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| **AUTUMN CARE OF CORNELIUS** | **19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031** |

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| E 000 | Initial Comments<br><br>An unannounced COVID-19 Focused Survey was conducted on 07/15/20. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 5MBM11 | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 07/15/2020. Additional record review and interviews were obtained on 07/16/20-07/23/20; therefore the survey exit date was changed to 07/23/20. There were three complaint allegations investigated and one was substantiated. Event ID #5MBM11. | F 000 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 | F 880 | | 7/30/20 |

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

Electronically Signed | 08/07/2020

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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 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.

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| F 880 | Continued From page 2<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review, review of the facility's staff education logs, review of posted signage for Advanced Droplet Contact Precautions, and review of the facility document entitled, "General Infection Control Policy", the facility failed to ensure staff performed hand hygiene after contact with a resident or objects in the residents room for 3 of 3 residents (Resident #1, #2, and #3), failed to ensure proper Personal Protective Equipment (PPE) were donned and doffed when entering and exiting a resident room with signage indicating Advance Droplet Contact Precautions for 3 of 3 residents (Resident #1, #2,and #3), failed to perform proper decontamination and removal of items removed from a room with signage indicating Advanced Droplet Contact Precautions (Resident #3), the facility failed to develop and implement policies on wearing face coverings (Staff 1 of 1), the facility failed to develop and implement policies for wearing PPE and performing hand hygiene when entering and exiting resident care rooms for residents on Advanced Droplet Contact Precautions (Staff 5 of 5), and ensure proper usage of face coverings by reception staff when screening employees and visitors. (Staff 1 of 1). These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through | F 880 | All residents had the potential to be affected. Resident #1, Resident #2 and Resident #3 were monitored for potential adverse effects. No adverse effects were noted.<br>To prevent this from recurring, a policy was developed for regular mask use and the Director of Nursing or Designee will provide education to current staff by 7/16/2020 on proper screening process. A policy was developed for Advance Droplet Precautions and the Director of Nursing or Designee will educate all staff by 7/21/20 on proper hand hygiene procedures after contact with a resident or object in a residents room, proper donning and doffing of Personal Protective Equipment (PPE) when entering and exiting a resident room with signage indicating Advance Droplet Precautions (ADP), proper decontamination and removal of items from a room with ADP and proper wearing of face coverings by all employees. Education will be provided to new hires during orientation.<br>To monitor and maintain ongoing compliance, beginning 7/17/20, the facility Administrator or his designee will audit 5 employees per day for two weeks, then 5 employees five days per week for two | |

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| F 880 | Continued From page 3<br>the transmission of COVID-19.<br><br>Findings included:<br><br>According to the facility protocol document titled "General Infection Control Policy" revised 07/19/19, all staff shall be knowledgeable of Standard and Transmission based precautions and hand washing procedures shall be followed.<br><br>According to the facility protocol document titled "Hand Hygiene/Handwashing Policy" revised Oct 2019, hand hygiene should be performed before and after contact with residents, after removing gloves, and be should performed after contact with inanimate objects including medical equipment in the immediate vicinity of the resident.<br><br>According to the facility protocol titled "Transmission-Based Precautions Policy" revised 06/29/20, Contact Precautions, Droplet Precautions, and Airborne Precautions were listed as transmission-based precaution categories, but there were no policies specifically addressing Advanced Droplet Contact Precautions for COVID-19 pandemic.<br><br>The facility did not have a policy addressing the use of face covering for all staff during the COVID-19 pandemic.<br><br>1. A physician's order dated 07/05/20 revealed an order for maintaining isolation precautions until negative testing and/or meets the requirements by CDC. Another physician's order dated 07/05/20 revealed an order for COVID-19 swab testing. | F 880 | weeks and randomly thereafter to validate compliance of facility screening process and ensuring proper usage of face coverings by all employees. Director of Nursing or designee will observe 5 opportunities per day for two weeks, then 2 opportunities per day for two weeks, and then randomly thereafter to validate compliance on proper hand hygiene procedures after contact with a resident or object in a resident room, proper donning and doffing of PPE when entering and exiting a room with signage indicating ADP, proper decontamination and removal of items from a resident room with ADP.<br>The results of the audits will be forwarded to the facility QAPI committee weekly for further review and recommendations during the duration of auditing. | |

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An observation on 07/15/20 at 12:42 PM revealed Nurse #1 enter Resident #1's room to answer the call light wearing a surgical face mask. There was signage visible on Resident #1's door indicating Advance Droplet Contact Precautions which included the use of a gown, gloves, mask, eyewear, as well as performing hand hygiene before and after entry. After entering the room, Nurse #1 touched Resident #1's call light, overbed table, and Resident #1's right arm before exiting the room. Nurse #1 was not observed to don personal protective equipment (PPE) when entering the room nor wash his hands following contact with Resident #1 before returning to the nurses' station to begin documentation.

An interview with Nurse #1 on 07/15/20 at 12:52 PM revealed Nurse #1 had entered Resident #1's room to answer the call light. Nurse #1 indicated all staff had received education on signs/symptoms (s/sx) of COVID-19, proper hand hygiene, transmission-based precautions, and donning/doffing of PPE. He stated the signage on the door of Resident #1's room indicated Advance Droplet Precautions and full PPE including gown, gloves, mask, and eye wear should be worn by all staff when entering the room and proper hand hygiene should be performed after exit. Nurse #1 stated he went in to answer the call light and didn't think about Resident #1 being on precautions at the time.

An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene, transmission-based precautions and donning and doffing of PPE including gowns, gloves, mask, and face shields/goggles. The Infection Control Nurse stated Nurse #1 should have donned a

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gown, gloves, facemask, and eyewear (face shield/goggles) when entering the room with signage indicating Advanced Droplet Contract Precautions, doffed PPE when exiting and followed by hand hygiene.

An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed the facility had not had any shortage of PPE since the start of the pandemic in March 2020 and all staff had received multiple in-services trainings related to COVID-19 including hand hygiene, transmission-based precautions, and donning and doffing of PPE. Nurse #1 should have worn full PPE to include gown, gloves, face mask, and eyewear and performed hand hygiene before exiting Resident#1's room.

An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene, transmission-based precautions, and proper use of PPE and he expected them to be followed by all staff. He stated all staff have received training in infection control and Nurse #1 should not have entered Resident #1's room without wearing full PPE and should have performed hand hygiene when exiting Resident #1's room.

2. An observation on 07/15/20 at 12:55 PM revealed Nurse Aide #1 was pushing a cart used for meal tray bussing wearing gloves and a surgical mask. Resident #2 was ambulating in the hallway without a mask and had stopped outside the closed door of another resident. Nurse Aide #1 approached Resident #2 in the hallway then removed her gloves and placed them in her hand. Nurse Aide #1 then locked arms with Resident

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#2's right arm and escorted her into her room which displayed signage that indicated Advance Droplet Contact Precautions. Nurse Aide #1 disposed of her gloves in the trash, then, transferred Resident #2 to her chair, placed her overbed table with her lunch tray in front of her, and begun encouraging her to eat. Then, Nurse Aide #1 exited the room. Nurse Aide #1 did not perform hand hygiene when exiting the room and returning to collecting other resident trays in rooms that were not on any transmission-based precautions.

An interview on 07/15/20 at 12:59 with Nurse Aide #1 revealed Nurse Aide #1 voiced she should have washed her hands when leaving the room to decrease the risk of spreading infections. Nurse Aide #1 stated she should have washed her hands and re-applied gloves before collecting meal trays in other resident rooms on her unit that were not on transmission-based precautions.

An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene. She also stated she should have applied clean gloves before returning to collect meal trays for other residents on the hall.

An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed Nurse Aide #1 should have performed hand hygiene before exiting Resident #2's room before continuing to collect trays from other resident rooms.

An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene and Nurse Aide #1

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should have performed hand hygiene when exiting Resident #2's room.

3. A physician's order dated 07/09/20 revealed an order for maintaining isolation precautions until negative testing and/or meets the requirements by CDC. There were additional physician's orders dated 07/09/20 for COVID-19 testing.

An observation on 07/15/20 beginning at 1:05 PM revealed Resident #3 to be suspended in a total lift with nursing personnel providing supervision for safety. Three male staff members identified as maintenance/ EVS workers (Maintenance #1, #2, and #3) approached Resident #3's room with a metal cart containing an air mattress and an air mattress motor. The signage on the door of Resident #3's room indicated Advanced Droplet Contact Precautions. Maintenance Worker #1 spoke to staff inside the room and was directed about which PPE to apply and where it was located. Maintenance Worker #1, Maintenance Worker #2, and Maintenance Worker #3 began applying the PPE from the cart outside of the room. Once Maintenance Worker #1 had donned a mask, gown, and face shield, a staff member from inside the room reached out of the door of Resident #3 and handed off the contaminated air mattress motor to Maintenance Worker #1 who placed the motor in the floor in the hallway with his bare hands. He then applied gloves and all three maintenance workers took the metal cart in the room and began exchanging the air mattress for the new one. After the contaminated air mattress was removed from the bed, Maintenance Worker #1 exited the room wearing full PPE that included gown, gloves, mask, and a face shield and placed the contaminated air mattress in the floor in the hallway outside

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Resident #3's room. The facility Administrator approached Maintenance Worker #1 and provided instruction to re-enter the room and dispose of Maintenance Worker #1's contaminated PPE. Maintenance Worker #1 re-entered Resident #3's room and disposed of his gown in the trash can provided and exited the room. When he exited the room, he laid his face shield on the isolation cart without sanitizing it, then the Administrator and Maintenance Worker #1 picked up the contaminated air mattress from outside of Resident #3's room and took it outside. Maintenance Worker #2 and #3 placed the new air mattress on the bed, disposed of their gown and gloves in Resident #3's bathroom, but exited the door pushing the metal cart from the room and placing their contaminated face shields in a plastic bag with their bare hands. Maintenance Worker #2 and Maintenance Worker #3 was not observed to perform hand hygiene after PPE was removed.

An interview with Maintenance Worker #1 on 07/15/20 at 2:23 PM revealed he was asked to change out the air mattress for Resident #3 along with Maintenance Worker #2 and Maintenance Worker #3. He stated he recalled the staff member handed him the air mattress motor while he was trying to don his PPE and acknowledged he had not yet applied his gloves when he touched the motor with his bare hands and placed it on the floor in the hallway without sanitizing it. He also revealed he removed the air mattress from the bed of Resident #3 and placed it in the hallway before re-entering the room to dispose of his PPE. He acknowledged Resident #3 had signage that indicated Advanced Droplet Contact Precautions and he should have worn gloves before touching the air mattress pump and

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should not have placed neither the contaminated mattress nor pump in the floor in the hallway. Maintenance Worker #1 stated the contaminated items should have been placed on a cart for removal and his contaminated face shield should have been placed in a plastic bag and disinfected. He divulged he observed Maintenance Worker #2 and Maintenance Worker #3 placing their face shields in plastic bags with their bare hands and stated the cart should have been taken outside to be sanitized wearing clean gloves.

An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene, transmission-based precautions and donning and doffing of PPE including gowns, gloves, mask, and face shields/goggles. The Infection Control Nurse stated Maintenance Workers #1, #2, and #3 should have donned a gown, gloves, facemask, and eyewear (face shield/goggles) when before entering the room of Resident #3 with signage indicating Advanced Droplet Contract Precautions or contacting contaminated objects from the room and correctly doffed and disposed of PPE when exiting Resident #3's room and should have performed hand hygiene after removal. The Infection Control Nurse also revealed contaminated items should not be placed in the floor in the hallway.

An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed the facility has not had any shortage of PPE since the start of the pandemic in March 2020 and all staff had received multiple in-services trainings related to COVID-19 including hand hygiene, transmission-based

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precautions, and donning and doffing of PPE. Maintenance Workers #1, #2, and #3 should have worn full PPE to include gown, gloves, face mask, and eyewear and performed hand hygiene before exiting Resident #3's room. The Regional Nurse Consultant further revealed contaminated objects from Resident #3's room should not have been touched without gloves and should not have been placed on the floor in the common areas.

An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene, transmission-based precautions, and proper use of PPE and he expected them to be followed by all staff. He stated all staff have received training in infection control and all three-maintenance staff should not have touched contaminated objects without proper PPE. They should not have exited Resident #3's room properly removing and disposing of the PPE worn in Resident #3's room and should have performed hand hygiene when exiting.

An interview with the Maintenance Director on 07/17/20 at 7:00 PM revealed the facility protocol for exchange of an air mattress in an Advanced Droplet Contact Precaution room included taking the new air mattress and motor to the room on a cart. Maintenance workers should don PPE including gown, gloves, mask and face shield before entering the room and should not touch any contaminated surfaces without gloves. The Maintenance Director stated staff should remove the old air mattress and motor from the bed and it can be sat in the floor in the room while the new air mattress and motor are removed from the cart and installed. The contaminated air mattress and pump should be sanitized and be brought back

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out of the room and placed on the cart for removal. He stated the cart should not be taken into the room and the contaminated objects should not be placed on the floor in the hallway nor handled without gloves. The Maintenance Director further revealed all worn PPE should be discarded in the appropriate receptacles in Resident #3's room, face shields should be bagged before gloves are removed, and staff should perform hand hygiene following the removal of PPE. Gowns should not be worn in the hallways and face shields should never be laid on the isolation carts after usage without being sanitized.

4. Observations on 07/15/20 at 10:15 AM, 10:20 AM,10:25 AM, 1:10 PM, 1:15 PM, 1:20 PM, and 1:25 PM revealed Receptionist #1 near the front door of the facility. She was screening and/or interacting with employees and visitors who entered the facility by taking their temperature and asking regulatory screening questions and those who stopped by the business office. Receptionist #1 was initially observed to be wearing a cloth face covering around her mouth. The observations further revealed Receptionist #1 touched her face and pulled the face covering down around her chin each time she spoke to an individual she was screening at the front desk. She was not positioned in a socially distancing environment and there were no visible screens between Receptionist #1 and anyone who entered the front door of the facility.

An interview with Receptionist #1 on 07/15/20 at 2:10 PM revealed she acknowledged she pulled down her cloth face covering to speak, and she had been trained the face covering should always cover both her nose and mouth when on duty.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345567 | A. BUILDING _____ B. WING _____ | C 07/23/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF CORNELIUS | 19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031 |

| (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 12<br><br>An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene, transmission-based precautions and donning and doffing of PPE including gowns, gloves, mask, and face shields/goggles. The Infection Control Nurse stated all staff are always to wear a face covering/mask when on duty. The face covering should be securely covering the nose and mouth to decrease potential spread of infections.<br><br>An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed the facility had not had any shortage of PPE since the start of the pandemic in March 2020 that included surgical face masks which were made available and distributed. The Infection Control Nurse stated all staff had received multiple in-services trainings related to COVID-19 including proper donning and doffing of face coverings. Receptionist #1 should always wear a face covering over her nose and mouth and the face covering should not have been pulled down to converse with individuals at the front desk.<br><br>An interview with the Business Office Manager on 07/15/20 at 2:15 PM revealed she was the supervisor for the front office staff which include Receptionist #1. She stated Receptionist #1 had been trained on how to properly wear a face covering and was always to wear it over her nose and mouth during her shift. She further revealed it was not acceptable practice and placed each person that entered at risk for the spread of infection when Receptionist #1 removed her face covering to speak. | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345567 | A. BUILDING _____ B. WING _____ | C 07/23/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AUTUMN CARE OF CORNELIUS** | **19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031** |

| (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 13<br>An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene, transmission-based precautions, and proper use of PPE and he expected them to be followed by all staff. He stated all staff have received training in infection control and Receptionist #1 should have a properly fitting face covering that always covered the nose and mouth when on duty. | F 880 | | |