STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345390	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE	7700 US 158 EAST STOKESDALE, NC 27357

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E 000	Initial Comments An unannounced COVID19 focused survey was conducted on 6-16-20 through 6-17-20. The facility was found in compliance with CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# GUQU11	E 000		
F 000	INITIAL COMMENTS An unannouned COVID19 Focused Infection Control Survey was conducted on 6-17-20. The facility was found not in compliance with 42 CFR 483.80 infection control regulations. Event ID# GUQU11	F 000		
F 880 SS=E	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;	F 880		7/14/20

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

Electronically Signed | 07/14/2020

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F 880	Continued From page 1 §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 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.	F 880		

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F 880	Continued From page 2 §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, record review, staff interviews, physician interview the facility failed to (1) establish and implement a surveillance/tracking system for residents with signs and symptoms of COVID19 and (2) failed to implement their policy to ensure reusable screening equipment, which included an oral thermometer, was properly sanitized after each use. This failure occurred during a COVID19 pandemic. Findings included: 1.Review of the facility's "Coronavirus (COVID19) Prevention and Control" policy and procedure dated May 2020 revealed in part; The Director of Nursing/ designee is responsible for establishing and overseeing the active surveillance and monitoring of COVID19. During an interview with the Administrator on 6-16-20 at 9:20am, the Administrator stated there were no positive cases of COVID19 in the building and there had not been any residents hospitalized due to having COVID19. She explained the facility had "some" suspected cases due to the residents having an increase in their temperature, but the residents had been tested and their results were negative. A facility tour occurred on 6-16-20 at 9:30am. The tour revealed no residents on quarantine status or droplet precautions. The Director of Nursing (DON) was interviewed	F 880	DF880- Infection Prevention & Control The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain incompliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility failed to establish and maintain an infection prevention and control program by (1) establishing and implementing a surveillance/tracking system for residents with signs and symptoms of COVID19. After a thorough review, no residents were	

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F 880	Continued From page 3 on 6-16-20 at 11:10am. Initially the DON questioned what type of surveillance this surveyor was asking to see, but once the DON understood she stated, "honestly no I have not been using any type of surveillance or tracking system." She further stated she believed the nurses taking the residents temperatures each shift and reporting to her any increase in temperature was enough. The Administrator was interviewed on 6-16-20 at 12:00pm. The Administrator stated she was not aware a surveillance and tracking system needed to be established but she would work with the DON to have a system established and followed. During an interview with the facility's Medical Director on 6-17-20 at 12:30pm, the Medical Director stated he was informed of the residents' symptoms and ordered the testing for COVID19 but was not directly involved in tracking or surveillance of the suspected cases so he did not know if the process had been done. 2. Review of the facility's Infection Control policy and procedure dated December 2007 revealed in part; ensure reusable equipment has been appropriately cleaned. An observation of the visitor screening table on 6-16-20 at 9:00am revealed an oral thermometer with a box of probe covers, a screening notebook to record temperatures and hand sanitizer. There were no sanitation wipes to clean the thermometer between uses. An observation was made on 6-16-20 at 9:51am of an employee entering the facility through the employee entrance, taking her temperature, applying her mask and sanitizing her hands. She	F 880	found at the time to be affected by the deficient practice due to no residents being under surveillance/ tracking for signs and symptoms of COVID19. For the residents who were monitored previously for COVID, DON/Designee reviewed the resident records to ensure no residents were affected at this time due to not using a specific COVID surveillance form. Frequent monitoring was performed and documented in electronic health record system. Going forward, on 6/21/20 all new admissions, return from hospital, and suspected cases will be monitored using the COVID specific surveillance form. To identify residents having the potential to be affected by same deficient practice, a surveillance form was immediately implemented. On 6/21/20, DON immediately implemented a COVID specific surveillance form that reviews all COVID like symptoms. This surveillance form will be used on all residents that return from hospital, new admissions, and any residents that may be a suspected COVID case. Administrator checked off on the form to ensure it was COVID specific. DON/Designee is responsible to keep the Resident Surveillance log book. DON/ Infection Control Nurse/ MDS nurse was educated on or before 6/22/20 on the new surveillance form. Address what measures will be put into place or systemic changes made to ensure what the deficient practice;	

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F 880	Continued From page 4 was observed to throw away the thermometer's probe cover and return the oral thermometer to the table without cleaning it before leaving the screening area. The employee screening area was observed on 6-16-20 at 9:52am. The area revealed a small table that contained a "daily temp log" with the employee's name, initials of the employee and their temperature which was obtained by each employee, an oral thermometer with a box of probe covers and hand sanitizer. There were no sanitation wipes present to clean the thermometer between each employee use. During an interview with Social Worker (SW) #1 on 6-16-20 at 9:55am, SW #1 was noted to be sitting at the employee screening area and said she was "sometimes" assigned to the area to make sure each employee took their temperature and recorded it. She also stated, "there are different people assigned, it just depends on people's workload." SW #1 said she had received training on infection control but could not recall the date or specific information. She also stated she had not realized the employee had not cleaned the thermometer or that there were not any sanitation wipes to clean the thermometer but that the thermometer should be cleaned after each use. The Administrator was interviewed on 6-16-20 at 12:00pm. The Administrator stated there were supposed to be alcohol wipes by the oral thermometer so the thermometer could be cleaned after each use. She further stated staff were responsible to let management know if there were no alcohol wipes available. The Administrator said she and the Director of	F 880	On 6/16, the Director of Nursing (DON) reviewed policy and procedure for COVID Infection Control Policy. The COVID surveillance form was reviewed by DON and Administrator and was implemented. The DON/Designee is responsible on keeping the surveillance log. The surveillance log will be used on new admissions, suspected cases, and residents returning from hospital stay. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing/ Designee will review surveillance logs once a week for the first 4 weeks to ensure logs are completed accurately. Thereafter, Director of Nursing/ Designee will review surveillance log once a month for the next three months to ensure logs are completed accurately. Reports/Audits will be presented to the QA committee by Director of Nursing/Administrator/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Medical Director, Director of Nursing, MDS Coordinator, Nursing Supervisors, Therapy, Administrator and other departmental managers. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will	

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F 880	Continued From page 5 Nursing would correct the issue and perform more frequent monitoring of the screening tables. The facility Medical Director was interviewed on 6-17-20 at 12:30pm. The Medical Director stated he believed if staff sanitized their hands before using the oral thermometer and after using the thermometer, that would be enough to stop any potential spread of the COVID virus. He also said he realized that practice was not happening and needed to be implemented if the oral thermometer was not being cleaned between each use.	F 880	identify other residents having the potential to be affected by the same deficient practice. The facility failed to establish and maintain an infection prevention and control program by failing to implement their policy to ensure reusable screening equipment, which included an oral thermometer, was properly sanitized after each use. After a thorough review of all residents, none were found at the time to be affected by the deficient practice. All employees were educated on or before 6/22/20 by DON/Designee on screening process. The in-services reviewed the following but not limited to: COVID testing, COVID questionnaire, screening process, thermometer use, handwashing, use of masks, EAP for COVID cases, laundry and trash, visitation protocols. To identify any residents having the potential to be affected by deficient practice, the DON/Administrator/Designee immediately ensured appropriate supplies were at employee check in table. Immediately the Administrator/Designees put up a notice at check in table to require all staff to wipe down thermometer/equipment after each use. DON and Administrator held all employee meetings 6/17, 6/18, 6/19, 6/22/20 to review Countryside COVID Policy, and screening process. Address what measures will be put into	

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F 880	Continued From page 6	F 880	place or systemic changes made to ensure what the deficient practice; On 6/16/20 DON and Administrator reviewed employee check in process. DON and Administrator held all employee meetings to review screening process and COVID19 policies. Countryside immediately implemented a step by step poster at check in table that reviews the screen in process. A new permanent signage has been established and hung on 7/8/20 at check in table that reviews step by step screening process. During 6/17/20 - 6/22/20, all employees were re-educated on screening process. All employees have been educated on sanitizing equipment by wiping down thermometer and equipment after each use. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing/Administrator/ Designee will conduct a review using an audit tool that will review the screen in process and ensure accurate supplies are available at the employee check in table. The Administrator/DON/ Designee will audit to ensure thermometer / equipment is getting properly cleaned every week for the first 4 weeks. The review will include appropriate supplies are on employee check in table, and thermometer/equipment is getting cleaned	

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F 880	Continued From page 7	F 880	after each use. Identified issues will be addressed with appropriate action. The Audit will then be conducted once a month for the next 3 months. Reports/Audits will be presented to the QA committee by Administrator/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Medical Director, Director of Nursing, MDS Coordinator, Nursing Supervisors, Therapy, Administrator and other departmental managers.	