DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 10, 2021

Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

RE: CCN: 245375
Cycle Start Date: November 20, 2020

Dear Administrator:

On December 16, 2020, we notified you a remedy was imposed. On January 6, 2021 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 23, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 30, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 16, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 30, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 23, 2020, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
December 16, 2020

Administrator
Sterling Park Health Care Center
142 North First Street
Waite Park, MN 56387

RE: CCN: 245375
Cycle Start Date: November 20, 2020

Dear Administrator:

On November 20, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 30, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 30, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 30, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 30, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Sterling Park Health Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 30, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 20, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	11/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK HEALTH CARE CENTER	**142 NORTH FIRST STREET WAITE PARK, MN 56387**

(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 A COVID-19 Focused Infection Control survey was conducted 11/20/20 at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in full compliance . Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is requires, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 11/20/20 at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was not in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/23/20

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

Electronically Signed | 12/23/2020

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	Continued From page 1 §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 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,	F 880		

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F 880	Continued From page 2 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 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, interview, and document review the facility failed to ensure eye protection was utilized by 2 of 2 staff observed to provide direct resident care for 2 residents (R1, R2). The facility also failed to ensure staff performed hand hygiene and utilized gloves as instructed to decrease the risk of infection transmission in the facility. This had the potential to affect all 34 residents residing in the facility during the focused infection control survey. Findings include:	F 880	PLAN OF CORRECTION Sterling Park Healthcare Center denies it violated any federal or state regulations. Accordingly, this plan of correction does not constitute an admission or agreement by the provider to the accuracy of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. Completion dates are provided for	

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F 880	Continued From page 3 EYE PROTECTION R1's annual Minimum Data Set (MDS), dated 8/30/20, identified R1 had severe cognitive impairment, required extensive physical assist for eating and drinking and displayed coughing or choking during meals or when swallowing medications. In addition, R1's MDS indicated R1 had a diagnosis of dementia, dysphagia from a past stroke, and COVID-19. R2's quarterly MDS, dated 8/29/20, identified R2 had severe cognitive impairment and required supervision of 1 staff with as needed physical assist for mobility. In addition, R2's MDS indicated R1 had a diagnosis of dementia and COVID-19. On 11/20/20, at 9:56 a.m. nursing assistant (NA) -A was observed to enter R1's room. NA-A's eye protection was located on NA-A's forehead and did not cover NA-A's eyes. NA-A proceeded to stand directly on the right side of R1 and assisted him to drink from a glass. On 11/20/20, at 9:57 a.m. the director of nursing (DON) entered R1's room and instructed NA-A to place the eye protection over NA-A's eyes. Upon exiting R1's room, the DON stated NA-A had been using eye protection incorrectly and the eye protection should have been covering NA-A's eyes. When interviewed on 11/20/20, at 10:01 a.m. NA-A stated eye protection was required with any type of resident contact. NA-A acknowledged not using the eye protection when working with R1 stated they had been recently educated on PPE	F 880	procedural processing purposes and correlation with the most recently completed or accomplished corrective action and do not correspond chronologically to the date the facility maintains it is in compliance with the requirements of participation, or that corrective action was necessary. 1. In continuing compliance with F880, Infection Prevention and Control, Sterling Park Healthcare Center corrected the deficiency by ensuring all staff have full PPE on during their shift and are properly washing their hands. 2. To correct the deficiency and to ensure the problem does not recur all staff were re-educated on facility PPE requirements regarding eye protection. The education also included proper hand hygiene specifically following glove use. The education was completed by the ED/DNS. 3. The ED/DNS and/or designee will audit beginning 12/28/2020 all shifts for 1 week x4 (12 audits per week) and then 2x a week for 1 week (6 audits per week) to achieve 100% compliance of PPE use. The ED/DNS and/or designee will audit all shifts daily for 1 week or until 100% compliance is achieved. As part of Sterling Park Healthcare Center's ongoing commitment to quality assurance, the ED/DNS and/or designee will report identified concerns through the community's QA Process. 4. The Director of Nursing is Responsible for this area of compliance.	

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F 880	Continued From page 4	F 880		

during orientation. NA-A explained the risk of not wearing the eye protection as directed would be that NA-A could become sick if R1 had coughed during the provided care.

On 11/20/20, at 10:21 a.m. case manager/registered nurse (RN)-A entered R2's room wearing prescription eyeglasses over her eyes and a pair of eye protection that was located on her forehead. RN-A placed her left arm around R2 who had been standing and assisted her to sit on her wheelchair seat. RN-A and R2 conversed during the seating assist. They continued to converse as RN-A bent over to disengage the wheelchair breaks which brought RN-A's face within about 12 inches of R2's face. Immediately after, R2 stated she wished to lay down. RN-A assisted R2 from the wheelchair to a laying position in bed. R2 and RN-A's faces were again within close proximity during the transfer process in which continued conversation between the two occurred.

During interview on 11/20/20, at 10:26 a.m. RN-A stated she had witnessed R2 was standing unassisted and due to R2's higher fall risk, RN-A had been in a hurry to reach R2 to prevent R2 from a possible fall. RN-A explained she experienced "double vision" when she wore her prescription glasses and the goggles (eye protection) at the same time. During the interview at 10:27 a.m. RN-A placed the eye protection on over her prescription glasses. RN-A stated she typically wore a face shield due to the double vision; however, the strap broke the evening prior and she had yet to find the time to obtain a new one.

HAND HYGIENE/GLOVE USE

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F 880	Continued From page 5	F 880		

During continued observation on 11/20/20, at 10:10 a.m. NA-A entered R3 and R4's shared room wearing gloves and picked up their disposable breakfast containers located on their individual tray tables and placed the containers into a small trash can located in the room. NA-A disposed of R3 and R4's garbage bag in the soiled utility room's larger garbage bin located about half way down the hallway after NA-A touched the soiled utility room door handle and the garbage bin lid with a gloved hand to open them. NA-A exited the soiled utility room, touched the handle on a metal cart situated in the hallway, and pushed it farther down the hallway to R5's room doorway. NA-A failed to remove the gloves and failed to perform hand hygiene.

-At 10:12 a.m. NA-A entered R5's room and took the trash bag out of R5's trash can and accidentally dumped the contents of the bag out onto the floor. The trash contained R5's breakfast items and uneaten food, along with other unidentified items. NA-A picked up the items, including some of the food remains with gloved hands, and placed them into the same trash bag the items were dumped from. NA-A disposed of the trash bag in the soiled utility room's garbage bin after NA-A touched the soiled utility room door handle and garbage bin lid to open them, grabbed a broom and dustpan from the soiled utility room, and returned to R5's room where NA-A finished cleaning up the remains of R5's breakfast up off of the floor. NA-A failed to remove the gloves and did not perform hand hygiene. NA-A carried the dustpan which contained the cleaned up remains out into the hallway and disposed of the contents in the soiled utility room's garbage bin after again touching the door handle and the garbage bin lid. NA-A

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F 880	Continued From page 6	F 880		

removed the gloves and performed hand hygiene.

-At 10:15 a.m. NA-A donned gloves and entered R6's room. NA-A exited R6's room with R6's trash bag and disposed of it in the soiled utility room's garbage bin after opening the utility room door and the garbage bin lid. NA-A removed the gloves, disposed of them in the soiled utility room garbage bin after touching the garbage bin lid with a bare hand, failed to perform hand hygiene, and walked to R7's room where NA-A donned a pair of gloves in the doorway.

-At 10:16 a.m. NA-A picked up R7's breakfast items while touching R7's tray table to tidy it up and placed the breakfast items into R7's trash can. NA-A exited R7's room carrying R7's trash can which had been positioned between the side of NA-A's torso and the inside of NA-A's upper arm and disposed of the trash bin's garbage bag in the soiled utility room's garbage bin after opening the utility room door and the garbage bin lid. NA-A brought R7's trash can back to R7's room and again returned to the soiled utility room. NA-A removed the gloves while in the soiled utility room and exited the utility room carrying a new pair of gloves; however, NA-A did not don the gloves and failed to perform hand hygiene.

-At 10:19 a.m. NA-A carried the gloves and entered R3 and R4's shared room where NA-A obtained a trash can liner from the designated holder on R2 and R4's room wall. NA-A proceeded to walk down the hallway toward R7's room. The surveyor stopped NA-A just before NA-A entered R7's room.

When interviewed on 11/20/20, at 10:19 a.m. NA-A acknowledged NA-A had not utilized gloves as directed and further confirmed failure to perform hand hygiene as educated on during recent orientation when NA-A disposed of that

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STERLING PARK HEALTH CARE CENTER	**142 NORTH FIRST STREET WAITE PARK, MN 56387**

(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 7 morning's resident breakfast items. NA-A explained NA-A should have performed hand hygiene before and after exiting R3, R4, R5, R6, and R7's rooms. . During interview on 11/20/20, at 11:34 a.m. the DON stated staff were expected to always wear either eye protection goggles or a face shield when caring for residents. The DON explained staff not wearing required eye protection had a "minimal" risk to the residents "unless they are rubbing their eyes on them" and voiced there was more of a risk to staff. In addition, the DON stated she would expect staff to wear gloves when disposing of breakfast trash items and to doff the gloves prior to exiting the resident's room. The DON further explained she expected staff to perform hand hygiene before and after entering a resident's room and after doffing gloves. During interview on 11/20/20, at 12:15 p.m. the administrator stated it was her expectation that staff wore eye protection "all the time." The administrator explained the risk of staff not wearing eye protection depended on what the staff would be doing at the time; however, stated this would put the staff at risk for potential exposure to "anything" and "contamination of their eyes." In addition, the administrator stated gloves were a one time use item and should not be worn out into the hallways. The administrator stated further she expected staff to perform hand hygiene before entering and exiting a resident's room. A facility policy Practice Guideline and Procedure: Standard Precautions, reviewed 3/1/20, indicated standard precautions was the basic level of infection control that should be used in the care of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245375	A. BUILDING _____ B. WING _____	11/20/2020

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F 880	Continued From page 8	F 880		

all residents all of the time in order to reduce the risk of transmission of microorganisms from both recognized and non-recognized sources of infection. This policy identified personal protective equipment (PPE) for standard precautions included eye protection and that personal eye glasses and contact lenses were not considered eye protection.

A facility policy Practice Guideline and Procedure: PPE Guidance: Selection and Use, reviewed 3/1/20, directed staff to position goggles over the eyes and secure to the head using the ear pieces or headband and if staff utilize a face shield the face shield should be positioned over the face and secured on the brow with a headband.

A facility policy Practice Guideline and Procedure: Hand Hygiene, revised 2/20, identified the purpose of cleaning your hands was to reduce the spread of potentially deadly germs to the residents and to reduce the risk to the healthcare provider of infection caused by germs acquired from the resident. The policy directs staff to use alcohol based hand sanitizer after touching a resident or the resident's immediate environment, after contact with contaminated surfaces, and immediately before putting on gloves and after glove removal.

A facility policy Practice Guideline and Procedure: Gloves, reviewed 3/1/20, identified the purpose of wearing gloves was to reduce the likelihood of transmitting organisms on the hands of staff contaminated with microorganisms from the resident or inanimate objects. The policy directs staff to wear gloves when there is a possibility of contact with blood or body fluids and to discard gloves after each individual use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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