STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345254	A. BUILDING _____ B. WING _____	C 04/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONROE REHABILITATION CENTER	1212 SUNSET DRIVE EAST MONROE, NC 28112

(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 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted 4/15/20 through 4/17/20. The facility was found to be in compliance with the requirement CFR 483.73 Emergency Preparedness. Event ID #5RVR11.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control 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	F 880		5/7/20

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

Electronically Signed | 04/30/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and interview with the local health department nurse, the staff failed to wear face masks and store worn	F 880	1) Corrected action for those affected by the deficient practice: There were no residents harmed by the alleged deficient	

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F 880	Continued From page 2 isolation gowns in resident rooms to prevent the spread of the COVID-19 virus. These failures occurred during the COVID-19 pandemic. Findings included: Facility records indicated an in-service was conducted on 4/2/2020. The in-service was provided to all staff members/all departments and educated staff to wear face mask at all times while inside the facility to prevent the spread of COVID-19 virus. Facility records indicated on 4/12/2020 an in-service was provided to all staff on facility wide droplet precautions. The in-service documents indicated employees should hang the used yellow isolation gown in the resident ' s room by the exit to be reused for the duration of the shift. Facility in-service records also specified in-service was provided to all employees on 4/14/2020 regarding the use of gowns. The in-service instructed employees to leave the yellow gowns in the rooms of residents who were on enhanced droplet precautions. The in-service also indicated employees were instructed to discard of yellow gowns in the trash receptacle in the resident ' s room at the end of their shift A Health Department report dated 4/13/2020 revealed an onsite visit was conducted by the local Health Department on 4/13/2020. It was the recommendation of the public health nurse that all kitchen employees wear masks as part of preventing the spread of the virus. At 12:25pm on 4/15/2020 nutrition staff were observed, through a window outside of the kitchen, preparing lunch trays for residents. One female staff member was observed wearing her	F 880	practice. The kitchen staff observed wearing the face masks/Personal Protective Equipment (PPE) inappropriately were re-educated verbally on the day of the survey by the administrator. 2) How the facility will identify other residents having potential to be affected by deficient practice: All residents have potential to be affected by alleged deficient practice. 3) What measures will be put into place or systemic changes to ensure deficient practice will not re-occur: a)All kitchen staff were re-educated on wearing appropriate PPE with a focus on face masks, by the Director of Nursing, Staff Development Coordinator and/or designee on or by 04/30/20. Those not educated/re-educated by 4/30/20 will not be allowed to work until the education has been provided. b) Kitchen staff will be observed randomly at least 5 times a week for 8 weeks for compliance with wearing their masks in the kitchen. The Director of Nursing (DON), Staff Development Coordinator (SDC), Administrator, and other clinical team members will make observations. Staff observed not in compliance will be re-educated and or disciplined as determined by his or her direct supervisor and/or the administrator. 4) How the facility will monitor changes: The results of audits will be submitted by the Infection Preventionist Certified Official (IPCO) to Quality Assurance Performance Improvement (QAPI) committee monthly x 3 months to evaluate	

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F 880	Continued From page 3 mask pulled down below her nose while preparing trays for residents. During a follow up observation of kitchen staff, at 1:15pm, another kitchen staff member was observed in the kitchen without a mask. The Director of Nursing (DON) was interviewed at 1:15pm on 4/15/2020 at the time of the kitchen observation. She stated all kitchen staff should wear masks as part of the facility ' s droplet precaution measures. DON stated all staff had been in-serviced on when and how to wear personal protective equipment (PPE). On 4/15/2020 at 12:15pm an observation of the 100 hall revealed what appeared to be used yellow isolation gowns hanging on a hook outside the doors of rooms 103, 104, 120, and 132. These rooms had yellow enhanced precaution signs on the doors. An interview was conducted on 4/15/2020 at 1:00pm with nursing aide (NA) #1. She stated she was assigned to the 100 hall on 4/15/20. She stated she did receive in-service training earlier in the week regarding COVID-19 and donning and doffing of PPE. She stated the training included leaving the used yellow gown hanging in the resident ' s room on a hook prior to exiting the room. She further stated on 4/15/20 she hung the yellow isolation gowns on the door outside some of the resident ' s room because there was not a hook in the room. During an interview on 4/15/2020 at 1:10 pm with NA #2 she stated she was working the 100 hall with NA#1 on 4/15/20. She further stated she did receive in-service a few days prior on donning and doffing PPE and was aware the used gown	F 880	need for on-going audits. 1) Corrected action for those affected by the deficient practice: No residents were noted to be affected by the deficient practice. The gowns observed on the outside of the residents doors were removed immediately by the Director of Nursing and the outside of the doors were wiped down with an EPA approved cleaner/disinfectant. The Director of Nursing immediately initiated staff re-education on proper storing of gowns in the rooms verbally. 2) How the facility will identify other residents having potential to be affected by deficient practice: All residents have potential to be affected by alleged deficient practice. 3) What measures will be put into place or systemic changes to ensure deficient practice will not re-occur: a) The facility staff will be re-educated by the Director of nursing, Staff Development Coordinator (SDC) and or his or her designee related to the storage of PPE (disposable gowns) on or by 4/30/20. Those not educated by 04/30/20 will not be allowed to work until the education has been provided. b) Staff will be observed randomly at least 5 times a week for 8 weeks for compliance with storage of PPE. The Director of Nursing (DON), Staff Development Coordinator (SDC), Administrator, and other clinical team members will make observations. Staff observed not in compliance will be re-educated and/or disciplined as determined by his or her direct supervisor and/or the administrator.	

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F 880	Continued From page 4 should be left in the room prior to exiting. She stated she did hang the gown on the outside of the door because there was not a hook to hang it in the resident ' s room. The DON was interviewed on 4/15/2020 at 1:30pm regarding the yellow isolation gowns hanging outside of the rooms with yellow enhanced droplet precaution signs posted on their doors. She stated the gowns did appear to have been worn. She further stated the employees had been in-serviced on leaving the used yellow gowns in the resident ' s room prior to exiting. The DON explained that resident rooms were equipped with hooks, inside the rooms, by the doors for the NAs to hang the yellow gowns and they should not be hung outside the rooms, in the hall. A phone interview was conducted on 4/15/2020 at 1:35pm with the local Health Department nurse who stated she had been in contact with the facility daily since the first suspected case of COVID-19 in the facility on or around 4/8/2020. She further stated she discussed with the staff proper donning and doffing of PPE due to concerns during her observations in the building on 4/13/2020 which included staff wearing PPE while eating their lunch. She further stated she observed the kitchen staff not wearing masks and recommended all kitchen staff to wear masks at all times to protect themselves and the residents. An interview was conducted with the Administrator on 4/15/2020 at 1:40pm. The Administrator stated all employees should be donning masks while in the facility. She further stated all employees were in-serviced on how to handle PPE in the enhanced droplet contact	F 880	4) How the facility will monitor changes: The results of audits will be submitted by the Infection Preventionist Certified Official(IPCO) to Quality Assurance Performance Improvement(QAPI) committee monthly x 3 months to evaluate need for on-going audits.	

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F 880	Continued From page 5 rooms and used yellow gowns should not be hung outside of the resident ' s rooms but inside the rooms by the exit.	F 880		