STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165529	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Shenandoah	1203 South Elm Street Shenandoah, IA 51601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 44420 Based on clinical record review and staff interview, the facility failed to obtain physical signatures or record attempts to obtain physical signatures on notification of the Notice of Medicare Non-Coverage (NOMNC) Centers of Medicare & Medicaid (CMS)-10123 and CMS form CMS-10055 for 1 of 3 sampled residents (Residents #38). The facility reported a census of 41 residents. Findings Include: Record review for Resident #38 revealed form CMS 10123-NOMNC with a services end date of 9/24/24. Resident #38's representative gave verbal consent for signature on 9/20/24 however lacked a signature of resident or resident representative. CMS-10055 form lacked a services ending date and reason Medicare may not pay. Resident #38's representative gave verbal consent for signature on 9/20/24 however lacked a signature of resident or resident representative. Review of Resident #38 Progress Notes lacked any documentation on resident representative giving verbal consent and any attempts to obtain physical signatures on CMS 10123-NOMNC and CMS-10055. Review of the Centers (CMS) Medicare Claims Processing Manual Chapter 30 with a revision date of 1/21/22 revealed the following information under ABN options for Delivery other than in-person revealed ABN's should be delivered in-person and prior to the delivery of medical care which is presumed to be non-covered. In circumstances when in-person delivery is not possible, notifiers may deliver an ABN using another method. Examples include: Direct telephone contact; Mail; Secure fax machine; or Internet e-mail. All methods of delivery require adherence to all statutory privacy requirements under HIPAA. The notifier must receive a response from the beneficiary or his/her representative in order to validate delivery. (continued on next page)

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.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When delivery is not in-person, the notifier must verify that contact was made in his/her records. In order to be considered effective, the beneficiary should not dispute such contact. Telephone contacts should be followed immediately by either a hand-delivered, mailed, emailed, or a faxed notice. The beneficiary should sign and retain the notice and send a copy of this signed notice to the notifier for retention in the patient's record. The notifier must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the notifier should document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself. Review of the CMS NOMNC form instructions for the NOMNC CMS-10123 revealed the signature line: beneficiary/enrollee or the representative must sign this line and the date line: The beneficiary/enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered. CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered. The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee's medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date. Interview on 10/18/24 at 03:01 p.m., with the Director of Nursing revealed she was unaware the facility was required to have physical signatures if the facility had obtained verbal consent from the resident's representative. The DON reported the facility does not have a policy for advance beneficiary notices, however the facility followed standard regulations.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47673 Based on clinical record review, and staff interviews the facility failed to represent an accurate assessment of the resident's status during the observation period of the Minimum Data Set (MDS) by not accurately assessing the use of a diuretic for 1 of 5 residents reviewed (Resident #22). The facility reported a census of 41 residents. Finding include: The MDS assessment dated [DATE] for Resident #22 documented a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. The MDS also documented a diagnosis of essential (primary) hypertension. Review of Resident #22's MDS dated [DATE] documented no use of diuretic therapy by Resident #22. Review of Resident #22's MAR-TAR documented a physician's order to give one furosemide 20 mg oral tablet by mouth daily that was started on 8/2/24. On 10/16/24 at 9:56 AM Staff A, MDS coordinator acknowledged Resident #22 was on furosemide, a diuretic. Staff A acknowledged that the use of a diuretic should have been documented on the MDS. Staff A acknowledged that Resident #22 started furosemide on 8/2/24. On 10/16/24 at 10:15 AM the DON stated she expected the MDS would reflect the use of a diuretic. The DON acknowledged Resident #22 was on a diuretic since 8/2/24. On 10/16/24 at 1:05 PM the Administrator stated the facility followed standards of care and regulations for MDS assessments.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review and staff interview the facility failed to develop care plans to address COVID-19, oxygen therapy and medications in 4 out of 14 sampled residents reviewed for comprehensive care plans (Resident #16, 22, 29 and 35). The facility reported a census of 41 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #16 showed the resident returned to the facility from a critical access hospital on 9/6/24. The Medical Diagnosis report for Resident #16 documented diagnoses of COVID-19, heart failure, atrial fibrillation and dementia. Observation on 10/14/24 at 12:28 PM showed Resident #16 received continuous oxygen therapy at 1.5 Liters (L). The Physician Orders for Resident #16 showed oxygen ordered at 2 L continuous and to titrate oxygen to keep blood oxygen saturation above 90%. The Care Plan last reviewed on 8/2/24 for Resident #16 showed the facility failed to develop a care plan for oxygen therapy. 2. The MDS assessment dated [DATE] for Resident #29 documented diagnoses congestive heart failure, fluid overload and pulmonary hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Observation on 10/14/24 at 1:17 PM for Resident #29 showed a sign on the door that indicated personal protective equipment (PPE) required to enter the room. The Progress Notes for 10/5/24 at 9:49 AM for Resident #29 showed the facility notified family of COVID-19 positive test results. The Care Plan last reviewed on 8/10/24 for Resident #29 showed the facility failed to develop a care plan for management of COVID-19. In an interview on 10/16/24 at 3:01 PM, the Director of Nursing (DON) reviewed Resident #29's care plan and determined the facility lacked a care plan for oxygen therapy. When asked if COVID-19 should be included on the care plan, the DON stated, It has already been added. The DON and nurse consultant reported the facility lacked a policy for care plan development. 47673 3. The MDS assessment dated [DATE] for Resident #22 documented a BIMS score of 8 indicating moderate cognitive impairment. The MDS also documented a diagnosis of essential (primary) hypertension. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #22's Medication Administration Record (MAR) documented a physician's order to give one furosemide 20 mg oral tablet by mouth daily that was started on 8/2/24. Review of Resident #22's Care Plan documented no focus, goals or interventions for diuretic therapy. 4. The MDS assessment dated [DATE] for Resident #35 documented a BIMS score of 13 indicating no cognitive impairment. Review or Resident #35's electronic health record (EHR) documented a diagnosis of Covid-19 on 10/5/24. Review of Resident #35's Care Plan documented no focus, goals or interventions for a diagnosis of Covid-19. On 10/16/24 at 9:56 AM Staff A, MDS Coordinator acknowledged Resident #22 was on furosemide, a diuretic. Staff A stated she developed care plans for the facility. Staff A acknowledged that Resident #22 did not have a care plan associated with the use of a diuretic and should have. Staff A acknowledged Resident #35 did not have a care plan in place associated with a diagnosis of Covid 19 and should have. On 10/16/24 at 10:15 AM the DON acknowledged Resident #22 had an order for furosemide. The DON acknowledged there was no care plan in place related to diuretic therapy for Resident #22. The DON stated the facility's expectation was that use of a diuretic would have been addressed on the care plan. The DON acknowledged Resident #35 did not have a care plan in place associated with a diagnosis of Covid-19 and should have. On 10/16/24 at 1:05 PM the Administrator stated the facility followed standards of care and regulations for care plan development.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on clinical record review, staff interviews and facility policy review, the facility failed to provide professional standards of care by not obtaining daily weights per physician orders, and allowing a resident to self administer medications without a physician's order for 2 of 14 residents reviewed (Resident #6 and #29). The facility reported a census of 41 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #29 documented diagnoses Congestive Heart Failure (CHF), fluid overload and pulmonary hypertension. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. Observation on 10/14/24 at 1:17 PM for Resident #29 showed a sign on the door that indicated personal protective equipment (PPE) required to enter the room. The Progress Notes for 10/5/24 at 9:49 AM for Resident #29 showed the facility notified family of COVID-19 positive test results. Review of signed Physician Orders dated 6/13/23 revealed an order for daily weights, give extra dose of Lasix if weight gain of 5 pounds in one week. The Care Plan for Resident #29 documented altered cardiovascular status related to atrial fibrillation, CHF, fluid overload, and hypertension. The care plan instructed staff to obtain daily weights. Review of Treatment Administration Record (TAR) for October 2024 revealed the facility failed to obtain weights for the following dates: a. 10/5/24 b. 10/6/24 c. 10/7/24 d. 10/8/24 e. 10/9/24 f. 10/10/24 g. 1011/24 h. 10/12/24 i. 10/13/24 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. 10/14/24 The Progress Notes for Resident #29 indicated because of COVID-19 staff failed to weigh the resident daily. Review of Resident #29's medical record revealed the facility failed to clarify the daily weight order with the physician while the resident was infected with COVID-19. In an interview on 10/16/24 at 3:01 PM, the Director of Nursing (DON) revealed staff should have clarified the daily weight order with the physician while the resident had COVID-19, or ask the DON for further instructions. The DON reported the facility does not have a policy regarding professional standards or following physician orders. The DON stated, we follow professional standards and regulations. 47673 2. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Observation on 10/14/24 at 1:15 PM revealed medication in a nebulizer sitting in Resident #6's room. On 10/14/24 at 1:20 PM Staff E, Registered Nurse (RN) stated Resident #6 had a breathing treatment in the morning, afternoon, and evening. Staff E acknowledged that she had left the medication in Resident #6's nebulizer for him to return to lunch and administer himself. Staff E stated she had been leaving the medication in Resident #6's nebulizer in his room for him to self administer since she started. On 10/15/24 at 1:08 PM a continuous observation revealed Staff E removed medication from medication cart and entered Resident #6's room. Staff E emptied a vial of ipratropium / albuterol into Resident #6's nebulizer. Staff E applied nebulizer mask to Resident #6. Staff E left a tablet of gabapentin 100 mg in a medication cup on Resident #6's bedside table. Review of Resident #6's electronic health records (EHR) documented a physician's order for Gabapentin 100 mg TID and Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3 ML 1 vial daily. On 10/15/24 a continuous observation from 1:08 PM - 1:21 PM revealed Resident #6 shut off the nebulizer and picked up the medication cup at 1:21 PM and self administered medication with a sip of water. No staff present in the room. Review of Resident #6's EHR documented no self administration assessment. On 10/16/24 at 7:59 AM Staff F, Licensed Practical Nurse (LPN) stated she never left medication in Resident #6's room because the resident could forget to take the medication. Staff F stated there were no self administration assessments at the facility. Staff F stated she would not leave a breathing treatment in the room for a resident to take on their own either. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 1:11 PM the Director of Nursing (DON) stated the medication should not have been left in the room with the resident. The DON stated she felt that Resident #6 had been administering his own nebulizer treatments since he had entered the facility. The DON stated she felt that was how the treatments were given to him at the previous facility. The DON acknowledged no self administration assessment. The DON acknowledged medication in the medication cup in Resident #6's room at that time. Review of policy dated 4/16/24 titled Medication Management / Medication Administration documented to explain to the resident the type of medication being administered and after administration return to the medication cart and document the administration of medication.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 47673 Based on facility document review and staff interview the facility failed to ensure a Registered Nurse (RN) was in the facility for eight (8) consecutive hours for 7 of 33 days reviewed. The facility reported a census of 19 residents. Findings include: The PBJ Staffing Data Report run date 10/9/24 triggered for failure to have a RN in the facility for 8 consecutive hours on 5/11 and 5/26/24. Review of the last 30 days of nursing schedules revealed no RN coverage on 5/11, 5/26, 9/14, 9/15, 9/28, 9/29, and 10/12/24. On 10/16/24 at 3:09 PM the Administrator acknowledged there was no RN coverage on 5/11, 5/26, 9/14, 9/15, 9/28, 9/29, and 10/12/24. The Administrator stated the facility's expectation was 8 consecutive hours of RN coverage every day.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44420 Based on observations, staff interviews, and facility policy review the facility failed to ensure proper sanitary conditions in the kitchen area, where staff prepared food, and failed to keep utensils on a sanitary surface during meal service. The facility identified a census of 41 residents. Findings included: a. The initial kitchen walkthrough on 10/14/24 at 10:05 AM revealed the following: b. The stove top and backsplash showed a thick layer of grease with food splatter and a variety of food debris. c. The oven and stacked oven splattered with food. d. The hood with visible grease buildup. e. A clean dish cart contained a variety of scattered food debris at the bottom of the cart. f. The floor contained an accumulation of food debris and a variety of dried liquid. g. Two stand up freezer units with debris on the bottom of the unit. h. The dishwasher with thick, crusty layers of lime. i. Lime build up on the floor under the dishwasher. j. During the initial kitchen tour the Dietary Manager (DM) reported the inability to join the tour due to filling in as the cook. Observation of lunch service on 10/16/24 at 12:40 PM showed the following: a. Staff B, [NAME] used a knife to cut a sandwich then placed the knife on top of the meal ticket. Staff B later used the knife to cut another sandwich. b. Staff B placed a rubber spatula on an unsanitized counter, used the spatula to scoop butter from the container then spread the butter on bread. c. Staff B placed a food scoop on an unsanitized area of the steam table then later used the scoop to plate food. The Food Safety and Sanitation policy dated 2021 identified the state and or federal survey team as part of the annual survey process will inspect the department. The food and nutrition service department will follow regulations as outlined by official health agencies and organizations with jurisdiction over the facility. The policy also identified food should be protected from contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/16/24 at 2:20 PM, the DM stated, the deep cleaning doesn't get done because there isn't enough time in the day. We have the help that we're supposed to but it's not enough to get everything done.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44420 Based on observations, facility policy review, procedure review and staff interviews, the facility failed to perform proper transmission based precaution techniques, perform appropriate hand hygiene during wound care, and failed to effectively sanitize a glucometer for 2 of 14 residents reviewed (Resident #16, #25). The facility reported a total census of 41 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #16 showed the resident returned to the facility from a critical access hospital on 9/6/24. The Medical Diagnosis report for Resident #16 documented diagnoses of COVID-19, heart failure, atrial fibrillation and dementia. Observation on 10/15/24 at 1:35 PM showed Staff C, Licensed Practical Nurse (LPN) failed to perform hand hygiene, donned gloves and removed the brace from Resident #16's left leg. Staff C removed the dressing from the left heel, examined the wound then asked the Infection Preventionist (IP) if the wound should have a dressing. The IP replied, she wouldn't know. Staff C applied skin prep to the open wound on the left heel then instructed Staff D, Certified Nursing Assistant (CNA) to put the leg down. Staff C failed to place a barrier under Resident #16's heel before Staff D lowered the resident's leg to the bed. Resident #16's heel rested directly on the bed linens. Staff C doffed gloves, failed to perform hand hygiene, opened the door and left the room. Staff C arrived back to the room, removed the dressing from the package, wrote the date on the dressing then donned gloves without performing hand hygiene. Staff C covered the wound with the dressing, failed to remove gloves and perform hand hygiene before she assisted the resident to drink from the water pitcher, used the bed controls and arranged the bedside table. Staff C then doffed gloves, discarded the gloves and exited the room without performing hand hygiene. The Hand Hygiene policy last updated 9/6/24 identified proper hand washing techniques should be used to protect against the spread of infection. The policy documented that cleaning your hands reduces the spread of potentially deadly germs to the resident and reduces the risk of health care provided causation or infection caused by germs acquired from the resident. Hand hygiene may occur multiple times during a single care episode. The policy indicated hand hygiene is required immediately before touching a resident, immediately before putting on gloves and after glove removal, after touching a resident or the resident's immediate environment, and contact with blood, body fluids or contaminated services. In an interview on 10/16/24 at 3:17 PM, the IP reported during Resident #16's wound care observation, she noticed Staff C failed to perform hand hygiene. The IP stated, there were many times hand hygiene should have been done. When asked if hand hygiene should have been performed before, after and in between glove changes, the IP replied, yes. When asked if she noticed additional infection control concerns, the IP replied, the open wound was put down directly on the bed. 47673 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #25 documented a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. An observation on 10/15/24 at 12:04 PM revealed Staff C donned mask, gown, glove, and face shield. Staff C entered Resident #25's room with medications, administered medications, checked CGM with Resident #25's reader in the room. Resident #25's reader read HI. Staff C left the room, removed the gown, rolled the gown up, and placed it on the hand rail in the hall with a face shield. Staff C obtained the blood glucose machine from the medication cart and returned to the room. Staff C donned the gown inside out and then reapplied correctly with gloves and face shield. Blood sugar of 438 obtained. Staff C returned to the medication cart with the blood sugar machine, placed it on the cart, utilized an alcohol wipe to cleanse the machine, and placed the machine back in the drawer. Staff C kept her gloves, gown, and N95 on while at the cart. Staff C opened the computer, opened the drawer, leaned on the cart, removed gloves, reapplied gloves without any hand hygiene and entered Resident #25's room without a face shield in place. Staff C left Resident #25's room with a gown mask and gloves. Staff C removed gloves, leaned on the medication cart, opened the computer with gown and N95 in place under her chin. Staff C then removed gloves, mask, gown, and hand hygiene was completed. Staff G LPN / IP present making observations during that entire observation. On 10/15/24 at 12:25 PM Staff C stated she had always just wiped the blood glucose monitors down with alcohol wipes before and after each resident and placed them back in the drawer. On 10/15/24 at 12:32 PM Staff G LPN / IP stated hand hygiene would be expected with all gloved changes, prior to and after resident care. Staff G acknowledged that Staff C concerns with doffing PPE and hand hygiene after entering Resident #25's room and when returning to the cart. Staff G stated ideally Staff C would have doffed PPE appropriately with hand hygiene completed appropriately as well. Staff G stated she would have to check with the corporate nurse for the policy on the reuse of gowns. Staff G stated her expectation was the gown would not have been balled up and stuffed in the hand rail. Staff G stated the facility's expectation was the blood glucose machine would have been cleansed by utilization of the sanitizing wipes. Staff G stated the blood glucose machine should have been wiped down with the sanitizing wipe then wrapped with sanitizing wipe and placed in a disposable cup for 3 minutes per the sanitizing wipe wipe instructions. On 10/15/24 at 1:11 PM the DON stated the facility's expectation was the blood glucose machine should have been wiped down with the sanitizing wipe then wrapped with sanitizing wipe and allowed to sit for 3 minutes wrapped per the sanitizing wipe wipe instructions. Observation on 10/15/24 at 11:17 AM revealed Staff E entered a residents room and obtained a sample for blood glucose reading. Staff E exited the room after obtaining blood glucose with the blood glucose monitor. Staff E returned to the medication cart and wiped the blood glucose machine off with alcohol wipe and put in the drawer. On 10/15/24 at 11:23 Staff E stated each cart has a blood glucose machine for each hall. Staff E stated the machine should be wiped with alcohol wipe and placed back in the medication cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Shenandoah		STREET ADDRESS, CITY, STATE, ZIP CODE 1203 South Elm Street Shenandoah, IA 51601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of procedure titled Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID -19. PPE must be donned correctly before entering the patient area. PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. Put on a face shield or goggles before entering the room. When exiting doff PPE. Perform hand hygiene after removing and before putting it on again if your workplace is practicing reuse. Review of procedure titled Competency for Finger Stick Blood Glucose updated 5/11/21 documented to cleanse equipment with PDI pad, microkill, or other approved agent and put away.