STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165437	A. BUILDING _____ B. WING _____	02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CREST MANOR	100 BOLGER DRIVE FAYETTE, IA 52142

(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
F 000	INITIAL COMMENTS -- Correction Date:_____ The Iowa Department of Inspection and Appeals (DIA) in accordance with the Medicare Conditions of Participation set forth in 42 CFR 483, Subpart B-C, conducted this recertification survey. The facility was found to be NOT IN COMPLIANCE. Total residents: 40 Onsite dates: 02/16/2021 - 02/25/2021	F 000		
F 582 SS=D	-- Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582		

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

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F 582	Continued From page 1	F 582		

nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due

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F 582	Continued From page 2 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: -- Based on record review and staff interview, the facility failed to provide 1 of 3 residents reviewed the required CMS (Centers for Medicare and Medicaid Services) form at the completion of the skilled services. The facility Census was 40. Findings included: Records indicated Resident #3 received skilled services in the facility from 11/17/2020 through 11/27/2020. At the completion of skilled services, Resident #3 remained in the facility. There was no CMS form 10055 completed as required. Interview on 02/22/2021 at 3:44 p.m., Administrator stated she was unaware of form 10055, she did not know it was required and had not completed one for the resident that remained in the facility.	F 582		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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F 689	Continued From page 3 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to keep 1 of 5 wandering residents safe from injury from an unsupervised steam table in the dining room (Resident #40). Wandering residents still able to access steam table with little to no intervention measures in place.The facility reported a census of 40 residents. Findings included: 1. The Minimum Data Set (MDS) assessment for Resident # 40 dated 05/27/20, included a diagnosis of Alzheimer's disease. The MDS listed the resident with short and long-term memory problems and severely impaired daily decision making skills. The MDS reflected the Resident # 40 wanders daily. The MDS recorded Resident is independent ambulatory without supervision. The Care Plan for Resident # 40 dated 5/20/20, directed staff the resident needs directional cues for ambulation, and a Wander Alert bracelet. The Care Plan further identified Resident # 40 needed a safe environment with: floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in a low position at night. Review of the documents in the paper chart included a form titled "Intervention For Skin Concerns for Resident # 40 dated 6/16/20, the form documented signs posted on steam table	F 689		

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F 689	Continued From page 4	F 689		

"STOP" "HOT".

The Care Pan intervention dated 6/18/20, directed signs on steam table "STOP" "HOT".

Review of the Notification of Skin Condition from Incident report dated 6/16/20, documented Resident # 40 touched the lids on the top of the steam table in the dining room resulting in red areas to the palms of both hands and complaints of severe pain.

Review of the Nurses Progress Notes dated 06/16/20 through 06/25/20, lacked documentation of the incident.

During an observation on 02/17/21 at 6:40 a.m., Resident # 40 was at the front door attempting to exit as staff let someone in from the outside of the building.

During an observation on 02/17/21 at 11:32 a.m., the steam table was assessable to residents in the dining room.

During an observation on 02/17/21 01:00 p.m., Resident # 40 was wandering in the halls.

During an observation on 02/17/21 at 03:00 p.m., the Steam table sat in the dining room outside the kitchen doors. The steam table was unplugged. The steam table lacked signs on or around the table to direct not to touch or warning.

During an observation on 02/17/21 at 04:25 p.m. Resident # 40 wandered through a closed door into the East Conference room, shut the door behind her. Resident # 40 sat down stood back up and remained in the room until 04:35 p.m.,

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F 689	Continued From page 5	F 689		

when the resident open the room door and walked out of the room at 4:37.

During an observation on 02/17/21 at 05:00 p.m., Resident # 40 was wandering in the dining room and pulling on the decorations hanging from the ceiling when staff noticed and redirected.

During an observation on 02/18/21 at 06:53 a.m., steam table was located in the dining room, not plugged in or hot. No signs on or around the cart. A resident was up with walker wandering around in the dining room.

During an observation on 02/18/21 at 07:47 a.m., 3 residents were sitting at tables in the dining room with the steam table plugged in and no staff in the area.

During an observation on 02/18/21 at 09:53 a.m., visualized no signs present on or around the steam table.

During an observation on 02/22/21 at 11:01 a.m., the steam table lids felt hot before contact, with steam coming out of the sides. The steam table burners are set to 4.

During an observation on 02/22/21 at 11:51 a.m., the steam table sat in the dining room the Dietary Manager (DM) walked away from the steam table, back in the kitchen leaving no staff observing the table for 1.5 minutes

During an observation on 02/22/21 at 04:44 p.m., the temperature, taken with the facility thermometer, of the top left corner of the steam table, with steam present read 283 degrees.

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F 689	Continued From page 6	F 689		

During an observation on 02/23/21 at 11:12 a.m., the temperature from the top of steam table lid with the facility's inferred Fluke 62 Mini thermometer read 135 degrees. Surveyor attempted to touch the top of the steam table lid with her hand to verify temperature to touch, had to pull her hand away immediately.

During an interview on 02/17/21 at 03:28 p.m., the Assistant Director of Nursing (ADON) reported that from last survey date Resident # 40 received a burn from the steam table in the dining room while it was heating up.

During an interview 02/17/21 at 03:00 p.m., Staff D Night Cook reported normally plugging in the steam table at 3:30 p.m. and the Certified Nurses Aids (CNA) will watch to make sure no resident are going around it. Staff D stated the steam table does not have constant supervision.

During an interview on 02/17/21 at 03:58 p.m., Staff F Certified Nurses Aid (CNA) verified knowing the facility does not have one to one care and the expectation was to keep an eye on the wandering residents.

During an interview on 02/18/21 at 08:50 a.m., Staff G Registered Nurse (RN) reported, they have to keep an eye on Resident # 40 around the steam table.

During an interview on 02/18/21 09:40 a.m., the Administrator reported the steam table location has not changed in a few years and does not have someone to watch it constantly in the dining room. The Administrator confirmed not having one to one staffing for wandering residents.

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F 689	Continued From page 7	F 689		

During an interview on 02/18/21 09:54 a.m., Staff C RN reported a CNA brought Resident # 40 to her with a report that the resident touched the steam table in the dining room. Staff C stated the palms of the resident's hands were red and the resident kept complaining "hurts, hurts". Staff C reported that the incident was around lunchtime because kitchen staff had been setting up for the meal.

During an interview on 02/22/21 at 11:01 a.m., the DM reported the steam table was normally set to 4.

During an interview on 02/22/21 02:15 p.m., the DM remembered Resident # 40 burned her hands on the steam table and that the nurses told her to put a "stop", "hot" sign on the steam table because the resident could still read, but stated the resident just tore them up so they stopped placing the signs.

During an interview on 02/22/21 at 1:08 p.m., the Director of Nursing (DON) reported the facility failed to complete whiteness statement or an investigation about the incident. The DON revealed the resident was guarding her hand related to the pain for the next few days when she was up wandering the hall.

The facility provided an undated list titled "Wandering Residents, the list included 5 residents.

The facility provided an undated policy titled "Accidents and Supervision" with the purpose directed at point

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F 689	Continued From page 8 # 1: To ensure the facility provides an environment that is free from accident and hazards over which the facility has control and provides appropriate supervision to each resident to prevent avoidable accidents. Point # 2. To ensure the facility has the following systems in place to prevent accidents and hazards. a. Identify hazards(s) and risk(s); b. Evaluated and analyze hazard(s) and risk(s); c. Implement interventions to reduce hazard(s); d. Monitor for the effectiveness and modify approaches as indicated. The Guidelines included Accident- refers to any unexpected or unintended incident or chain of events, which may or may not result in injury or illness to a resident. This does not include adverse outcomes that are a direct consequence of treatment or care that is provided in accord with recognized standards of practice. Avoidable Accidents - means that a resident had an accident and the facility failed to: Identify environmental hazards and individual resident risk of an accident, including the need for supervision: and/or Evaluate/ analyze the hazards and risk; and/ or Implement intervention, including adequate supervision, consistent with resident's needs, goals plan of care and recognized standards of practice in order to reduce the risk of an accident The situation detailed above resulted in Immediate Jeopardy (IJ) for the facility. The facility was notified of the Immediate Jeopardy on 02/22/21. The facility removed the IJ situation on 02/24/21. The scope and severity of the deficiency was lowered from a "J" to a "D." The facility removed the IJ by removing steam table	F 689		

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F 689	Continued From page 9 from dining area, assigning staff to be at steam table at all times when in hall during Covid, locking kitchen doors when meals not being served, and educating staff to new policy. Facility also conducting audits to ensure ongoing compliance with new procedure. IMMEDIATE JEOPARDY declared 02/22/21 at 4:30 p.m. The facility initiated corrective action and removal of the state of IMMEDIATE JEOPARDY was verified onsite by the surveyors on 02/24/21.	F 689		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: -- Based on record review, policy review and staff interview the facility failed to have written, signed, and dated progress notes and orders within the	F 711		

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F 711	Continued From page 10	F 711		

required timeframe for 5 of 9 residents reviewed. The facility reported a census of 40.

Findings included:

Clinical record review for Resident #20 showed a signed Order Summary Report for January 2020 and May 2020. There were no signed Order Summary Reports for the months of February, March, or April of 2020.

Clinical record review for Resident # 3 showed a date of admission of 11/17/2020. There were no signed Order Summary Reports for November or December 2020.

Clinical record review for Resident # 17 showed a signed Order Summary Report for March 2020 and July 2020. There were no signed Order Summary Reports for the months of April, May, or June of 2020.

Clinical record review for Resident # 21 showed a signed Advanced Registered Nurse Practitioner (ARNP) for February 2020 and June 2020. There were no ARNP progress notes for March, April, or May of 2020.

Clinical record review for Resident # 10 showed no signed physician progress notes for January, February, or March 2020. There is a signed physician progress note for April 2020.

Review of facility policy Physician Services states the physician must review the resident's total program of care including medications and treatments at each visit; write, sign, and date progress notes at each visit; and sign and date all orders. The policy states residents are to be seen

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F 711	Continued From page 11 at least every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The policy states for residents not receiving skilled services, an ARNP may satisfy the physician requirement. Review of the facility policy Physician Orders Summary Policy stated all physician's orders will be reviewed and signed by primary care provider at least every 60 days. During an interview on 02/25/2021 at 8:34 a.m., the Director of Nursing (DON) stated she expected the Order Summary Report to be signed at least every 60 days. She stated she expected physician's progress notes to be every 60 days. She stated she had no additional Order Summary Reports or physician progress notes to provide.	F 711		
F 835 SS=D	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: -- Based on record review and staff interview the facility failed to have a written transfer agreement with one or more hospitals in effect. The facility reported a census of 40. Findings included:	F 835		

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F 835	Continued From page 12 During an interview on 02/23/2021 at 1:47 p.m., the administrator stated she was unable to find a transfer agreement. She advised she had called the hospital in West Union to get a copy of the agreement. During an interview on 02/24/2021 at 1:52 p.m., the administrator stated West Union denied having a contract. She stated she reached out to the hospital in Sumner where their Medical Director practices and was able to reach an agreement. The administrator provided a signed transfer agreement dated 02/24/2021.	F 835		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: -- Based on record review and staff interviews, the facility failed to hold quarterly Quality Assessment	F 868		

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F 868	Continued From page 13 and Assurance (QAA) meetings at least quarterly or more often as necessary to fulfill the committee's responsibilities to identify and correct quality deficiencies effectively. The facility reported a census of 40. Findings included: The facility failed to provide QAA sign in sheets for 4th quarter meeting. The facility provided a sticky note dated 10/10/20 stating the Medical Director was called for a QA update, no sign in sheet. The sticky note was not signed and facility was unable to provide meeting minutes or any evidence a meeting was held. During an interview on 02/25/20 at 11:27 a.m, the Assistant Director of Nursing (ADON) stated the QAA committee meets every 3 months. During an interview on 02/25/21 at 11:45 a.m., the Director of Nursing (DON) stated that she was unable to provide sign in sheet for October meeting. Stated they did have the meeting but was unable to produce sign in sheet or minutes. She stated the previous administrator took documents home to approve them and the DON believes that is where the missing sign in sheet is.	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880		

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(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
F 880	Continued From page 14 diseases and infections. §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: §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 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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	165437	A. BUILDING _____ B. WING _____	02/25/2021

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F 880	Continued From page 15 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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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, interviews, and record review the facility failed to follow the Centers for Disease Control and Prevention (CDC) recommendation for hand hygiene after contact with residents and the resident's environment, staff failed to follow Guidance for SARS-CoV-2 (COVID-19) Point-of-Care Testing dated 02/02/21, failed to screen resident according to Preparing for COVID-19 in Nursing Homes Updated 10/20/20. The facility reported a census of 40 residents. Findings included: 1. During a random observation on 02/16/21 at 01:30 p.m., Staff A Certified Nurses Aid (CNA)	F 880		

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F 880	Continued From page 16	F 880		

went in Resident # 22's room in quarantine, removed the full body lift from next to the bed, and pushed it out in the hall and up into room 204. Staff failed to clean the lift after removing from a quarantine room and before moving the lift into a non-quarantine room.

2. During observation of meal time on the 200 Hall 02/16/21 at 12:41 p.m. through 12:56 p.m., Staff A CNA sat in a chair with wheels and went back and forth from feeding Resident # 8 and Resident # 18 with out completing hand hygiene between feeding the 2 residents. At times Resident #8 and Resident #18 handled their own silverware that the Staff handled.

3. During a Dining Room observation on 02/17/21 at 08:05 a.m. through 8:16 a.m., Staff B CNA held the red meal tray under her armpit and then continued to serve meals off of it. Staff E CNA held the red meal tray completely against the front of her top until setting it on the steam table picked it back up after plate placed on it and took food to a resident. Staff E scratched her nose over mask and continued to hold the meal tray and serve residents.

During an observation on 02/17/21 at 11:52 a.m., Staff H Dietary Aid moved a resident's walker and continued to serve dessert to residents in the dining room.

During an observation on 02/17/21 at 11:56 a.m., Staff B CNA got up from helping set Resident # 8 up for the meal and went directly over to get a tray from the Dietary Manager (DM). Staff B delivered food to Resident #8 and handed her silverware, Staff B went to the DM picked up another tray of food served Resident #8 all

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F 880	Continued From page 17	F 880		

without performing hand hygiene.

During an observation on 02/17/21 at 11:59 a.m., the Speech Therapist (ST) sitting next to Resident # 38 at the dining room table with gloved hands got up from the table and picked up something from floor, the ST then touched Resident # 18 on the back. The ST walked over put trash in the trash can, and went back to sit next to Resident # 38. The ST put her hand on the shoulder of Resident # 38 and sat down. The ST failed to complete hand hygiene after handling trash off the floor and touching another resident. At 12:03 p.m., the ST still with same set of gloves on got up from the table, and pushed Resident # 18 up to the table in the wheelchair. The ST then sat back down next to Resident # 38. From 12:07 to 12:12 p.m., the ST still wearing the same unchanged gloves fed Resident # 18 and rubbed her back.

4. During a random observation on 02/17/21 at 03:53 p.m., Staff C Licensed Practical Nurse (LPN) obtained Covid tests on the 200 hall. Staff C lacked wearing a gown going in and out of resident's room to complete the COVID-19 test.

5. During an observation on 02/18/21 at 11:46 a.m., the Dietary Manager (DM) and Staff D Cook took turns serving a plate and delivering food to residents. The DM and Staff D went from delivering to resident and on to the next resident to and then taking orders from residents. The DM placed hand on the tabletops when asking resident what they want to eat 2 times and went back to serving the meal without hand hygiene.

During an observation on 02/18/21 at 11:54 a.m., the DM scratched her head with right hand and

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F 880	Continued From page 18	F 880		

continued to serve food from the steam table without completing hand hygiene.

During an observation on 02/22/21 at 12:13 p.m., the DM pulled down the bottom of her facemask to talk, then went back to serving lunch without completing hand hygiene.

6. During a random observation on 02/18/21 at 11:12 a.m., Staff I Laundry pushed an uncovered basket full of laundry down the 200 hall.

During an observation on 02/22/21 at 10:45 a.m., Staff I pushed a laundry cart stacked full of clean towels wash clothes on the 200 hall the sides exposed to residents and staff passing by.

During an interview on 02/22/21 at 10:45 a.m., the Director of Nursing (DON) stated the expectation is that the laundry carts are covered.

During an interview on 02/23/21 at 12:14 p.m., Staff F CNA reported hand hygiene is done whenever needed, after glove use, after cares, before meals, after touching residents or resident things, and after contact with any of the PPE I have on. Staff F continued to report hand hygiene is also done between feeding residents. Staff F revealed a lack of training on when and how to clean the lifts. Staff F stated the lifts are cleaned on the night shift.

During an interview on 02/23/21 01:33 p.m., the DON stated the expectation is staff to complete hand hygiene after adjusting PPE, touching masks, between feeding residents, after coming in contact with the resident environment. The DON further stated expecting staff not to remove mask to talk to people staff/resident.

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F 880	Continued From page 19	F 880		

During an interview on 02/23/21 at 01:42 p.m., the Infection Preventionist reported expecting the laundry covered while out of the laundry room.

During an interview on 02/23/21 at 03:16 p.m., the DON reported the personal protective equipment (PPE) needed for staff obtaining a COVID-19 test from asymptomatic resident is gloves, face shield, and mask. The DON stated a gown is not needed. The DON continued to report residents are screened daily by having the staff check respiration, temperature, pulse, and oxygen saturation. The DON further stated if any of the vitals were abnormal, or if a resident had a complaint, the nurses would assess further for other signs and symptoms of COVID-19.

During an interview on 02/24/21 at 11:29 a.m., the Assistant Director of Nursing (ADON) reported the facility did not have the Medical Director complete an annual review of Infection Control policies and procedures.

The facility provided an undated sheet titled Report Sheet, listing all the resident names per room with blanks per resident for pulse, temperature, respirations, and oxygen saturation.

The facility provided a sheet titled Remember undated, directing hand washing is the single most important precaution to prevent the transmission of infection from one person to another. Wash hands with soap and water before and after each resident contact, and after contact with resident belonging and equipment. Alcohol based hand rub may be used when hands are not visible soiled.

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F 880	Continued From page 20 The facility provided an undated policy titled Standard Precautions instructing that -Patient Care Equipment - under which the following guidance is found -Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and sanitized. The facility provided a policy titled Laundry Guidelines undated, directing clean linen will be covered when stored or transported. The policy further directed clean laundry will be transported to the area of use in a covered container	F 880		