STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535029	A. BUILDING _____ B. WING _____	C 03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROOK COUNTY MEDICAL SERVICES DISTRICT LTC	**713 OAK STREET SUNDANCE, WY 82729**

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F 000	INITIAL COMMENTS A recertification survey and infection control and prevention survey was conducted by Healthcare Licensing and Surveys from 3/1/21 to 3/4/21. Also reviewed in the course of the survey were complaint intakes WY000002920 and WY000002859. The following common abbreviations are used throughout this document; CDC: Centers for Disease Control CNA: Certified Nursing Assistant DON: Director of Nursing BIMS: Brief Interview for Mental Status MDS: Minimum Data Set NHA: Nursing Home Administrator IPC: Infection Preventionist and Control DNR: Do not resuscitate Less commonly used abbreviations will be annotated in each deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489,	F 578		4/1/21

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

Electronically Signed | 03/24/2021

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 578	Continued From page 1 subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and policy review, the facility failed to address advance directives within the care plan for 3 of 12 sample residents (#2, #5, #13). The census was 27. The findings were: 1. Review of resident #2's advance directive in the "Durable Power of Attorney for Health Care and Advance Health Care Directive" dated 2/1/07 showed "...VII. End-of-Life Decisions. 1. Treatment. I authorize my agent to make	F 578	The facility will ensure that residents have the right to request/refuse/discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an Advanced Directive. This will be accomplished by: 1) Residents #2,5,13 will have reviews of their Advanced Directives conducted with the resident and the POA to ensure that the DNR is desired and the Advanced Directive is clarified to reflect the DNR	

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F 578	Continued From page 2 treatment decisions for me, to include but not be limited to, withholding or withdrawing health care treatment in accordance with this provision. I do not want my life to be prolonged if: (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits...." The following concerns were identified: a. Review of the "Resident Code Status" showed the resident as electing DNR. b. Review of the physician's orders failed to show advance directives were addressed. Review of the care plan failed to show advance directives were addressed. 2. Review of resident #5's medical record failed to show signed advance directives. The following concers were identifed: a. Review of the care profile showed the resident as electing DNR. b. Review of physician orders showed a DNR order dated 1/17/19. Review of the care plan failed to show advance directives were addressed. 3. Review of the medical record for resident #13 showed "Living Will Declaration" dated 6/6/97, "...Treatment For Restoration. Provide life-sustaining treatment only if and for so long as you believe treatment offers a reasonable possibility of restoring to me the ability to think and act for myself." The following concerns were identified: a. Review of the "Resident Code Status" showed the resident as electing DNR.	F 578	status. The Advanced Directives will be addressed by the Physician and documented in the medical record by the Compliance Date. The care plans have all been updated to ensure that the Advanced Directives are included. 2) A review of 100% of the resident□s Advanced directives will be done to ensure that the Advanced Directive reflects the DNR status. 3) 100% of residents□ Advanced Directives will be reviewed/addressed in the next scheduled appointment with the physician and documented in the medical record. 4) All care plans will be updated to ensure that the Advanced Directives are included 5) Education was done on the Advanced Directive Process to ensure understanding within the IDT to ensure that Advanced directives are reviewed and addressed by the Physician on admission, that a copy is placed in the chart on admission, and that the care plan includes the wishes of the resident. 6) The Admission Checklist has been updated to include a review of the Advanced Directives to be done by the Physician with the resident upon admission and a copy is placed in the chart and that Advanced Directives are included in the Care plan. 7) An audit, to be completed by the DON or designee using an audit tool, of 100% of active residents will be done to ensure that a review of the Advanced Directives is done by the Physician with the resident, a copy is placed in the chart and that	

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F 578	Continued From page 3 b. Review of the physician's orders failed to show advance directives were addressed. Review of the care plan failed to show advance directives were addressed. 4. Interview on 3/4/21 at 11:35 AM with the IPC/MDS nurse confirmed the advance directive were missed in the care plans. Interview with CNA #1 on 3/4/21 at 12:11 PM revealed if a resident stopped breathing and had no pulse, "we would start compression and get the nurse." 5. Review of the policy "Advance Directives" last review 04/2009 showed "...4. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record..." "9. The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care..."	F 578	Advanced Directives are addressed in the Care plan. This audit will be reviewed by the IDT to ensure that each element is completed. 8) An audit, to be completed by the DON or designee using an audit tool, will be done of each new admission within 24 hours of admission to ensure that Advanced Directives are received, addressed and care planned. This audit will be reviewed in IDT for completion and correction weekly. 9) The results of these audits will be presented to the IDT committee to ensure continued compliance for a minimum of 3 months or until the IDT committee is satisfied that the facility is in compliance with F578.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the	F 690		4/1/21

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F 690	Continued From page 4 resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, medical record review, and policy review, the facility failed to ensure treatment and services for indwelling urinary catheters to prevent infection were provided for 2 of 5 sample residents (#7, #11) with catheters. The findings were: 1. Review of the medical record showed resident #11 was admitted to the facility on 1/25/21 with diagnoses that included benign prostatic hyperplasia (BPH) with lower urinary tract symptoms, weakness, and urinary tract infection (UTI). Review of the resident's admission MDS assessment showed the resident was admitted with an indwelling catheter. Review of the resident's care plan, last revised 3/4/21, showed the resident has " ...Indwelling Suprapubic	F 690	The facility will ensure that treatment and services for indwelling urinary catheters will be used to prevent infection. This will be accomplished by: 1. Education will be done with LTC nursing staff and resident #11 on importance of bag placement and catheter care and monitoring, to ensure proper emptying of the bladder of catheterized patients and to ensure infection prevention is achieved. 2. Resident #7 and staff will be educated on importance of bag placement should the need arise to place an indwelling catheter in the future. Resident #7 had their catheter discontinued on 3/9/21. 3. The standing orders have been	

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F 690	Continued From page 5 Catheter r/t [related to] BPH with obstruction" and contained interventions that included "Monitor for s/sx [signs and symptoms] of discomfort on urination and frequency", "Monitor/document for pain/discomfort due to catheter", and "Monitor/record/report to MD [physician] for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns." The following concern was identified: a. Observation on 3/2/21 at 4:05 PM showed the resident ' s Foley catheter bag was hanging between the resident's recliner and his/her bed. Urine was noted in the tubing, and the bag was located at or above the waist-level of the resident due to how low the resident was sitting in the chair. Interview with the resident at that time revealed the resident had just gotten over an infection " ...from this catheter." Review of the resident ' s completed orders showed the resident had been on two different antibiotics for a UTI between 1/25/21 and 2/4/21. 2. Review of the medical record showed resident #7 was admitted to the facility on 2/1/21 with diagnoses that included hemiplegia unspecified affecting left non-dominant side, type 2 diabetes mellitus without complications, essential primary hypertension, weakness, and cerebral infarction. Review of the resident's admission MDS assessment showed the resident was admitted with an indwelling catheter. Review of the resident's care plan, last revised 3/4/21, showed the resident had an indwelling catheter, with interventions that included: "Call provider once pain at night is well controlled", "Monitor for s/sx of discomfort on urination and frequency",	F 690	updated to include an order set for residents admitted with an indwelling catheter to ensure compliance with F690. 4. All catheter bags will be monitored daily by the staff, to include but not limited to CNAs, nurses, restorative aides, etc., and documented in PCC to ensure they are hanging below bladder level and that catheter care is completed at a minimum of twice a day. If errors exist, the situation will receive immediate correction and education provided to the resident and/or staff to ensure compliance. The DON, or other designee, will conduct audits, using an audit tool, to ensure that the Foley bag is hanging below bladder level. If errors are found, the situation will be immediately corrected and immediate education will be conducted with staff and the resident to ensure compliance. The results of these audits will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F690.	

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F 690	Continued From page 6 "Monitor/document for pain/discomfort due to catheter", "Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns." The following concerns were identified: a. Observation on 3/2/21 at 3:56 PM showed the resident in his/her chair, with the Foley catheter bag hanging from the right side of the chair. Further observation showed the catheter tubing contained urine that was moderately dark in color and very cloudy. b. Review of the resident's orders since admission on 2/1/21 revealed no physician orders related to the catheter. c. Interview with the DON and IPC on 3/4/21 at 1:50 PM revealed they were unaware of the absence of physician orders related to the catheter. 3. Review of the facility policy titled "Catheter Care, Urinary", last revised 10/2010, showed the purpose of the policy was " ...to prevent catheter-associated urinary tract infections."	F 690		
F 880 SS=L	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 diseases and infections. §483.80(a) Infection prevention and control	F 880		4/1/21

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F 880	Continued From page 7	F 880		

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 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 8 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, review of policy and procedure, resident and staff interview, and review of professional standards, the facility failed to implement infection control practices to prevent the spread of infectious disease including COVID-19. Specifically, the facility failed to ensure source control through face coverings and social distancing, and failed to ensure effective hand hygiene. It was determined these failures placed the residents in immediate jeopardy. The census was 27. On 3/2/21 at 12:55 PM the administrator was informed of an immediate jeopardy situation in the area of infection control related to the lack of source control, and insufficient hand hygiene. The facility submitted an action plan which included the following immediate changes: 1. Effective immediately staff will put dirty water	F 880	The facility will ensure that hand hygiene and source control are compliant with tag F880. This will be accomplished by: 1. Drink cart will be disinfected with bleach solution prior to clean glasses being placed on it. Staff will perform hand hygiene per facility policy when passing water. 2. Charge nurse or designee will document on Infection Control water pass log compliance to proper water pass to include dirty glasses being collected in dirty dish bin, disinfection of cart prior to clean glasses being placed on it and hand hygiene per policy every shift. Log will be completed every shift until compliance has been maintained for 30 days. 3. Maintenance will install mask holders in the lobby and on the unit to ensure masks are readily available at all times.	

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F 880	Continued From page 9 glasses directly into a bin on their cart instead of the railing. Staff will perform hand hygiene per policy. Dirty water glasses will be taken to kitchen immediately after task is finished. Dirty glasses will not be on the cart at the same time as any clean glasses. 2. Effective immediately the charge nurse on each shift will supervise water pass until it is determined that the above infection protocol is being routinely utilized and then randomly supervised to ensure continued compliance. 3. Effective immediately all staff will utilize facility surgical masks or N95 masks in accordance with CDC guidelines at the start of their shift and will change PPE as needed throughout the shift. 4. Effective immediately the screener will document that a new surgical mask or N95 mask was obtained for each employee presenting for their shift. 5. Effective immediately the staff will be educated on hand hygiene at the start of their next shift. 6. Effective immediately Management/IC will supervise meal times until it is determined that proper hand hygiene is being routinely utilized. After that time meal times will be randomly supervised to ensure continued compliance. 7. Effective immediately residents have been reeducated on the importance of wearing a mask and social distancing. DON/IC will review importance of masks and social distancing with residents or designated POA, if resident is not mentally competent to understand, and a	F 880	4. The next staff meeting will cover education on proper PPE. Dietary and housekeeping will receive the same education. 5. All employees have completed social distancing and hand hygiene education and competency. Education and competency will be repeated the month of April and then will go back to yearly education. Staff will also cover hand hygiene during their yearly CNA competency checklist. 6. Weekly audits on social distancing and hand hygiene during mealtime will be done until compliance is reached. 7. Activities will log each activity and if masks were worn during activity or if resident refused mask. Documentation will be done in resident EHR if they refuse to wear a mask and IDT will follow-up weekly. 6 feet social distance will be maintained and masks will be encouraged. 8. Charge nurse or designee will monitor the dining room at mealtimes to ensure masks are being worn and social distancing is being maintained. Documentation will be done in resident EHR if they refuse to wear a mask and IDT will follow-up weekly. 6 feet social distance will be maintained and masks will be encouraged. The results of these audits will be presented to the QAPI committee to ensure continued compliance for a minimum of 3 months or until the QAPI committee is satisfied that the facility is in compliance with F880.	

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signature will be obtained. They understand they have the right to refuse a mask, but staff will ask them to wear a mask when leaving their room. Residents will be educated that staff will be asking every time they leave their room.

8. Effective immediately 6 feet social distance will be maintained and masks will be encouraged.

9. Effective immediately during activities and dining 6 foot distance will be maintained in between residents. Roommates and spouses will be allowed to sit at the same table <6 feet apart.

The action plan was accepted on 3/3/21 at 5:20 PM.

Observation on 3/4/21 at 8:23 AM showed IP performing re-education to kitchen staff regarding hand hygiene. Observation during the lunch meal on 3/4/21 at 11:56 AM showed the staff were wearing surgical face masks and performing hand hygiene between handling the resident cups and assisting the residents. The residents were seated at the dining area tables, and were socially distanced. Further observation on 3/4/21 at 12:04 PM showed the meal being served to the residents and staff assisting the residents. Hand hygiene was observed after each resident. Staff were all wearing surgical face masks. Interview with the DON and IP on 3/4/21 at 12:20 PM revealed the facility was performing re-education to staff before the start of their shift. Documentation provided showed the specific education given to the staff, and the staff who had received the education. Review of IP audit at that time showed initial evaluations being performed, with no annotations of corrective actions needed to that point.

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The implementation of the action plan was verified and immediacy was removed on 3/4/21 at 1:05 PM, however, deficient practice remained at a scope and severity of "F".

The survey findings were:

Review of CMS memo QSO-20-39-NH (updated 3/10/21) showed the core infection prevention principles for preventing the spread of COVID-19, which should be adhered to at all times, included the following:

"...Hand hygiene (use of alcohol-based hand rub is preferred)...Glove use is not a substitute for hand hygiene...Use enough alcohol-based hand sanitizer to cover all surfaces of your hands, keeping them wet for at least 20 seconds, rubbing them together until dry...Healthcare providers not performing hand hygiene 100% of the time at every opportunity for cleansing, they put themselves and their patients at risk for infections...Face covering or mask (covering mouth and nose)...Social distancing at least six feet between persons ...Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit...Appropriate staff use of Personal Protective Equipment (PPE)..."

Review of facility policy titled " Standard Precautions - Overview " and last reviewed January 2017 regarding standard precautions showed staff were to " ...Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply [the following] infection control practices during the delivery of

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	535029	A. BUILDING _____ B. WING _____	C 03/04/2021

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health care... " and to utilize hand hygiene when " ...Hands are visibly soiled, or after caring for a resident ... " Further review showed " Gloves ... are not a substitute for hand hygiene... " and " ...Staff must perform hand hygiene even if gloves are utilized ... " Staff are expected to " Remove gloves after contact with a patient, bodily fluid/excretions, and the surrounding environment (including medical devices) using proper technique to prevent hand contamination. Do not wear the same pair of gloves for the care of more than one patient. " The following concerns were identified:

Regarding source control:

1. Observation of the evening meal on 3/1/21 from 4:59 PM to 5:20 PM showed initially 18 residents were sitting at small square tables in the dining area, rising to 21 residents by the end of the observation. The residents were not wearing masks, and were not distanced at least 6 feet apart. Staff were not observed to encourage residents to wear masks or to socially distance. There were 7 total tables, of which 2 tables had 4 residents sitting side by side, 2 tables had 2 residents sitting beside each other, and 3 tables with 3 residents sitting by each other. In addition, two unidentified CNAs were observed wearing cloth face masks while passing trays and assisting residents with their food.

2. Observation on 3/02/21 at 9:24 AM showed an activity being conducted with a small group of 7 residents, all of whom were within arms length of each other. The residents were positioned in a circle and hitting a balloon back and forth. None of the residents were wearing masks. Staff were not observed to encourage the residents to wear

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masks or to socially distance. The activity was observed to be still ongoing at 9:35 AM.

3. Interview with the IPC/MDS coordinator on 03/01/21 at 2:47 PM revealed the facility had relaxed source control requirements for residents. She stated 20 residents had been vaccinated with the 2 doses, 3 residents refused the vaccination, and 2 more residents were scheduled for their vaccinations. Later interview at 3:01 PM confirmed facility residents were not wearing face masks, with the IPC stating, "Some of the residents would not even wear the mask if offered. Some would blow up if asked to wear a mask. Our county positivity is zero. That is why they are not wearing face masks...We have relaxed the expectation on residents."

4. Review of CMS county positivity data for the week ending 3/2/21, found at COVID-19 Nursing Home Data - Test Positivity Rates | Data.CMS.gov, retrieved 3/12/21, showed Crook County administered fewer than 20 tests. However, positivity rates for 3 surrounding counties (Campbell County WY, Fall River County SD, and Custer County SD) ranged from 1.7% to 11.4%.

Regarding hand hygiene:

5. Observation on 03/01/21 at 3:04 PM showed used water containers had been removed from resident rooms and placed on the handrails outside the rooms. CNA #3 was observed leaving room 206 wearing gloves. She did not remove her gloves or perform hand hygiene upon exit. She then grabbed the dirty water containers that were sitting on the handrail, and placed them onto the cart she was utilizing. This cart

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contained clean water containers that she was distributing, as well as the dirty water containers from the handrails. She then pushed the cart farther down the hall and entered room 205, all while wearing the same contaminated gloves, with no hand hygiene or glove exchange observed prior to entering the room. While wearing the same contaminated gloves, she then delivered clean water containers into the room, grabbing the dirty containers from the handrail upon exiting, and placing them onto the cart with the clean containers. No glove removal or hand hygiene was observed upon exit. She pushed the cart down the hall to room 208, delivered clean water containers, and collected the dirty containers from the rail upon exit, still wearing the same contaminated gloves. No glove exchange or hand hygiene observed upon entry or exiting of the room. Observations of entry and exit of rooms 207, 209, 210, 211, 212, 213, 214, 215, 216, and 217 showed the CNA continued to collect dirty water containers and distribute clean water containers wearing the same gloves for the duration of this entire task. No glove exchange or hand hygiene was observed upon entry or exit of the rooms, or after contamination of the gloves.

6. Observation on 03/01/21 at 3:25 PM showed RA-CNA #4 leaving room 215. No hand hygiene was observed upon exit. She then returned to room 215 at 3:29 PM, with no hand hygiene prior to entry. She exited a few seconds later, did not perform hand hygiene, and then entered room 213 without performing hand hygiene. She was observed moving the resident's tray table, and assisting the resident with positioning in bed. Next, she exited the room, again with no hand hygiene observed. She went down the hall to the restorative therapy office, retrieved two small

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hand-held exercise balls, and then entered room 207. No hand hygiene was observed upon entry.

7. Observation on 03/01/21 at 4:14 PM showed RA-CNA #4 entered room 210, with no hand hygiene observed before entry. She exited at 4:19 PM, and no hand hygiene was observed. She then went into the clean utility storage/bathing suite to retrieve clothing protectors used for meals, and began disbursing them to every place setting in the dining room.

8. Observation on 3/01/21 at 4:35 PM showed RA-CNA #4 walking with resident #22, who was utilizing a crutch, to the dining room. After the resident was seated, RA-CNA #4 took the crutch and leaned it against the wall. She then retrieved a coffee cup for the resident and a communal pitcher of coffee for the table. Two more residents joined the table and poured themselves coffee from the communal pitcher. No hand hygiene was observed after contact with the resident or his crutch before contacting items to be shared at the table.

9. Observation on 3/01/21 at 4:39 PM showed CNA #2 took the coffee cup of resident #125 from the table to a microwave inside the nurses station to warm up its contents. She then took the cup to the beverage counter to add sugar, and returned the cup to the resident. No hand hygiene was performed after delivery of the cup. She then assisted two other residents with the warming and adding of condiments to their coffees, using the same microwave and beverage counter. No hand hygiene was performed in between contacts.

10. Observation on 3/01/21 at 4:43 PM showed

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dietary aide #1 wearing gloves in the dining room. He touched the shoulder of resident #14 with gloved hands, and then went to the clean dietary cart to put trays together with supplies for each resident. No hand hygiene or glove exchange was performed after the contact.

11. Observation on 3/01/21 at 4:53 PM showed LPN #1 helped resident #14 set up his/her meal place setting, and assisted the resident with positioning in his/her chair. No hand hygiene was observed before or after contact with the resident. LPN #1 then left the dining room and went to the nurses station, where she made contact with the counter and computer inside the nurses station.

12. Observation on 3/01/21 at 4:56 PM showed CNA-MA #5 made contact with resident #3 through a hug, and with the resident's food and place setting, as well. She then left the dining room, opened the gate to the nurses station, touched the med cart and its contents, and began retrieving the next resident's medications. No hand hygiene was observed between contacts or tasks.

13. Observation on 3/01/21 at 5:17 PM showed dietary aide #1 wearing gloves, and making contact with resident #3 and his/her wheelchair. He then returned to the clean dietary cart, touching the cart and passing out desserts. No glove exchange or hand hygiene was observed after contact.

Review of the Centers for Disease Control ' s "Preparing for COVID-19 in Nursing Homes" found at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, accessed 3/17/21, showed

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F 880	Continued From page 17 core practices included "...Implement Source Control Measures. HCP should wear a facemask at all times while they are in the facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance..." Review of the Centers for Disease Control ' s "Hand Hygiene in Healthcare Settings" found at https://www.cdc.gov/handhygiene/index.html, accessed 3/12/21, showed "... Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an Alcohol-Based Hand Sanitizer. Immediately before touching a patient. After touching a patient or the patient ' s immediate environment...Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the patient or the patient environment.	F 880		

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F 880	Continued From page 18 Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. Never wear the same pair of gloves in the care of more than one patient. Carefully remove gloves to prevent hand contamination."	F 880		