STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345053	A. BUILDING _____ B. WING _____	04/08/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETTIGREW REHABILITATION CENTER	1515 W PETTIGREW STREET DURHAM, NC 27705

(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 Emergency Preparedness Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 7-8, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. The census was 69.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 7-8, 2020. The facility was not in substantial compliance with 42 CFR §483.80 (Infection Control), Subpart-B-Requirements for Long Term Care Facilities. The facility was not following infection control safety practices and guidance recommended by CMS and the Centers for Disease Control and Prevention (CDC), during a COVID-19 pandemic. The census was 69. COVID-19 is a Coronavirus disease, an infectious disease caused by a new virus. This disease has been determined by the CDC to spread primarily through contact with an infected person, when they cough, sneeze, touch a surface or object that the viruses may be present on, then touch their eyes, nose and mouth, etc. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity "K." It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury,	F 000		

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

Electronically Signed | 04/27/2020

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F 000	Continued From page 1 harm, impairment or death to residents. The Immediate Jeopardy was related to 480.80 Infection Control. The facility failed to ensure 1) Housekeeping staff performed hand hygiene prior to exiting Resident #'1's room, who was on droplet precautions, and before proceeding to enter other residents' rooms, 2) Nursing care staff failed to remove gloves and perform hand hygiene, after performing incontinence care for Resident #1. The nursing care staff proceeded from Resident #1's room with the same gloves on, and provided care to Resident #6, who was, located across the hallway, and 3) failed to ensure that social distancing was maintained for four (4) Residents (#s 2, 3, 4, and 6), and 4) failed to ensure personal protective equipment was readily available and accessible (masks), for staff to use for Resident #1. These failures occurred during a COVID-19 pandemic. The Administrator, Director of Nursing, Staff Development Coordinator, Regional Clinical Director, and the facility's Vice President, were made aware that Immediate Jeopardy existed on April 7, 2020 at 5:52 p.m. Immediate Jeopardy was removed on April 8, 2020 at 8:01 p.m., after an acceptable removal action plan was received and further observations, staff interviews, policy review and review of training's to verify the immediate corrective action taken. The facility remained out of compliance at a lower scope and severity of "E" at F880.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity.	F 557		4/30/20

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F 557	Continued From page 2 The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews, and facility policy, entitled, "Resident Dignity & Personal Privacy," the facility failed to ensure, a resident was not exposed to public view, during provision of care for one (1) of one (1) resident (Resident #1). This was from a total sample of six (6) residents. The findings include: On 04/07/2020 at 2:53 p.m., Certified Nursing Assistant (CNA) #1 was observed providing care to Resident #6. From the hallway, the resident was observed positioned on the left side, with the back to feet able to be seen. The CNA checked the resident's incontinence depends or brief, and repositioned the resident, then pulled the sheet/linens back up on the resident. During an interview on 04/07/2020 at 3:00 p.m., accompanied by the DON, CNA #1 stated, that he should have maintained the resident's privacy while providing care. The DON stated she expected the curtain to have been pulled or the door closed. Review of resident assessment details provided by the facility, revealed, Resident #1's cognitive ability was severely impaired.	F 557	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. On 4/7/20 a certified nursing assistant was observed providing ADL to Resident #6. From the hallway, Resident #6 was observed positioned on the left side, with the back of feet able to be seen. At that time the certified nursing assistant checked the resident's incontinence brief and reposition the resident, then pulled the sheet/linens back up on the resident. Criteria 1 Resident #6 was not noted to be affected by the deficient practices of the Certified Nursing Assistant (C.N.A.) The certified nursing assistant (C.N.A) observed by the surveyor was	

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F 557	Continued From page 3 Review of the facility's policy, revised on 04/04/2019, revealed, "...3. Drape and dress residents appropriately at all times to avoid exposure and embarrassment...4. Maintain resident privacy during toileting, bathing, and other activities of personal hygiene...a. Use a top sheet or bath blanket as a cover-up during bedside care..."	F 557	re-educated and disciplined 4.7.20 at which time he resigned. Criteria 2 All residents who were cared for by this C.N.A would be at risk for the same deficient practices. Criteria 3 The DON and or the SDC provided education regarding providing privacy during Activities of Daily Living (ADL) on or by 4.25.20 and will be included as part of the certified nursing assistant orientation. Criteria #4 Random daily audits will be conducted by the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and other clinical team members to ensure compliance with the center's dignity and hand hygiene protocols. Criteria #5 This information will be tracked and trended by the DON and or designee and presented to the QAPI committee at which time will determine the need for continued monitoring.	
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		4/30/20

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F 880	Continued From page 4	F 880		

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, 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

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F 880	Continued From page 5 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 medical record review, staff interviews, and review of the "Outbreak of Communicable Diseases," "Suspected COVID-19 Isolation Precautions Guidelines," policies, the facility failed to ensure 1) Housekeeping staff (HKS) #1 performed hand hygiene prior to exiting Resident #1's room, who was on droplet precautions, and before proceeding to enter other residents' rooms, 2) Certified Nursing Assistant (CNA) #1 failed to remove gloves and perform hand hygiene, after performing incontinence care for Resident #1. CNA #1 proceeded from Resident #1's room with the same gloves on, and provided care to Resident #6, who was, located across the hallway, 3) failed to ensure that social distancing was maintained for four (4) Residents (#s 2, 3, 4,	F 880	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. Criteria #1 No residents were noted to be affected by	

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F 880	Continued From page 6 and 5), and 4) failed to ensure personal protective equipment (PPE) was readily available and accessible (masks), for staff to obtain for Resident #1. These failures occurred during a COVID-19 pandemic, and had the potential to affect all residents that resided at the facility. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy was related to 480.80 Infection Control scope and severity of "K." The Administrator, Director of Nursing, Staff Development Coordinator, Regional Clinical Director, and the facility's Vice President were made aware, that Immediate Jeopardy existed on April 7, 2020 at 5:52 p.m. Immediate Jeopardy was removed on April 8, 2020 at 8:01 p.m., after an acceptable removal action plan was received and further observations, staff interviews, policy review and review of training's to verify the immediate corrective action taken. The facility remained out of compliance at a lower scope and severity of "E" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) at F880. The findings include: Review of Resident #1's medical record revealed, the resident was 82 years old. Diagnoses history included Cerebral Palsy, Peripheral Vascular Disease, Hypertension, Vitamin D Deficiency, Chronic Pain, Disorders of Prostate and Hyperlipidemia (elevated cholesterol). Review of the temperature history that exceeded the	F 880	the alleged deficient practice. The housekeeper observed leaving the room of resident #1 by the surveyor was re-educated by the Director of Nursing (DON) and or his/her designee on 04 /07/2020 at approximately regarding infection control practices/procedures as it relates to the COVID-19 Pandemic. This education included review of how to identify residents on droplet and or contact precautions, handwashing requirements and expectations when cleaning and going in and out of resident rooms, and performing hand hygiene prior to and after applying gloves for residents presumed to be positive for COVID-19. Criteria #2 All residents receiving housekeeping services would be at risk for the same alleged deficient practice. Criteria #3 Housekeepers were re-educated by the DON and or his or her designee on or by 04/07/2020. This education included review of how to identify residents on droplet and or contact precautions, handwashing requirements and expectations when cleaning and going in and out of resident rooms, and performing hand hygiene prior to and after applying gloves for residents presumed to be positive for COVID-19. This education will be added to the housekeeping general orientation as well. Staff not educated on 04/07/2020 will not be allowed to work	

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F 880	Continued From page 7 facility's "Warnings" threshhold of "99.0" revealed, "99.1 (oral) 03/17/2020 03:54 (3:54 AM)...99.4 (oral) 03/20/2020 0149 (1:49 AM)...99.8 (temporal) 04/05/2020 11:47...99.7 (oral) 04/06/2020 0545 (5:45 AM). Further review of the medical record revealed, an order on 04/05/2020, that read, "Droplet precautions r/t (related to) high temp every shift for 7 days." Levaquin 500-milligram (mg) tablets by mouth was ordered on 04/05/2020 for "Empirical treatment," for "Fever" for seven (7) days. Empirical is defined as, "Based on experience rather than on scientific principles," according to the Taber's medical dictionary. The nurse's notes dated 04/05/2020, revealed, "...Elevated temp 102.5 this shift...rechecked again was still elevated at 103.6...Tylenol 650 mg given..." and the Physician Assistant (PA) was notified. The temperature decreased to "98.6." Further review of the nurse's note dated 04/05/2020, revealed, the PA ordered Resident #1 to be sent to the emergency room to be evaluated. However, when emergency medical transport arrived at the facility, the emergency medical technicians questioned the facility staff, whether the resident should be treated at the facility, due to the risk of contracting something more, during the COVID-19 pandemic. The PA was updated by the nursing staff and the PA ordered the resident to remain at the facility. In addition to the orders aforementioned, a chest-x-ray read, "No acute findings...chest is normal at this time...clinical indication: fever, cough..." urinalysis and culture sensitivity (UA C&S), and complete blood count with differential were ordered. The facility was awaiting the final results of the flu swap specimen (collected on 04/06/2020) and UA C&S (collected on	F 880	until the education has been provided. Criteria #4 Random daily audits will be conducted by the Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and other clinical team members to ensure compliance with the center's infection control program as it relates to hand hygiene when cleaning from one room to the next, identification of rooms on isolation, and performing hand hygiene for residents with presumed COVID-19. Criteria #4 The results of the audits will be presented by the Staff Development Coordinator and/or the Director of Nursing to the QA committee for further review and recommendations monthly for three months and as deemed necessary thereafter. Criteria #5 Date of compliance 4/30/2020 Criteria #1 No residents were noted to be affected by the alleged deficient practice. The certified nursing assistant of resident #1 is no longer employed by the center. Criteria #2 All residents cared for by the observed C.N.A had the potential to be affected by the alleged deficient practice. Therefore, continued monitoring of residents for	

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F 880	Continued From page 8 04/07/2020), at the time of the survey findings. 1. On 04/07/2020 at 11:24 a.m., accompanied by the Director of Nursing (DON), HSK #1 was observed in Resident #1's room, with a mask and gloves on, sweeping the floor. HSK #1 cleaned in close proximity to, around, and underneath the resident's bed. HSK #1 exited the resident's room with the same mask and gloves on and proceed down the hallway, where several residents' rooms were located. Upon inquiry, HSK #1 confirmed that he was in route to other residents' rooms. He stated, that he only performed hand hygiene, when he entered and exited the facility, for his work shift. He further clarified, that he only washed his hands with soap and water, upon entering and exiting the facility. He said, he did not perform hand hygiene, when he completed housekeeping duties, between residents' rooms. HSK #1 acknowledged that he was aware of the COVID-19 pandemic. He also confirmed the droplet precautions signage posted on the resident's door. During an interview on 04/07/2020 at 11:36 a.m., the DON stated, she expected HSK #1 to perform hand hygiene before exiting the resident's room, and follow the facility's policy related to droplet precautions. Review of the "Hand Hygiene Competencies with Return Demonstration," dated and signed on 03/27/2020, revealed, HSK #1 was aware of the importance of hand hygiene. Review of the "COVID-19 Test for Understanding," dated 03/27/2020, revealed, HSK#1 demonstrated understanding and awareness of COVID-19.	F 880	signs and symptoms of presumptive COVID-19 remain in place. Criteria #3 Licensed and non-licensed nursing staff were re-educated on infection control practices and procedures as it relates to the COVID-19 Pandemic. The education was specific to identification of residents on isolation precautions for droplet and contact precautions, handwashing requirements and expectations before and after providing care, before doffing and donning of gloves, and when entering and exiting resident rooms identified as being on precautions due to presumed COVID-19 infections. This education was provided by the Director of Nursing and or his/her designee. This education will be added to the general orientation. Criteria #4 Random daily audits will be conducted by the DON/designee to ensure proper identification of residents on isolation precautions (droplet and contact), hand hygiene requirements and expectations before and after providing care, before doffing and donning of gloves, and when entering and exiting resident rooms identified as being on precautions due to presumed COVID-19 infections and with a focus on proper infection control procedures. The results of the audits will be presented by the Staff Development Coordinator and/or the Director of Nursing to the QA	

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F 880	Continued From page 9 Review of the "Droplet "Precautions," signage posted on Resident #1's door read, "...Perform hand hygiene before entering and before leaving the room..." Review of the "Outbreak of Communicable Disease," infection control policy, revised on 03/13/2020, revealed, " ...11. All employees should: a. Practice good hand hygiene and handwashing technique..." Review of the "Suspected COVID-19 Isolation Precautions Guideline," dated "03/19/20" revealed, "...1. If a resident develops acute fever (99.6 or higher) or respiratory symptoms determine if the resident: >=65 with chronic health conditions or immunocompromised. If the answer to #1 is yes, immediately put the resident on droplet/contact precautions...PPE will include face masks, eye protection; gowns and gloves. Place a trash can near the exit inside the resident room on isolation to make it easy for employees to discard PPE..." 2. On 04/07/2020 at 2:53 p.m., CNA #1 exited Resident #1's room with gloves and a mask on, and proceeded into Resident #6's room. The CNA observed from the door, physically touched the resident, and checked Resident #6's incontinence depends or brief, repositioned the resident, and touched the bed and bed remote. During an interview on 04/07/2020 at 3:00 p.m., accompanied by the DON, CNA #1 stated, prior to entering Resident #6's room, he provided incontinence care to Resident #1 with the same gloves. He stated he was aware that Resident #1 was on droplet precautions. CNA #1 also	F 880	committee for further review and recommendations monthly for three months and as deemed necessary thereafter. Criteria #5 Date of compliance 4/30/20 Criteria #1 Resident #1 PPE droplet precautions which included masks and standard precautions of gloves, were replenished with masks immediately at the time it was reported to the DON. The facility uses the CDC recommendations/guidelines for droplet precautions. Resident #1 was not noted to be affected by the alleged deficient practice. Criteria #2 There is only (1) resident that is on droplet precautions that requires PPE. No other residents were noted to be affected by the alleged deficient practice. Criteria #3 All staff received education on 4/7/2020 on the process for reporting and replenishing of personal protective equipment (PPE) as well as how to identify what personal protective equipment (PPE) is required for droplet precautions. This information is provided on the isolation sign noted on the door of the affected person(s) room. Those not educated by 04/07/2020 will not be	

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F 880	Continued From page 10	F 880		

acknowledged that he was aware of the COVID-19 pandemic. The DON stated she expected the staff to wash their hands, before and after resident care, and before proceeding to another resident.

Review of the "Droplet "Precautions," signage posted on Resident #1's door read, "...Perform hand hygiene before entering and before leaving the room..."

Review of the "Outbreak of Communicable Disease," infection control policy, revised on 03/13/2020, revealed, "...11. All employees should: a. Practice good hand hygiene and handwashing technique..."

3. On 04/07/2020 at 12:00 noon, accompanied by Licensed Practical Nurse (LPN) #1, Resident #s 2, 3, 4 and 5 were located in the common day room area. The television (TV) was loud and some residents were watching the TV. LPN #1 confirmed that all residents present were less than four (4) to five (5) feet from each other. At 12:05 pm., the Staff Development Coordinator (SDC) confirmed the aforementioned. Both LPN #1 and the SDC acknowledged awareness of the COVID-19 pandemic, and the importance of maintaining social distancing.

During an interview on 04/07/2020 at 12:10 p.m., the DON stated, she expected the facility staff to monitor and maintain social distancing amongst the residents. The DON further indicated, residents should not be grouped in close proximity to each other, due to the COVID-19 pandemic. She stated, although there were no facility confirmed positive COVID-19 residents, to her knowledge, she expected social distancing

allowed to work until the education has been provided.

Criteria #4
PPE needs for residents placed on droplet precautions will be checked by the DON and or designee at the beginning of the day shift (7a-3p) and prior to leaving for the day. Also PPE supplies will be kept in the medication rooms so that it can be rationed under the supervision of the nurse. Staff have been educated to let the nurse know if PPE supplies need to be replenished. If PPE supplies in the medication room are running low the nurse is to notify the Director of Nursing and or the Administrator for replenishing (initiated 04.07.2020).

The DON/designee will conduct random weekly audits through direct observation of droplet isolation rooms for the appropriate PPE supplies (masks, gowns).

The results of the audits will be presented by the Staff Development Coordinator and/or the Director of Nursing to the QA committee for further review and recommendations monthly for three months and as deemed necessary thereafter.

Criteria #5
Date of compliance 4/30/20

Criteria #1
All residents (#2, #3, #4, and #5) were

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PETTIGREW REHABILITATION CENTER	1515 W PETTIGREW STREET DURHAM, NC 27705

(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 11 amongst residents. Review of an in-service report dated 03/18/2020, revealed, "...All staff: COVID-19 and Social Distancing..." were educated regarding the COVID-19 pandemic. 4. On 04/07/2020 at 11:24 a.m., accompanied by the DON, "Droplet precautions" signage was observed on Resident #1's door. The isolation door caddy did not contain any masks. On 04/07/2020 at 6:15 p.m., the DON explained that nursing staff were responsible for ensuring the isolation caddy was restocked, with the appropriate PPE. She indicated that she expected the CNA staff, to notify the nurse on the hallway, when PPE supplies needed to be restocked. The DON said, the hall nurse had access to additional PPE in the med-room. The DON proceeded to the med-room located on the same hallway as Resident #1, and confirmed there were no additional masks, that were readily accessible or available for the staff to use. The DON stated, she expected nursing staff to have notified either she or the Administrator, so that additional mask could have been provided. Additional mask were confirmed located in the Administrator's office. The DON and Administrator acknowledged they needed to monitor more closely, to ensure PPE was readily available for the staff to use. During a telephone interview on 04/08/2020 at 7:42 p.m., accompanied by the DON and Administrator, the Medical Director (MD) described droplet precautions, to be the same type of isolation as someone with the flu. He stated as part of diagnostic evaluation, to determine the source of the fever for Resident #1,	F 880	redirected to their rooms on 4.7.20 by a facility certified nursing assistant (C.N.A) immediately when made aware of the noncompliance observation of social distancing reported by the surveyor. Resident # 5 who is alert and oriented, was re-educated during the survey by the Director of Nursing on social distancing of 6 feet from all persons as it relates to the COVID-19 Pandemic. Residents #2, 3, and 4 were not able to be educated on social distancing due to their cognitive status. None of the residents were affected by the alleged deficient practice. Criteria #2 No other residents were identified to be affected by the alleged deficient practice. Criteria #3 Staff were re-educated by the Director of Nursing and or his/her designee on monitoring and observing residents and for social distancing of at least 6 feet as it relates to the possible transmission of COVID-19. Staff were educated and instructed on redirecting and re-educating residents when the behavior of social distancing of less than 6 feet is observed amongst residents. Employees not educated by 04/07/2020 will be educated prior to being allowed to clock in for their next scheduled shift. Criteria #4 All staff are responsible for maintaining and enforcing of social distancing of 6 feet between residents. Compliance of this directive will be monitored via the facility	

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F 880	Continued From page 12 the aforementioned orders were implemented. The MD indicated that he did not understand being asked about COVID-19 or recognizing potential presumptive signs and symptoms, until determined otherwise. The MD stated Resident #1 had a history of pulmonary edema. He acknowledged awareness of the COVID-19 pandemic. He also acknowledged understanding of the importance of the facility staff following safe infection control practices, during the COVID-19 pandemic. The DON and Administrator confirmed Resident #1's final test results, for the flu and UA C&S had not been received, at the time of the survey. The facility provided an acceptable removal action plan on April 8, 2020 at 5:12 p.m., that read: "Housekeeping staff failed to provide hand hygiene prior to exiting room of presumptive COVID 19 resident#1: - The housekeeper observed by the surveyor was re-educated by the Director of Nursing (DON) and or his/her designee on 04.07.2020 at approximately 2:30 PM regarding infection control practices/procedures as it relates to the COVID-19 Pandemic. This education included review of how to identify residents on droplet and or contact precautions, handwashing requirements and expectations when cleaning and going in and out of resident rooms, and performing hand hygiene prior to and after applying gloves for residents presumed to be positive for COVID-19. - All Housekeepers were re-educated by the DON and or his or her designee on or by 04/07/2020.	F 880	rounds (angel rounds) that are completed daily by the department heads and other assigned support staff. Any of observations of non-compliance should be addressed immediately by the staff member completing the facility observation round. Any findings of non-compliance will be discussed in the morning meetings along with the corrective action(s) that was implemented. Those with continued noncompliance will be addressed through the facility's disciplinary action. The results of the audits will be presented by the Staff Development Coordinator and/or the Director of Nursing to the QA committee for further review and recommendations monthly for three months and as deemed necessary thereafter. Criteria #5 4/30/20	

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This education included review of how to identify residents on droplet and or contact precautions, handwashing requirements and expectations when cleaning and going in and out of resident rooms, and performing hand hygiene prior to and after applying gloves for residents presumed to be positive for COVID-19. Those not educated on 04/07/2020 will not be allowed to work until the education has been provided.

- All residents in the facility will be observed and evaluated on-going, by the Director of Nursing (DON), Staff Development Coordinator (SDC), and other clinical team members every shift to identify any possible signs and symptoms of COVID-19. The signs and symptoms of COVID-19 that the staffs have been educated and continue to be educated on are residents with elevated temperatures and or any other respiratory signs symptoms such as shortness of breath, cough, and or sore throat. Staff education as it relates to signs and symptoms and prevention of COVID-19 is ongoing as new information is communicated to our organization via Centers for Disease Control (CDC), Federal and State organizations. Those residents identified will be discussed with the MD for further recommendations. If it is determined by the physician that a resident requires to be tested for COVID-19, the facility will follow the CDC, State and Federal regulations in regards to notification of the Department of Health and any other regulatory agency.

- All education will be provided by the Director of Nursing and or his/her designee.

Direct care staff failed to remove gloves and provide hand hygiene after providing incontinence

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care to resident #1 and then going onto providing care to resident #6.

- The direct care staff member observed during the survey was re-educated on infection control practices and procedures as it relates to the COVID-19 Pandemic. The education was specific to identification of residents on isolation precautions for droplet and contact precautions, handwashing requirements and expectations before and after providing care, before doffing and donning of gloves, and when entering and exiting resident rooms identified as being on precautions due to presumed COVID-19 infections. This education was provided by the Director of Nursing and or his/her designee. (completed 04.07.2020)

- All direct care staff currently in the facility will be re-educated by the Director of nursing and his or her designee related to infection control practices and procedures as it relates to the COVID-19 Pandemic. The education was specific to identification of residents on isolation precautions for droplet and contact precautions, handwashing requirements and expectations before and after providing care, before doffing and donning of gloves when entering and exiting resident rooms identified as being on precautions due to presumed COVID-19 infections. Those not educated by 04/07/2020 will not be allowed to work until the education has been provided.

- All residents have a potential to be affected by the deficient practice. Therefore, all residents in the facility will be observed and evaluated by the Director of Nursing (DON), Staff Development Coordinator (SDC), and all staff every shift to identify any possible signs and symptoms of

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COVID-19. The signs and symptoms of COVID-19 that the staffs have been educated and continue to be educated on are residents with elevated temperatures and or any other respiratory signs symptoms such as shortness of breath, cough, and sore throat. Staff education as it relates to signs and symptoms and prevention of COVID-19 is ongoing as new information is communicated to our organization via Centers for Disease Control (CDC), as well as Federal and State organizations. Those residents identified will be discussed by the nurse with the attending physician and or medical director for further recommendations. If it is determined by the physician that a resident requires to be tested for COVID-19 the facility will follow the CDC, State and Federal regulations and guidelines in regards to notification of the Department of Health.

- Those resident identified as having signs and symptoms will be considered presumed COVID-19 positive and will be placed on Droplet precautions. Personal Protective Equipment (PPE) required for droplet precautions will be identified on the isolation sign noted on the outside of the door of the affected person/persons. The attending physician/medical director will be notified for further recommendations/orders. If it is determined by the physician that a resident requires to be tested for COVID-19 the facility will follow the CDC, State and Federal regulations and guidelines in regards to notification of the Department of Health.

- All education will be provided by the Director of Nursing and or his/her designee.

Facility failed to ensure PPE on resident #1 was

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readily accessible:

- Resident #1 PPE droplet precautions which included masks and standard precautions of gloves, were replenished with masks immediately at the time it was reported to the DON. The facility uses the CDC recommendations/guidelines for droplet precaustions.

- There is only (1) resident that is on droplet precautions that requires PPE. All staff were educated on 4/7/2020 on the process for reporting and replenishing of personal protective equipment (PPE) as well as how to identify what personal protective equipment (PPE) is required for droplet precautions. This information is provided on the isolation sign noted on the door of the affected person(s) room. Those not educated by 04/07/2020 will not be allowed to work until the education has been provided.

- PPE needs for residents placed on droplet precaution will be checked by the DON and or his/her designee at the beginning of the day shift (7a-3p) and prior to leaving for the day. Also PPE supplies will be kept in the medication rooms under the supervision of the nurse. Staff have been educated to let the nurse know if PPE supplies need to be replenished. If PPE supplies in the medication room are running low the nurse is to notify the Director of Nursing and or the Administrator for replenishing. (initiated 04.07.2020).

- All education will be provided by the DON and or his designee.

The facility failed to ensure social distancing was

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maintained in the resident setting for residents #2, #3, #4, and #5:

- All residents (#2, #3, #4, and #5) were redirected to their rooms by a facility certified nursing assistant (C.N.A) immediately when made aware of the noncompliance observation of social distancing reported by the surveyor. Due to their cognitive status these residents are not able to be educated on social distancing (04.07.2020).

- Resident #5 who is alert and oriented, was re-educated during the survey by the Director of Nursing on social distancing of 6 feet from all persons as it relates to the COVID-19 Pandemic. Staff were also re-educated by the Director of Nursing and or his/her designee on monitoring and observing residents and for social distancing of at least 6 feet as it relates to the possible transmission of COVID-19. Staff were educated and instructed on redirecting and re-educating residents when the behavior of social distancing of less than 6 feet is observed amongst residents. Employees not educated by 04/07/2020 will be educated prior to being allowed to clock in for their next scheduled shift.

- All staff are responsible for maintaining and enforcing of social distancing of 6 feet between residents. Compliance of this directive will be monitored via the facility rounds (angel rounds) that are completed daily by the department heads and other assigned support staff. Any of observations of non-compliance should be addressed immediately by the staff member completing the facility observation round. Any findings of non-compliance will be discussed in the morning meetings along with the corrective

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F 880	Continued From page 18 action(s) that was implemented. This process will be ongoing. - All education related to social distancing will be provided by the DON and or his/her designee. This tracking and trending of findings with be presented by the DON in QAPI committee for continue monitoring for 60 days, unless the QAPI committee determines otherwise." Validation of the removal plan was completed on April 8, 2020 at 8:01 p.m., after the survey team verified corrective actions taken by the facility had been implemented. This included observations, staff interviews, policy review and review of training's to verify the immediate corrective actions were in place.	F 880		