STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING: _____ B. WING _____	02/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

(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) COMPLETE DATE
4 000	Initial Comments A licensure survey was conducted from 02/02/21 through 02/08/21. At the time of entrance, there was a census of 88 residents. The SA also investigated the following Aspen Complaints/Incidents Tracking System (ACTS) #8675, #8373, #8422, #8338, #8264. Complaint #8675 was found substantiated. Complaint #8373, #8422, #8338, #8264 were found to be unsubstantiated.	4 000		
4 148	11-94.1-39(a) Nursing services (a) Each facility shall have nursing staff sufficient in number and qualifications to meet the nursing needs of the residents. There shall be at least one registered nurse at work full-time on the day shift, for eight consecutive hours, seven days a week, and at least one licensed nurse at work on the evening and night shifts, unless otherwise determined by the department. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures were followed for COVID-19 and other communicable diseases and infections. This is evidenced by staff failing to follow transmission-based precautions (TBP) such as wearing the proper personal protective equipment (PPE), and removing and discarding the soiled PPE in a safe manner. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings Include:	4 148	1) Rooms 109 and 116 had signage updated with appropriate infection control protocols. 2)Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3)DON re-educated nursing and therapy staff regarding Infection Control guidelines including PPE, donning/doffing and signage. 4)Unit Managers/Designee will audit ten (10) random isolation rooms for appropriate signage daily for two (2)	3/18/21

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4 148	Continued From page 1 1) On 02/02/21 at 0830 AM, an observation was made of Certified Nurse's Aide (CNA)6 doffing a gown outside of Room 109. Room 109 had a label at the entrance as on droplet and contact precautions. The waste receptacles for the personal protective equipment (PPE) worn in this room were located outside the doorway, in the hall. 2) On 02/02/21 at 09:09 AM, an observation was made of a staff member doffing outside the room of 116, a room labeled at the entrance as on droplet and contact precautions, requiring those who enter to wear a gown, gloves, face shield, and N95 respirator. The waste receptacles for the PPE worn in this room were located outside the doorway, in the hall. 3) On 02/03/21 at 12:09 PM, an observation was done of a Physical Therapist (PT)2 at the entrance of 116 talking with Registered Nurse (RN)3 regarding a resident that was in room 116. Room 116 had a label at the entrance of the room as on droplet and contact precautions. Apparently, the resident in Room 116 wheeled himself to the physical therapy department on his own. RN3 was not able to clarify droplet and contact precautions for room 116 to PT2. PT2 then went to the Director of Nursing (DON). DON explained to PT2 that resident was only on droplet and contact precautions at night when he was receiving Continuous Positive Airway Pressure (CPAP) because of the aerosol mist. There was no explanation of this modification of contact and droplet precautions on entrance of the door. Interview with DON who acknowledged that the label on the room was not clear who is on precautions for droplet and contact precautions.	4 148	weeks, then six (6) six audits weekly for four (4) weeks, then five (5) audits monthly for two (2) months. Unit Managers/Designee will also complete random infection control audits including donning/doffing procedures and appropriate PPE. Five (5) random audits will be completed daily for two (2) weeks, then four (4) random audits weekly for two (2) weeks, then four (4) random audits monthly for two (2) months. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained	

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4 148	Continued From page 2 In addition, there was no label to state a modified droplet and contact precautions. The RN assigned to the area was not able to clarify droplet and contact precautions for room 116. Labels were not clear. This was confusing to ancillary staff who are delivering healthcare to residents. 4) On 02/05/21 at 09:02 AM, an observation was done of Physical Therapy Aide (PTA) 1 exiting Room 117, a room labeled at the entrance as on droplet and contact precautions, requiring those who enter to wear a gown, gloves, face shield, and N95 respirator. The waste receptacles for the personal protective equipment (PPE) worn in this room were located outside the doorway, in the hall. PTA1 was observed doffing (removing) her gown after exiting the room, as she stood in front of the dirty gown receptacle. 5) On 02/05/21 at 12:16 PM, an observation was done of Physical Therapist (PT) 1 exiting Room 102, a room labeled at the entrance as on droplet and contact precautions. PT1 was observed exiting the room with no gown and no gloves on. When questioned about his lack of gown and gloves, PT1 stated that he was in the room to see the resident in bed B, who was not on TBP. PT1 further explained that he usually asked a nurse prior to entering a room labeled as on TBP, in order to determine which resident in the room was on TBP. In this instance, PT1 stated that as he entered the room, he observed "a nurse" already in the room who was not gowned and gloved so he did not think he had to. 6) On 02/05/21 at 12:17 PM, Surveyor observed an occupational therapy assistant (OTA) coming out of room 215. On the wall prior to entering	4 148		

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4 148	Continued From page 3 room 215, signs posted indicated that the residents were placed into contact and droplet isolation (the use of PPE is required for protection against infection by microorganisms transmitted through direct or indirect contact (cough or sneeze) with the patient or patient care items). Plastic drawers located under the posted signs, contained clean gowns that staff are required to don prior to entry into room 215. The OTA wore his dirty PPE gown coming out from room 215 and into the hallway, removed his gloves and placed them into a trash receptacle adjacent to the door frame of room 215. The nurse's medication cart, where resident's medications are stored and prepared, was approximately ten feet away. The OTA proceeded back into room 215, removed his gown while in the room, walked out of room 215 and disposed of it in the dirty gown receptacle next to the trash receptacle adjacent to the room's door frame. In an interview with the OTA on 02/05/21 12:35 PM, he was asked to outline the process of donning and doffing PPE for contact and droplet isolation rooms. He stated that prior to entry into the room, he puts on his gown and then his gloves making sure to cover both wrists and that he has an N95 mask and face shield on. For the process of doffing his PPE, he stated that he removes his gloves and then takes off his gown before he exits the room. He acknowledged the previous incident that the surveyor observed and explained that he stepped out of the room wearing his dirty gown to let the certified nursing assistant (CNA) pass by him to enter the room. He stated that he understands "how important it is for strict protocol" and that he needed to remove his dirty gown prior to exiting the contact and droplet isolation room.	4 148		

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4 148	Continued From page 4 7) On 02/05/21 at 12:19 PM an observation was done of Certified Nurse Aide (CNA) 1 exiting the same room (Room 102), also not wearing any gown or gloves. CNA1 confirmed that both residents in Room 102 were on TBP due to recent admissions. When asked why she was not wearing a gown and gloves, CNA1 replied, "if we don't give direct care we don't have to gown and glove, I just delivered a [lunch]tray, I didn't touch the patient." 8) On 02/05/21 at 12:30 PM an observation was done of CNA1 entering Room 109 with a lunch tray, a room labeled at the entrance as on droplet and contact precautions, without donning any gown or gloves. CNA1 was observed delivering the lunch tray to the resident in 109B, who was sitting upright in a wheelchair with a bedside table in front of him. CNA1 was then observed closing the bathroom door to make room, adjusting the resident's bedside table, setting up the resident's lunch tray, arranging his adaptive utensils, cutting his food into smaller pieces, and tucking a napkin under his chin, before sitting down to help him eat per his request. 9) On 02/05/21 at 12:40 PM, an interview was done with Unit Manager (UM) 1 at the Station 1 Nurses' Station. UM1 stated that the TBP policy is, "if one of the patient[s] in the room is on contact/droplet precautions, we treat them both like they are." Review of the Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated July 2019, noted the following guidance regarding standard precautions, "Before leaving	4 148		

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4 148	Continued From page 5 the patient's room or cubicle, remove and discard PPE." https://www.cdc.gov/niosh/npptl/pdfs/PPE-Sequence-508.pdf, Further review of this same guideline specifically noted that "Isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room." These deficient practices place the residents, healthcare personnel, and visitors to the facility at risk for unnecessary exposure, transmission, and development of COVID-19 and other communicable diseases and infections.	4 148		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and	4 185		3/18/21

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4 185	Continued From page 6 (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on observation, interview, record review and facility policy review, the facility failed to ensure pharmacy services included a thorough process to prevent medication errors by identifying and disposing of discontinued medications for three residents (Residents (R) 67, 138 and 139) selected for review. This deficient practice has the potential to affect all residents in the facility. Findings Include: 1) On 02/08/21 at 12:05 PM, an observation and concurrent interview was done while reviewing the Station 2B medication cart located outside Room 216 with Registered Nurse (RN) 3. Observed a Lisinopril 2.5mg blister pack for R67 in the medication drawer. "D/C d" had been written at the top of the label in black ink. When RN3 checked the medication order, it was noted that the medication was discontinued on 01/26/21. RN3 stated the policy is that whoever notes the order is responsible to make sure the discontinued medication is taken out of the drawer and confirmed that the medication should have been taken out of the drawer and discarded. A review was done of the facility's Nursing Care Center Pharmacy Policy & Procedure Manual, Disposal of Medications, Syringes, and Needles, dated 2007. The following was noted under Section 5.1, Discontinued Medications, "If a prescriber discontinues a medication, the medication container is removed from the	4 185	1.The lisinopril noted for (R57) was removed and discarded. The ampicillin for (R138) was removed and discarded. The lidocaine patches for (R139) were removed and discarded. The six (6) prefilled Lovenox syringes were also removed and discarded. There were no adverse outcomes. 2.Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3.DON re-educated nurses on checking medications for expiration dates and removing them from the medication carts and/or Medication Rooms for prompt disposal. Additionally, DON re-educated nurses on discarding medications after residents are discharged from facility. 4.Unit Managers/Designee will audit medication carts and Medication Room (including refrigerator medications) daily for two (2) weeks, then weekly for two (2) weeks, then monthly for two (2) months to validate that discharged residents□ medications are not left in the medication carts or the Medication Room(s). Any issues identified during the audits will be addressed immediately per facility policy. DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting	

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4 185	Continued From page 7 medication cart immediately." 2) On 02/08/21 at 11:28 AM, an observation and concurrent review of the Station 1 medication room was done with RN4. In the bottom cabinet, there were two large clear plastic bags containing medications labeled for R138's use. Each bag contained approximately 10, "Ampicillin for injection USP 2 grams per vial, for IV use" medications. The RN4 read the pharmacy label which stated, "Bag room temp expires 09/20/20." RN4 said R138 was no longer at the facility. RN4 said the nurse was supposed to have discarded these medications, but said she herself was uncertain as to how they were to discard it, "because of the vials" (vials with solution bags for reconstitution). On 02/08/21 at 12:19 PM, the Director of Nursing stated, "Anything in a syringe needs to be drawn up and disposed of in the drug buster." 3) On 02/08/21 at 12:01 PM, an observation and concurrent review of the Station 1A medication cart was done with the unit manager (UM) 1. The medication cart was found to contain a packet of 11 Lidocaine 5% patches for R139. The UM1 said R139 was no longer at the facility. The UM1 said if the resident was no longer there, the nurse "has to pull the medication and put it into the medication storage room." (There is a discard box in the medication room for that purpose). 4) The medication cart also had six Lovenox prefilled injectable syringes with no label on them. Per the UM1, she said these should have been discarded. She said they rely on the night shift nurses to do this task, but stated any nurse should be able to do this task of appropriately	4 185	monthly until QAPI team validates compliance is sustained	

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4 185	Continued From page 8 discarding outdated, unlabeled medications and those not in use (discharged residents). Further review of the facility's Nursing Care Center Pharmacy Policy & Procedure Manual, Disposal of Medications, Syringes, and Needles, dated 2007, was done. At Section 5.5, Disposal of Medications, it stated, "Policy 1. Discontinued medications and/or medications left in the nursing care center after a resident's discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition. . . . 3. Methods of disposition of pharmaceutical hazardous or non-hazardous waste are consistent with applicable state and federal requirements, local ordinances, and standards of practice. . . Procedures 1. The director of nursing and the consultant pharmacist will monitor for compliance with federal and state laws and regulations regarding the disposable of medications. . . . 7. Outdated medications, contaminated or deteriorated medications, and the contents of containers with no label shall be destroyed according to the above policy." The licensed staff failed to ensure discontinued, unusable medications and/or medications without labels were properly disposed of following their facility practice and protocols. Based on observation, interview, record review, and facility policy review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional	4 185		

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4 185	Continued From page 9	4 185		

standards, including expiration dates. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility.

Findings Include:

1) On 02/08/21 at 12:05 PM, an observation and concurrent interview was done while reviewing the Station 2B medication cart located outside Room 216 with Registered Nurse (RN) 3. Observed a Lantus SOLOSTAR insulin pen, labeled as opened on 01/06/21 and "Date to Discard: 2/3/21." Attached to the pen was an "EKIT" label with a last name handwritten in. The last name was also written in black ink on the pen cap. No first name, room number, or other identifier noted on the label or pen.

RN3 looked up the medication order and reported that the pen was for resident (R) 285. RN3 further noted that R285 was admitted on 01/06/21 and discharged on 01/15/21. RN3 explained that the EKIT label indicated it was issued to resident on admission as an emergency medication, for use until his pharmacy-labeled pen arrived. RN3 stated the policy is to write first and last name and room number on any medications issued from the EKIT. RN3 also confirmed that the pen should have been pulled out of the drawer, stating that the policy is that all medications are pulled from the medication cart when a resident is discharged.

A review was done of the facility's Nursing Care Center Pharmacy Policy & Procedure Manual, Disposal of Medications, Syringes, and Needles, dated 2007. The following was noted under

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4 185	Continued From page 10 Section 5.5, Disposal of Medications, " ...medications left in the nursing care center after a resident's discharge ...are identified and removed from current medication supply in a timely manner for disposition." 2) On 02/08/21 at 11:28 AM, an observation and concurrent review of the Station 1 medication room was done with RN4. In the medication refrigerator, there were two Tuberculin Purified Protein Derivative (PPD) vials which were "opened" (used), but per RN4, "they didn't put the date" as to when the vials were opened for use. RN4 clarified their process and said for licensed staff, "the first person who opened it supposed to put date opened, and date to discard," and to write it on the label. RN4 said the discard date was 30 days after opening the vial, and it was not the expiration date noted on each box as "Exp 02/22." It was found the white label on the side of the box was left blank, and was typewritten as, "Discard 30 days After Opening. Date Opened: ___ Date to Discard: ___". The RN4 verified this part was incomplete and not done by the licensed staff who opened/used these two vials. 3. Also in the Station 1A medication cart, there were different insulin pens for various residents. One Novolog pen was for R140, which had been opened for use on 01/31/21. However, the date to discard was handwritten as 02/29/21. Per the UM1, she said the date to discard should be 03/01/21, and acknowledged the month of February did not have a 29th date in 2021. The UM1 further acknowledged licensed staff was not accurate in their way of labeling medications.	4 185		

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4 204	Continued From page 11	4 204		
4 204	11-94.1-53(b)(1) Infection control (b) The facility shall have provisions for isolating residents with infectious diseases until appropriate transfers can be made. (1) The facility shall have a written policy that outlines proper isolation and infection control techniques and practices; This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures were followed for COVID-19 and other communicable diseases and infections. This is evidenced by staff failing to follow transmission-based precautions (TBP) such as wearing the proper personal protective equipment (PPE), and removing and discarding the soiled PPE in a safe manner. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings Include: 1) On 02/02/21 at 0830 AM, an observation was made of Certified Nurse's Aide (CNA)6 doffing a gown outside of Room 109. Room 109 had a label at the entrance as on droplet and contact precautions. The waste receptacles for the personal protective equipment (PPE) worn in this room were located outside the doorway, in the hall. 2) On 02/02/21 at 09:09 AM, an observation was made of a staff member doffing outside the room	4 204	1)Rooms 109 and 116 had signage updated with appropriate infection control protocols. 2)Residents residing at the facility have the potential to be affected by the alleged deficient practice. 3)DON re-educated nursing and therapy staff regarding Infection Control guidelines including PPE, donning/doffing and signage. 4)Unit Managers/Designee will audit ten (10) random isolation rooms for appropriate signage daily for two (2) weeks, then six (6) six audits weekly for four (4) weeks, then five (5) audits monthly for two (2) months. Unit Managers/Designee will also complete random infection control audits including donning/doffing procedures and appropriate PPE. Five (5) random audits will be completed daily for two (2) weeks, then four (4) random audits weekly for two (2) weeks, then four (4) random audits monthly for two (2) months.	3/18/21

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

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4 204	Continued From page 12 of 116, a room labeled at the entrance as on droplet and contact precautions. The waste receptacles for the PPE worn in this room were located outside the doorway, in the hall. 3) On 02/03/21 at 12:09 PM, an observation was done of a Physical Therapist (PT)2 at the entrance of 116 talking with Registered Nurse (RN)3 regarding a resident that was in room 116. Room 116 had a label at the entrance of the room as on droplet and contact precautions. Apparently, the resident in Room 116 wheeled himself to the physical therapy department on his own. RN3 was not able to clarify droplet and contact precautions for room 116 to PT2. PT2 then went to the Director of Nursing (DON). DON explained to PT2 that resident was only on droplet and contact precautions at night when he was receiving Continuous Positive Airway Pressure (CPAP) because of the aerosol mist. There was no explanation of this modification of contact and droplet precautions on entrance of the door. Interview with DON who acknowledged that the label on the room was not clear who is on precautions for droplet and contact precautions. In addition, there was no label to state a modified droplet and contact precautions. The RN assigned to the area was not able to clarify droplet and contact precautions for room 116. Labels were not clear. This was confusing to ancillary staff who are delivering healthcare to residents. 4) On 02/05/21 at 09:02 AM, an observation was done of Physical Therapy Aide (PTA) 1 exiting Room 117, a room labeled at the entrance as on droplet and contact precautions, requiring those	4 204	DON/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained	

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4 204	Continued From page 13	4 204		

who enter to wear a gown, gloves, face shield, and N95 respirator. The waste receptacles for the personal protective equipment (PPE) worn in this room were located outside the doorway, in the hall. PTA1 was observed doffing (removing) her gown after exiting the room, as she stood in front of the dirty gown receptacle.

5) On 02/05/21 at 12:16 PM, an observation was done of Physical Therapist (PT) 1 exiting Room 102, a room labeled at the entrance as on droplet and contact precautions. PT1 was observed exiting the room with no gown and no gloves on. When questioned about his lack of gown and gloves, PT1 stated that he was in the room to see the resident in bed B, who was not on TBP. PT1 further explained that he usually asked a nurse prior to entering a room labeled as on TBP, in order to determine which resident in the room was on TBP. In this instance, PT1 stated that as he entered the room, he observed "a nurse" already in the room who was not gowned and gloved so he did not think he had to.

6) On 02/05/21 at 12:17 PM, Surveyor observed an occupational therapy assistant (OTA) coming out of room 215. On the wall prior to entering room 215, signs posted indicated that the residents were placed into contact and droplet isolation (the use of PPE is required for protection against infection by microorganisms transmitted through direct or indirect contact (cough or sneeze) with the patient or patient care items). Plastic drawers located under the posted signs, contained clean gowns that staff are required to don prior to entry into room 215. The OTA wore his dirty PPE gown coming out from room 215 and into the hallway, removed his gloves and placed them into a trash receptacle adjacent to the door frame of room 215. The nurse's

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4 204	Continued From page 14	4 204		

medication cart, where resident's medications are stored and prepared, was approximately ten feet away. The OTA proceeded back into room 215, removed his gown while in the room, walked out of room 215 and disposed of it in the dirty gown receptacle next to the trash receptacle adjacent to the room's door frame.

In an interview with the OTA on 02/05/21 12:35 PM, he was asked to outline the process of donning and doffing PPE for contact and droplet isolation rooms. He stated that prior to entry into the room, he puts on his gown and then his gloves making sure to cover both wrists and that he has an N95 mask and face shield on. For the process of doffing his PPE, he stated that he removes his gloves and then takes off his gown before he exits the room. He acknowledged the previous incident that the surveyor observed and explained that he stepped out of the room wearing his dirty gown to let the certified nursing assistant (CNA) pass by him to enter the room. He stated that he understands "how important it is for strict protocol" and that he needed to remove his dirty gown prior to exiting the contact and droplet isolation room.

7) On 02/05/21 at 12:19 PM an observation was done of Certified Nurse Aide (CNA) 1 exiting the same room (Room 102), also not wearing any gown or gloves. CNA1 confirmed that both residents in Room 102 were on TBP due to recent admissions. When asked why she was not wearing a gown and gloves, CNA1 replied, "if we don't give direct care we don't have to gown and glove, I just delivered a [lunch]tray, I didn't touch the patient."

8) On 02/05/21 at 12:30 PM an observation was done of CNA1 entering Room 109 with a lunch

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4 204	Continued From page 15	4 204		

tray, a room labeled at the entrance as on droplet and contact precautions, without donning any gown or gloves. CNA1 was observed delivering the lunch tray to the resident in 109B, who was sitting upright in a wheelchair with a bedside table in front of him. CNA1 was then observed closing the bathroom door to make room, adjusting the resident's bedside table, setting up the resident's lunch tray, arranging his adaptive utensils, cutting his food into smaller pieces, and tucking a napkin under his chin, before sitting down to help him eat per his request.

9) On 02/05/21 at 12:40 PM, an interview was done with Unit Manager (UM) 1 at the Station 1 Nurses' Station. UM1 stated that the TBP policy is, "if one of the patient[s] in the room is on contact/droplet precautions, we treat them both like they are."

Review of the Centers for Disease Control and Prevention (CDC) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last updated July 2019, noted the following guidance regarding standard precautions, "Before leaving the patient's room or cubicle, remove and discard PPE."
https://www.cdc.gov/niosh/npptl/pdfs/PPE-Sequence-508.pdf,

Further review of this same guideline specifically noted that "Isolation gowns should be removed before leaving the patient care area to prevent possible contamination of the environment outside the patient's room."

These deficient practices place the residents, healthcare personnel, and visitors to the facility at

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4 204	Continued From page 16 risk for unnecessary exposure, transmission, and development of COVID-19 and other communicable diseases and infections.	4 204		
4 217	11-94.1-55(d) Housekeeping (d) The facility shall be kept free of unreasonable accumulation of personal possessions. This Statute is not met as evidenced by: Based on observations, interview and record review, the facility failed to provide a safe and functional environment for residents, staff and the public due to inadequate space caused by wheelchair storage in room 210. This deficient practice hinders the life and safety of the residents residing in that room and the safety of the staff that need to provide care for these residents and the safety of visitors who come to visit the residents of room 210. Finding includes: Surveyor's initial observation on 02/02/21 at 08:16 AM revealed that room 210 with four residents was crowded. Bed A for R60 on the left side of the room, closest to the entrance, had floor pads on each side of his bed. Bed B with R14 also had floor pads on both sides of his bed was next to and parallel to R60's bed, farthest away from the entrance. R14's bed was situated adjacent to the bathroom and parallel to the resident's closets. Bed C for R77 was located on the right side of the room parallel to the wall with windows, farthest away from the entrance. Two wheelchairs were placed in a small space to the right of the resident's closets ending at the foot of R77's bed. R77 was sitting up in his wheelchair located in	4 217	1. R60, R14, R77 and R10 did not have a negative outcome. Facility-wide floor mat and room audit was conducted to ensure floor mats are utilized and care-planned appropriately, and to validate that doors are capable of closing without impediment. 2. Residents with fall mats have the potential to be affected by this practice. 3. Administrator/ designee has educated staff on the importance of providing a safe, functional, sanitary and comfortable environment. 4. Administrator/designee will audit compliance during weekly rounds x 8 week to validate floor mats are necessary and that room is safe, functional, sanitary and comfortable. Administrator will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained	3/18/21

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4 217	Continued From page 17 between the wall with windows and his bed, eating breakfast under the supervision of CNA2. His floor pads for the left side of his bed were folded and located in between the wall and his bed. To ensure that there was adequate space for wheelchair storage, R77 and CNA2, R77's bed was pushed to the right towards R10's bed (bed D). R10's bed was located parallel to R77's bed on the right side of the room, closest to the entrance. There was less than three feet of space in between R77's and R10's beds. On 02/03/21 at 12:49 PM an observation made revealed that there were three wheelchairs situated in front of the window against the far wall to the right of the resident's closets and to the left of R77's bed. R77 was in bed with floor pads placed on each side of his bed. R77's and R10's beds had less than three feet of space in between them because R77's bed was pushed towards R10's bed to ensure enough storage space for the three wheelchairs. CNA2 moved R10, who was sitting up in his wheelchair eating lunch and watching television, towards the right in order to make space for herself on the right side of R77's bed to assist CNA3 in repositioning R77 for lunch. On 02/05/21 at 09:24 AM, CNA4 was providing care to R77. His bed was pushed towards R10's bed to allow sufficient space for CNA4 on the left side of his bed to provide care to R77 with the floor pad on the floor. Three wheelchairs were stored in the little space in between the resident's closets and the foot of R77's bed. Surveyor did not have room to situate herself on the right side of R77's bed for an observation of R77's care because there was less than three feet of space in between R77's and R10's beds. In a query with CNA4 assessing whether or not she had enough room to conduct her job safely she stated	4 217		

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4 217	Continued From page 18 that it was a hazard to work with the little space available around R77's bed. The room was crowded with the three wheelchairs stored in a small space next to the resident's closets and R77's bed. There was no other space to store the wheelchairs in room 210 because the beds for R60, R14 and R77 had floor pads for fall precautions, which occupied approximately 4 feet width of space on each side of the beds. The facility's policy, "Resident Rights Safe, Clean and Comfortable Environment," stated "2. The provision of such an environment will include supporting the resident in receiving care and services safely."	4 217		