry it to Resident #8's room, enter the resident's room and serve the meal to the resident. Resident #8 had signage that indicated she was on Droplet Precautions.</p> <p>An interview with MA #1 on 07/22/20 at 12:15 PM revealed she did not wear gloves to setup the meal tray for Resident #6 who was on Droplet Precautions. She stated she was not sure why she did not have on gloves when delivering meal trays to residents, who were eating in their rooms, but had received training and should have worn full PPE including gloves when entering resident rooms to deliver and set up their meal trays.</p> <p>An interview with Nurse #1 was conducted on 07/22/20 at 12:20 PM and revealed she was the nurse for the New Admission/Observation unit and was the supervisor for MA #1. She stated full PPE including gown, gloves, mask, and a face shield are to be worn to deliver meal trays in Resident #6 and Resident #8's room who was on Droplet Precautions.</p> <p>An interview with the IC Nurse/DON was conducted on 07/22/20 at 1:40 PM revealed MA #1 should always wear gloves to deliver a meal tray in Resident #6 and #8's room who was on Droplet Precautions on the New Admission/Observation quarantine unit followed by</p>	F 880			

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F 880	<p>Continued From page 14 performing hand hygiene.</p> <p>An interview with the Administrator was conducted on 07/22/20 at 2:45 PM revealed MA #1 should have worn a gown, gloves, mask, and a face mask when delivering a meal tray for Resident #6 and Resident #8.</p> <p>4. Observations was made of a blood pressure machine located on the New Admission/Observation quarantine unit on 07/22/20 at 10:00 AM, 11:00 AM, and 12:30 PM. The machine was observed to have a plastic bag attached to it that was overflowing with yellow gowns that appeared to be wadded up and placed in the open bag.</p> <p>An interview was conducted on 07/22/20 at 11:13 AM with Nurse Aide #1. She revealed the bag attached to the blood pressure cart had been there at the start of her shift. She examined the bag and identified the gowns inside to be soiled. She stated gowns were placed in the bag after use in Droplet Precaution rooms on the unit. She was not observed to discard the bag after the interview.</p> <p>An interview with Nurse #1 on 07/22/20 at 12:20 PM revealed she was not aware there was a bag containing soiled isolation gowns attached to the blood pressure cart and that staff should discard of PPE in the trash receptacles.</p> <p>An interview with Nurse #2 on 07/22/20 at 12:30 PM revealed she was one of the Infection Control nurses in the facility. She stated she was unaware staff were disposing of isolation gowns in a bag attached to the blood pressure machine and immediately applied gloves and removed the</p>	F 880			

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F 880	<p>Continued From page 15 bag from the cart and disposed of the bag.</p> <p>An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on 07/22/20 at 1:40 PM. The IC Nurse revealed all staff had received in-service training on transmission-based precautions and donning and doffing of PPE including gowns. The IC Nurse and the DON both stated no member of staff should attach a bag to the blood pressure machine and isolation gowns should be disposed of immediately and not placed in a bag on the cart which is used from room to room.</p> <p>An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions and proper use of PPE. She stated staff should properly remove PPE into waste receptacles and not placed in a bag on the blood pressure machine. She acknowledged it was unsafe practice and posed an increased risk of infection through cross contamination.</p> <p>5. Review of facility policies revealed there was no policy available that addressed how a mattress that was used by a resident, who was on droplet precautions and resided on the in a on the quarantine unit, should be cleaned and disinfected and removed from the room and the unit.</p> <p>An observation on 07/22/20 at 10:15 AM revealed an uncovered resident bed mattress was leaned against the wall in the hallway of the New Admission/Observation quarantined unit. The mattress was in the hallways outside of Resident #4's room. Signage posted on the door to</p>	F 880			

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F 880	<p>Continued From page 16</p> <p>Resident #4's room indicated she was on Droplet Precautions on 7/22/20 at 11:05 AM revealed the mattress remained in the hallway floor outside of Resident #4's room. On 7/22/20 at 11:08 AM, the Environmental Services (EVS) Supervisor donned a pair of surgical gloves and picked up the contaminated mattress from the hallway and carried the mattress against his clothing out a side door on the unit. He was not observed to don a gown before placing the mattress against his skin and clothing nor disinfect the mattress or hallway surfaces before or after removing the mattress from the quarantined unit.</p> <p>An interview with Nurse Aide #1 was conducted on 07/22/20 at 11:13 AM. It revealed the mattress had been removed from the bed of Resident #4 and exchanged for a new mattress before her shift began at 7:00 AM. NA #1 was unsure why it was left in the hallway. She stated it should have been disinfected and taken outside.</p> <p>An interview with the Maintenance Director was conducted on 07/22/20 at 12:48 PM revealed items such as mattresses used in a Droplet transmission-based precaution room should be disinfected immediately, removed from the unit, and placed on the service hall for storage by appropriate Environmental Services (EVS) or Maintenance staff. He stated staff were trained to don PPE, when they removed a resident's mattress from the unit and to place the mattress on the service hall.</p> <p>An interview was conducted with the EVS Supervisor on 07/22/20 at 1:00 PM. The interview identified the mattress removed from the Admission/Observation quarantined unit during his shift had been removed from the bed of</p>	F 880			

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F 880	<p>Continued From page 17</p> <p>Resident #4 by second shift staff on 07/21/20 and was left in the hallway for housekeeping to disinfect and remove. The EVS Supervisor stated the mattress should have been immediately disinfected and removed from the unit after removal from Resident #4's room who was on transmission-based precautions. He stated it should not have been placed against a wall in the hallway. He stated he was trained, when removing a mattress from the quarantine unit he should have donned PPE to prevent the mattress from touching his uncovered skin and clothing.</p> <p>An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on 07/22/20 at 1:40 PM. The interview revealed all staff had received in-service training on transmission-based precautions and donning and doffing of PPE including gowns. The IC Nurse stated the EVS Supervisor should have worn PPE to remove resident objects that had been used in the Admission/Observation quarantined unit which included Resident #4's mattress.</p> <p>An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions and proper use of PPE. She stated staff should wear full PPE when contacting and moving contaminated items like Resident #4's mattress.</p>	F 880			