

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/04/2020
NAME OF PROVIDER OR SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 752 E CENTER AVENUE MOORESVILLE, NC 28115		
(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 Infection Control Survey, and Complaint Investigation Survey was conducted on 10/26/20 and 10/27/20 with exit from the facility on 10/27/20. Additional information was obtained through 11/04/20 therefore, the exit date was changed to 11/04/20. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 because a repeat citation of tag F 880. One of twenty five complaint allegations was substantiated which resulted in a deficiency. Event ID#ZE1L11.	F 000			
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		11/16/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/19/2020

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 561	<p>Continued From page 1</p> <p>with members of the community and participate in community activities both inside and outside the facility.</p> <p>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record reviews, staff and resident interviews, the facility failed to honor a food preference for 1 of 3 residents reviewed for choices (Resident #4).</p> <p>The finding included:</p> <p>Resident #4 was admitted to the facility on 05/13/19 with diagnoses which included renal disease and seizure disorder.</p> <p>Review of Resident #4's Physician Order dated 05/13/19 indicated a regular diet.</p> <p>Review of a Nutritional Status Review (NSR) dated 08/19/19 revealed Resident #4 was alert, oriented and able to make her needs known. The NSR further indicated she voiced concerns and chose menu items herself.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 09/29/20 indicated Resident #4 was cognitively intact and fed herself with set up assistance only.</p> <p>An interview was conducted with Resident #4 on 10/26/20 at 10:30 AM. The Resident explained she usually got a double portion of grits with her</p>	F 561	<p>F 561 – Resident Preferences</p> <ol style="list-style-type: none"> 1. Resident # 4 food preferences were re-assessed, and any changes were made to tray card. 2. 100% audit of all residents Food Preference Sheets were audited on 11/6/2020 by Administrator to ensure all residents had a Food Preference Sheet completed. Audit revealed that 16 residents did not have Food Preference Sheets completed. These were completed on 11/13/2020. 3. On 10/30/2020 Administrator in-serviced Dietary Manager and Lead Cook on making sure resident's likes and dislikes are honored. Each card's dislikes and likes must be called out during the tray line. The dietary aide at the end of the tray line must ensure that the tray is correct by reviewing tray card before it is put on the rack for delivery. A Food Preference Tool must be completed on each new resident upon admission to ensure resident's preferences are being honored. 		

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F 561	<p>Continued From page 2</p> <p>breakfast meal but that morning she did not get the grits but received oatmeal instead. She continued to explain, that the staff knew she didn't like oatmeal because it was on her meal ticket as a dislike and that she was supposed to receive a double portion of grits for breakfast every morning. The Resident stated when she realized she didn't have the grits on her tray that morning she hollered for Nurse Aide (NA) #1 who delivered her tray to her, but the NA did not respond to her. Resident #4 stated she ate all her breakfast except the oatmeal. The Resident commented that she was always getting the wrong foods on her meal trays and that particular morning it happened to be the oatmeal.</p> <p>On 10/26/20 at 3:40 PM during an interview with NA #1 she confirmed she delivered Resident #4's breakfast tray to her that morning. The NA explained that Resident #4 usually received a big bowl of grits with her breakfast meal every morning but that morning she did not have grits on her tray and was given oatmeal instead. She admitted she heard Resident #4 holler for her grits, but the NA stated she felt like the residents should not eat the same thing for breakfast every morning and there was another option on Resident #4's tray. The NA reported she did not know if double grits was listed on Resident #4's meal ticket for likes or if oatmeal was listed as dislikes, but the NA stated that she knew for sure that double grits was Resident #4's preference for breakfast.</p> <p>During an interview with the Cook on 10/27/20 at 9:35 AM she was asked if Resident #4 had a preference for the breakfast meal in which she stated that Resident #4 liked a double portion of grits and confirmed that oatmeal was a dislike for</p>	F 561	<p>On 10/30/2020 Dietary Manager and Lead Cook in-serviced dietary cooks and aides on making sure resident's likes and dislikes are honored. New hires will be educated on the process during orientation. Each card's dislikes and likes must be called out during the tray line. The dietary aide at the end of the tray line must ensure that the tray is correct by reviewing tray card before it is put on the rack for delivery.</p> <p>4. Dietary Director and/or Lead Cook and/or designee will audit 1 meal daily for 2 weeks then 3x weekly for 2 weeks then 1x weekly x 1 month,, alternating between meals, using the Tray Accuracy Audit Tool, to ensure residents preferences/ likes and dislikes are being honored. A Food Preference Audit of all residents will be completed 2 x yearly to ensure that all resident's food preference is up to date.</p> <p>Administrator will check audits weekly to ensure they are being completed per POC.</p> <p>Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.</p>		

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F 561	<p>Continued From page 3</p> <p>Resident #4. The Cook confirmed that on 10/26/20 for the breakfast meal she served Resident #4 oatmeal instead of her preference of a double portion of grits because she had "slept on her wrist wrong" the night before and that she did not feel like making the grits that morning because she had to wisk the grits by hand and her wrist hurt too bad.</p> <p>On 10/27/20 at 10:30 AM an observation was made of Resident #4's meal ticket. The meal ticket indicated double portions of grits as a like and oatmeal as a dislike.</p> <p>During an interview with the Director of Nursing (DON) on 10/27/20 at 12:15 PM she explained that it was Resident #4's right to receive the food of her choice for meals and that if Resident #4 chose to have double grits every morning then her preference should be honored. The DON further stated that NA #1 should have went to the kitchen and got Resident #4 the double portion of grits.</p> <p>On 10/27/20 at 5:55 PM during an interview with the Administrator he explained, Resident #4 should not have been given the oatmeal for breakfast and that NA #1 should have went to the kitchen and gotten the grits for Resident #4. The Administrator also indicated, NA #1 would be addressed.</p>	F 561			
F 694 SS=D	<p>Parenteral/IV Fluids CFR(s): 483.25(h)</p> <p>§ 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the</p>	F 694		11/16/20	

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F 694	<p>Continued From page 4</p> <p>comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff, Guardian and Nurse Practitioner interviews the facility failed to assess or flush a peripheral inserted central catheter line for 1 of 3 sampled residents reviewed for parenteral intravenous fluids (Resident #6).</p> <p>The findings include:</p> <p>Resident #6 was admitted to the facility on 06/17/20 with diagnoses which included heart failure and a urinary tract infection (UTI) in the last 30 days. The Resident was discharged on 09/08/20.</p> <p>The admission Minimum Data Set (MDS) assessment dated 06/24/20 revealed, Resident #6 had intact cognition. The MDS also indicated the Resident received an antibiotic 2 out of 7 days of the look back period.</p> <p>Review of Resident #6's medical record revealed:</p> <ul style="list-style-type: none"> -A Physician's order dated 09/02/20 to place a midline for IV antibiotics. -A document dated 09/03/20 that confirmed the insertion of a Midline/Peripherally Inserted Central Catheter (PICC) line in Resident #6's right upper arm. The facility contact person listed on the document was the Unit Manager. -A Physician's order dated 09/04/20 for chest x-ray to verify placement of midline placement. -A Physician's order dated 09/04/20 for Gentamicin Sulfate Solution (an antibiotic) 40 milligrams (mg) per milliliter (ml), use 120 mg intravenously in the evening related to UTI until 	F 694	<p>F 694- Parenteral Fluids</p> <ol style="list-style-type: none"> 1. The resident identified had been discharged prior to the survey on October 26, 2020 and October 27, 2020 2. An audit of residents in the facility with peripheral IVs, Midlines, an PICC lines was conducted by the Director of Nursing on October 29,2020. At that time, there was just 1 current admitted who hd a Midline in place. Orders were updated to include Midline maintenance orders. 3. Education of all nurses regarding the proper orders that are to be in place when a resident is either admitted with a peripheral, midline, or PICC line or when a peripheral IV, midline, or PICC line is placed during admission to the facility to be completed on or before November 16, 2020. New hires will be educated on the process during orientation. <p>Corporate PointClickCare support was contacted on Friday November 13, 20202 regarding creating a batch order set for Midlines and PICC lines, this batch order set will be formed according to policy and the facility will be informed once this is complete.</p> <ul style="list-style-type: none"> - Once this batch order set is created, the Director of Nursing will educate all nurses on utilizing this order set for all residents who are admitted with a midline or PICC line or who have one 		

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F 694	<p>Continued From page 5 09/11/20. -A Physician's order dated 09/06/20 to discontinue Gentamicin, no longer needed.</p> <p>Review of Resident #6's Treatment Administration Record (TAR) for 09/2020 indicated, insert peripheral IV (PIV) for antibiotics as needed for dislodgement or infiltration of PIV as needed. There were no nurses' initials documented on the TAR for the area. The TAR did not indicate a PICC line or any directions for the use of a PICC line.</p> <p>Resident #6's Progress Notes contained no documentation of assessment or care of the PICC line from the date of insertion 09/03/20 to the Resident's discharge date from the facility on 09/08/20.</p> <p>Review of the Nurse Practitioner progress note dated 09/04/20 indicated, Resident #6 was currently being treated for a UTI with intravenous Gentamicin, which was to end on 09/06/20.</p> <p>On 10/27/20 at 12:15 PM an interview was conducted with the Director of Nursing (DON). The DON reviewed Resident #6's Electronic Health Record (EHR) during the interview and explained, the Resident was diagnosed with a UTI and had an order for a Midline/PICC line placement in order to receive the IV antibiotic. The DON stated she should have been able to follow how the Midline/PICC access attempts were made by reading the progress notes but there was no documentation of the attempts made by the nurses. It was the DON's understanding that the Midline/PICC access attempts were unsuccessful, and the line had not been placed.</p>	F 694	<p>placed during admission to the facility. New hires will be educated on the process during orientation.</p> <p>4. An audit will be conducted by the Director of Nursing or designee of all residents who are newly admitted to the facility on a daily basis (Monday through Friday) to determine if the resident has and IV, Midline, or PICC line in place at the time of admission. If it is determined that the resident has an IV, Midline, or PICC line in place, the audit will determine whether the appropriate maintenance orders are in place.</p> <p>- If it is found during the audit that the appropriate maintenance orders are not in place, the appropriate orders will be added at that time and the appropriate staff member will be provided with additional information as indicated.</p> <p>-Daily audits will continue until 100% compliance is achieved and maintained x 4 weeks.</p> <p>Review of audits will be conducted during Clinical Excellence QAPI meetings on a monthly basis, or more frequently as needed.</p>		

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F 694	<p>Continued From page 6</p> <p>On 10/27/20 at 2:20 PM during an interview with the Nurse Practitioner (NP) she stated, she remembered Resident #6 had recurrent UTIs. While referring to the EHR the NP explained on 09/02/20 she ordered a placement of a Midline catheter for IV antibiotics. The NP added that she expected the nurses to follow the policy regarding how to provide the care of the PICC line.</p> <p>On 10/28/20 at 3:25 PM an interview was conducted with Nurse #1 who confirmed she worked with Resident #6 on 09/04/20, 09/05/20, 09/06/20, and 09/07/20 from 7:00 AM to 7:00 PM. Nurse #1 also initialed Resident #6's Medication Administration Record (MAR) for 09/05/20 at 7:00 PM. The Nurse explained, she remembered Resident #6 and that she had an IV antibiotic for a UTI, but she could not remember giving the IV antibiotic on 09/05/20 at 7:00 PM. The Nurse continued to explain that the normal procedure for the care of the IV was to assess the site for infiltration and infection every shift and document the assessment in the progress notes or the daily charting notes. The Nurse also stated the Licensed Practical Nurses (LPN) could not care for the PICC lines but they could care for the peripheral IV's. She explained, the routine care for the peripheral IV was to flush the line before and after the medication was administered and that the specific steps for the care of the IV should be set up on the TAR.</p> <p>An interview was conducted on 10/28/20 at 4:00 PM with Nurse #2. The Nurse explained she remembered Resident #6 and that she had a UTI but could not remember if she had an IV access line. Nurse #2 initialed Resident #6's MAR for 09/04/20 at 7:00 PM which indicated she</p>	F 694			

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F 694	<p>Continued From page 7</p> <p>administered the IV antibiotic, but the Nurse stated too much time had passed since then and she could not remember giving the medication. The Nurse explained that the specific care of the IV was set up on the MAR or the TAR (she could not remember which one) and the nurses should follow it. The Nurse also explained that they should assess the IV site every shift and document it in the nurses' notes.</p> <p>During an interview with Nurse #3 on 10/28/20 at 5:15 PM she explained, she remembered Resident #6 and that she had an IV but could not remember if it was a peripheral or PICC line access. Nurse #3 initialed Resident #6's MAR for 09/03/20 at 8:00 PM but stated she could not remember if she administered an IV antibiotic because too much time had passed since that date. Nurse #3 also explained, that the care of the IV included flushing before and after the medication administration and changing the dressing every 72 hours. The Nurse also indicated the specific instructions on how to care for the IV should be set up on the MAR and the Nurse should document the monitoring of the site in the nurses' notes every shift.</p> <p>On 10/29/20 at 12:00 PM during an interview with Resident #6's Guardian she reported the Resident had a PICC line in her right upper arm on 09/06/20 when the Resident was sent to the Emergency Department. The Guardian also reported that the PICC line was present when the Resident was discharged to another facility on 09/08/20.</p> <p>On 10/30/20 at 10:45 AM an interview was conducted with Nurse #4 who discharged Resident #6 on 09/08/20. The Nurse explained</p>	F 694			

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F 694	<p>Continued From page 8</p> <p>that the day of the Resident's discharge from the facility was the first time she had worked with the Resident. Nurse #4 stated she did not know the Resident had a PICC line until the facility the Resident was sent to called and asked what size PICC line the Resident had in place. Nurse #4 stated she had to get the Unit Manager (UM) to help her search in the Resident's medical record for the size of the PICC line.</p> <p>An interview was conducted with the Unit Manager (UM) who explained she could not remember if Resident #6 had a PICC line or that she assisted Nurse #4 in searching for the size of the PICC line. The UM also explained that the specific directions on how to care for the IV's should be set up on the MAR and the nurse should also monitor for any adverse reaction to the medication and assess the site every shift and document the assessment in the notes or on the flow chart.</p> <p>On 11/04/20 at 11:00 AM a follow up interview was conducted with the Director of Nursing (DON). The DON confirmed a PICC line was placed in Resident #6's right upper arm on 09/03/20. She also confirmed that there were no specific directions set up on the 09/2020 MAR or TAR related to how to care for the IV and no documentation in the progress notes or the daily charting notes on the assessment of the IV site. She explained that the Nurse who took the original order for the midline catheter should have set up the directions for the flushes and dressing changes so that every nurse would have cared for the IV line the way the policy directed them to care for it. The DON stated that it looked like she needed to have inservices for the nurses on the care and use of the IV line because the way she</p>	F 694			

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F 694	Continued From page 9 perceived it was if it was not documented it was not done. On 11/04/20 at 1:15 PM an interview was conducted with the Administrator, the DON and the Regional Director of Operations. During the interview the Administrator stated that the Nurses should have followed the policy for the care and use of the IVs and that the specific directions should have been set up on the Resident's MAR.	F 694			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		11/16/20	

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F 761	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to secure a medication cart (100 hall) that was left unlocked and unattended for 1 of 3 medication carts observed.</p> <p>The findings included:</p> <p>Review of the facility policy titled "Medication Storage in the Facility" dated April 2018 read in part, medication room, carts, and medication supplies are locked when not attended by persons with authorized access.</p> <p>A continuous observation was made of the 100-hall medication cart on 10/26/20 from 11:00 AM to 11:30 AM. The medication cart was parked on the 100 hall and was unlocked. Nurse #1 was observed cleaning the cart with a wet wipe and then went to the nurse's station. Nurse #1 was observed to sit down and look at a computer and then got up and went to the 200-hall medication cart and proceed down the 200 hall. The 100-hall medication cart remained unlocked on the hall while Nurse #1 was passing medication on the 200 hall which was out of sight of the 100 hall and 100 hall medication cart. There were residents and staff that passed by the unlocked medication cart 6 times during the continuous observation along with a resident who was seated in a wheelchair approximately 10 feet from the medication cart for the duration of the observation. At 11:31 AM Nurse #1 approached the 100-hall medication cart and confirmed that the cart was unlocked.</p> <p>An interview was conducted with Nurse #1 on</p>	F 761	<p>F 761 - Medication Storage</p> <ol style="list-style-type: none"> 1. No residents were affected. 2. No residents were affected. 3. On identification, this issue was immediately corrected by the nurse working the car. It was reported by the nurse working on the car the day that the issue was identified that the medication cart lock s difficult to lock and occasionally "popped back out." - The nurse working the cart that day stated that she called the pharmacy to report this issue, but no further information was received from the pharmacy regarding correcting this issue. On November 9, 2020, a phone call was placed to Polaris Pharmacy at 2pm to request that a representative come out to the facility to check the locks on all medication carts in the facility to assure that they are in proper function. All nurses and certified medication assistants will receive education regarding properly securing the medication carts when not in use. New hires will be educated on the process during orientation. 4. Spot checks of medication carts to 		

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F 761	<p>Continued From page 11</p> <p>10/26/20 at 11:32 AM. Nurse #1 stated she had only worked at the facility for a week. She stated she recalled locking the 100-hall medication cart and thought maybe the lock had popped out. Nurse #1 stated that had happened once before and she assumed that is what happened this time. She stated she would need to call the pharmacy and report the problem. Nurse #1 stated she had not called the pharmacy the first time she had an issue with the lock. Nurse #1 locked the medication cart and left the cart and the lock remained in the lock position and the cart was secured.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/27/20 at 2:44 PM. The DON stated that the medication cart should not have been unlocked and unattended and the problem should have been reported to the pharmacy so it would not have occurred again. The DON stated the facility had an extra cart that could have been used in the meantime to ensure that the cart was in good working order. She added that she had worked on the 100-hall medication cart recently and had no issues with the cart or locking device.</p> <p>An interview was conducted with the Administrator on 10/27/20 at 5:56 PM. The Administrator stated that if Nurse #1 took her eyes of the medication cart then it should have been locked.</p>	F 761	<p>assure that they are locked by nursing staff will be performed by the Director of Nursing, Unit Manager, or designee according to the following schedule:</p> <ul style="list-style-type: none"> - Twice a day Monday-Friday (random times will be selected) for a period of 2 weeks (Wednesday November 11, 2020- Tuesday November 24, 2020). - Twice a day Monday, Wednesday, and Friday (random times will be selected) for a period of 2 weeks (Wednesday November 25, 2020- Tuesday December 8, 2020). - Daily on Monday, Wednesday, Friday (random times will be selected) for a period of 2 weeks (Wednesday December 9, 2020- Tuesday December 22, 2020). - Weekly (random days and times will be selected) for a period of 4 weeks or until 100% compliance is reached (Wednesday December 23, 2020- Tuesday January 19, 2021 or until 100% compliance is reached). - Random audits during rounds to ensure maintenance of compliance (ongoing). <p>Review of audits will be conducted during clinical Excellence QAPI meetings on a monthly basis, or more frequently as needed.</p>		
F 880 SS=E	<p>Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program</p>	F 880		11/16/20	

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F 880	<p>Continued From page 12</p> <p>designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§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:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the</p>	F 880			

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F 880	<p>Continued From page 13</p> <p>least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 observations, record review, review of signage "Enhanced Droplet Isolation," and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 by not placing signage for transmission-based precautions at the entrance of the facility's COVID-19 care unit. The facility also failed to follow the CDC guidance for roommates of resident with COVID-19, when Resident #13's roommate tested positive for COVID-19 and was moved to the designated COVID-19 unit, the facility also moved Resident #13 to the COVID-19 unit after receiving a negative COVID-19 test. In addition the facility failed to follow the "Enhanced</p>	F 880	<p>F 880</p> <p>1. The facility failed to implement the Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19 by not placing signage for transmission-based precautions at the entrance of the facilities COVID-19 care unit. The facility also failed to follow the CDC guidance for roommates of resident with COVID-1*9, when resident #13's roommate tested positive for COVID-19 and was moved to the designated COVID-19 unit, the facility also moved</p>		

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F 880	<p>Continued From page 14</p> <p>Droplet Isolation" sign posted on the door of 3 of 5 residents that were on Enhanced droplet isolation (Resident #2, #11, and #14) by not donning eye protection before entering the room and failed to apply eye protection for 2 residents located on the COVID-19 unit that were on Enhanced Droplet Precautions (Resident #12 and #13) prior to entering their room. This affected 5 of 5 residents (Resident #2, #11, #12, #13, and #14). These failures occurred during a COVID-19 global pandemic.</p> <p>The findings included:</p> <p>The CDC guideline titled "Responding to Coronavirus (COVID-19) in Nursing Homes" and dated 04/30/20 read in part: Place signage at the entrance to the COVID-19 care unit that instructs Health Care Personnel (HCP) they must wear eye protection and N95 (respirator mask) or high respirator (or facemask if a respirator is not available) at all times while on the unit. Gown and gloves should be added when entering resident rooms. The CDC guideline further stated "all recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of N95 or high level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.</p> <p>Review of the facility's COVID Response Plan and dated October 2020 read in part, "All staff that come into direct contact with resident or resident environment to wear masks. It is recommended that all staff providing direct care wear face shields during care." Required Personal Protective Equipment (PPE) "on</p>	F 880	<p>resident #13 to the COVID-19 unit after receiving a negative COVID-19 test. The facility failed to follow the Enhanced Droplet Isolation sign posted on the door of 3 of 5 residents that were on Enhanced droplet isolation (Resident #2, #11, and #14) by not donning eye protection before entering the room and failed to apply eye protection for 2 residents located on the COVID-19 unit that were on Enhanced Droplet Precautions (Resident #12 and #13) prior to entering their room. This affected 5 of 5 residents (Resident #2, #11, #12, #13, and #14). These failures occurred during a COVID-19 global pandemic.</p> <p>2. Signage for transmission-based precautions was immediately placed on entrance of the facilities COVID-19 unit. Resident #13 was left on COVID-19 unit for a 14-day quarantine period per the direction of the Iredell County Health Department and was then moved back into general population. Eye protection was immediately added to all PPE Binds for each resident on Enhanced Droplet Precautions including Resident #2, #11, #12, #13 and #14.</p> <p>3. All staff, including Full Time, Part Time, and Agency will be retrained by 11/13/2020 on Donning and Doffing appropriate Personal Protective Equipment (PPE), appropriate signage at the entrance to the COVID-19 Unit and guidelines for cohorting residents by Director Of Nursing (DON), and Infection Preventionist. All PRN staff will be</p>		

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F 880	<p>Continued From page 15</p> <p>quarantine units- N95, gown, face shield, gloves worn in resident rooms. The plan further read, the roommate of a positive COVID-19 (if asymptomatic and negative) was placed in quarantine for 14 days. If the roommate becomes symptomatic, they were tested." The plan further read, "all new and readmissions are placed on the quarantine unit in a room by themselves for 14 full days.</p> <p>Review of the facility's Enhanced Droplet Isolation sign instructed staff to do the following: Before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain each piece of PPE.</p> <p>Upon entrance to the facility on 10/26/20 at 9:30 AM the Director of Nursing (DON) stated that the facility had just received a test result for Resident #12 that indicated he was COVID-19 positive. She stated that Resident #12 and his roommate Resident #13 would be moving from their room on the 100 hall (general population hall) to the facility's COVID-19 designated unit which was 700 hall. She explained that the 700 hall had previously been closed and they were in the process of opening the unit and getting supplies and such in place and as soon as it was ready Resident #12 and #13 would be moved to the 700 hall. The DON stated that Resident #13 had received a negative COVID-19 test result at the same time Resident #12 test showed he was</p>	F 880	<p>retrained prior to working on Donning and Doffing appropriate Personal Protective Equipment (PPE), appropriate signage at the entrance to the COVID-19 Unit and guidelines for cohorting residents by Director Of Nursing (DON), and Infection Preventionist. New hires will be educated on the process during orientation. A Root Cause Analysis (RCA) was conducted on 11/13/2020 with the assistance of the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body.</p> <p>Audit of education regarding Enhanced Droplet Precautions and the expectations to wear PPE including protective eye wear will be completed on 11/16/2020 to ensure 100% compliance.</p> <p>Central supply and/or Administrator and/or Nurse Supervisor and/or designee will round daily to verify that precautions bins are fully stocked with the appropriate PPE including gowns, gloves, K95's and eye protection and that appropriate Signage for transmission-based precautions are on every residents door that is currently on Enhanced Droplet Precautions. This will be audited using the Enhanced Droplet Precautions list.</p> <p>DON and/or Unit Manager (UM) and/or designee will audit staff to ensure that proper PPE is being worn correctly using the PPE Audit Sheet.</p> <p>4. Central supply and/or Administrator and/or Nurse Supervisor and/or designee will round daily to verify that precautions bins are fully stocked with the appropriate PPE including gowns, gloves, K95's and eye protection and that appropriate</p>		

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F 880	<p>Continued From page 16</p> <p>positive for COVID-19. The DON stated that the facility's quarantine unit that they used for all new admission and readmission was the 500 hall. She added that if the 500 hall was at full capacity they would place the resident in a private room under precautions.</p> <p>1a. An observation was made on 10/26/20 at 11:15 AM. Resident #13's room on the 100 hall (general population unit) contained a sign indicating he was on Enhanced Droplet Isolation and read: Before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain each piece of PPE. Nurse Aide (NA) #1 entered the room with a surgical mask in place without donning eye protection to assist Resident #13 to the 700 hall. She was observed to place a surgical mask on Resident #13 and push him in his wheelchair down the 100 hall and the 300 hall to the 700 hall. The entrance door of the 700 hall, which was the designated COVID-19 hall, did not have any signage for transmission-based precautions instructing health care personnel to wear all recommended COVID-19 PPE including eye protection. NA #1 proceeded through the double doors and took Resident #13 to his room on the unit without donning eye protection. Review of a COVID-19 test dated 10/21/20 and reported on 10/26/20 for Resident #13 indicated that COVID-19 was not detected.</p>	F 880	<p>Signage for transmission-based precautions are on every residents door that is currently on Enhanced Droplet Precautions. This will be audited using the Enhanced Droplet Precautions list. PPE audits using the PPE Audit Sheet will be completed on each shift 1x daily x 2 weeks, then 3x weekly x 2 weeks, then 1x weekly x 4 weeks by the DON, Unit Manager, or Nursing Supervisor. Audits will ensure staff are correctly Donning and Doffing appropriate PPE including appropriate eye ware.</p> <p>Administrator or designee to audit PPE Audit sheets and Enhanced Droplet Precautions list weekly for 30 days and randomly thereafter to ensure audits are being completed. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly by DON or designee with the QAPI Committee responsible for ongoing compliance.</p>		

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F 880	<p>Continued From page 17</p> <p>An observation was made of NA #1 on 10/26/20 at 12:30 PM. NA #1 was sitting in a chair next to Resident #13's bed on the 700 hall (designated COVID unit) bed dressed in a gown, gloves and mask. She was assisting Resident #13 with his lunch meal. NA #1 did not have on eye protection. There was a PPE cart sitting in the hallway outside of his room that contained mask and gowns. No eye protection was noted in the cart.</p> <p>An observation of the 700 hall COVID unit was made on 10/27/20 at 9:30 AM. The door at the entrance of the unit did not contain any signage indicating it was the COVID unit and no signage indicating all residents on the unit were on Enhanced Droplet Isolation that required universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room.</p> <p>1b. An observation was made on 10/26/20 at 11:28 AM. Resident #12's room on the 100 hall (general population hall) had a sign that indicated he was on Enhanced Droplet Isolation. The sign read: Before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain each</p>	F 880			

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F 880	<p>Continued From page 18</p> <p>piece of PPE. NA #1 entered Resident #12's room without donning eye protection to assist him to the 700 hall. She was observed to place a surgical mask on Resident #12 and push him in his wheelchair down the 100 hall and the 300 hall to the 700 hall. The entrance door of the 700 hall, which was the designated COVID-19 hall, did not have any signage for transmission-based precautions instructing health care personnel to wear all recommended COVID-19 PPE including eye protection. NA #1 proceeded through the double doors and took Resident #12 to his room on the unit without donning eye protection. Review of COVID-19 test dated 10/21/20 and reported on 10/26/20 for Resident #12 indicated that COVID-19 was detected.</p> <p>An observation of the 700 hall COVID unit was made on 10/27/20 at 9:30 AM. The door at the entrance of the unit did not contain any signage indicating it was the COVID unit and no signage indicating all residents on the unit were on Enhanced Droplet Isolation that required universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room</p> <p>An interview was conducted with NA #1 on 10/27/20 at 10:59 AM. NA #1 confirmed that she had moved Resident # 12 and #13 from their room on 100 hall to the 700 hall which was the COVID-19 hall. She indicated that she had just been assigned to the 700 hall COVID unit that morning when they learned that Resident #13's</p>	F 880			

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F 880	<p>Continued From page 19</p> <p>COVID test was positive. NA #1 stated that she had received "a lot of education from the news and from the facility" and that she had just put it all together. NA #1 stated that back in March 2020 when the pandemic started, they were not wearing mask then everyone started wearing mask as that was all the news talked about. NA #1 stated that everyone was to stay 6 feet apart, but she recently heard on the local news that we needed to stay 8 feet apart. She further stated that "there had been confusion as to what we use." NA #1 stated we have shoe covers and some staff wear them. We have face shields and "if I have a face shield then I would wear one." NA #1 stated the sign on the door instructed her to put on gown, gloves, and mask. She added, "I was not fully informed of the eye wear until yesterday" and I was told I needed to wear eye protection, "I depend a lot on the example of people around me" and if I wear a face shield it would just depend on the risk of my transmission. She added I want to protect the resident but "I don't get sick."</p> <p>2a. An observation was made on 10/26/20 at 10:21 AM of Resident #14 on the 200 hall (general population). Resident #14 had readmitted to the facility on 10/13/20. The door to Resident #14's room was closed and contained a sign that read Enhanced Droplet Isolation. The sign read, before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room.</p>	F 880			

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F 880	<p>Continued From page 20</p> <p>The sign contained a picture to explain each piece of PPE. NA #2 was observed to open a cart that was right outside of Resident ##14's room. She opened the top drawer which contained surgical mask. The second and third drawer contained gowns. No eye protection was noted in the cart. NA#2 was observed to don a gown, gloves, and mask and enter Resident #14's room. NA #3 was inside Resident #14's room and had donned a gown, gloves, and mask. Neither NA #2 nor #3 donned eye protection. They proceed to apply lotion to Resident #14's leg and turn her from side to side. NA #2 and NA #3 then transferred Resident #14 from her bed to chair using a mechanical lift. NA #3 was observed to replace the oxygen tubing that Resident #14 had removed prior to her the transfer and handed her the call bell. Both NA #2 and NA #3 removed their PPE and exited the room.</p> <p>An interview was conducted with NA #3 on 10/27/20 at 9:41 AM. NA #3 stated that she was aware of which PPE was required for the room by the sign on the door. She added "if the sign on the door tells me to wear PPE then I wear the PPE." NA #3 stated that they placed the enhanced droplet isolation sign on Resident #14's door yesterday morning and any room that has isolation we were required to wear eye protection. NA #3 stated that when she entered Resident #14's room on 10/26/20 there was no eye protection available to her. In the past NA #3 stated she would go to the supply closet and there would be none, so she just went ahead and took care of Resident #14's needs. She added she wore what was available to her and when she went to check the PPE cart there was no goggles there.</p>	F 880			

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F 880	<p>Continued From page 21</p> <p>An interview was conducted with NA #2 on 10/28/20 at 3:05 PM. NA #2 stated that if the room had an enhanced droplet isolation room then she applied full PPE including gown, gloves, mask, and goggles. She stated that when she entered Resident #14's room on 10/26/20 she was in a rush and forgot to put on the goggles, "it just slipped my mind." NA #2 stated that the enhanced droplet isolation rooms have a cart outside of their room where she would obtain her PPE. She stated that the cart had the correct PPE, but she just forgot to put it on.</p> <p>2b. An observation was made on 10/26/20 at 11:52 AM of Resident #2 on the 200 hall (general population). Resident #2 was readmitted to the facility on 10/17/20. The door to Resident #2's room was open and contained a sign that read Enhanced Droplet Isolation. The sign read: Before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain each piece of PPE. Resident #2 was lying in bed with while NA #2 and the Physical Therapist (PT) were preparing for Resident #2 to transfer to her wheelchair. NA #2 and the PT were dressed in a gown, gloves, and surgical mask. Neither had eye protection on. NA #2 was observed to move Resident #2's wheelchair to the preferred location in the room. The PT was observed to grab Resident #2's hand as she reached for him to assist with pulling Resident #2 into a sitting position. The PT also</p>	F 880			

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F 880	<p>Continued From page 22</p> <p>was observed to Velcro Resident #2's shoes once she had put them on. Resident #2 ambulated from her bed to wheelchair before both NA #2 and the PT removed their PPE and exited the room.</p> <p>An interview was conducted with the PT on 10/27/20 at 11:18 AM. The PT stated that when a resident was admitted or readmitted from the hospital, they were COVID-19 negative but were on isolation for 14 days. During that isolation period the PT stated they wore gloves, gown, and face covering. He stated that the PPE was generally placed in a cart outside of the resident's room for staff to use as needed. My understanding of the enhanced droplet precautions was only for people who were COVID-19 positive. As he rule, he stated he did not wear eye protection unless he was on the COVID-19 designated unit. He added that there have been some inconsistencies of what exactly was expected of the staff to wear in these rooms.</p> <p>An interview was conducted with NA #2 on 10/28/20 at 3:05 PM. NA #2 stated that if the room had an enhanced droplet isolation room then she applied full PPE including gown, gloves, mask, and goggles. She stated that when she entered Resident #2's room on 10/26/20 she was in a rush and forgot to put on the goggles, "it just slipped my mind." NA #2 stated that the enhanced droplet isolation rooms have a cart outside of their room where she would obtain her PPE. She stated that the cart had the correct PPE, but she just forgot to put it on.</p> <p>2c. An observation was made on 10/26/20 at 10:12 AM of Resident #11 on 100 hall (general population unit). Resident #11 had readmitted to</p>	F 880			

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F 880	<p>Continued From page 23</p> <p>the facility on 10/02/20. The door to Resident #11's room was open and contained a sign that read Enhanced Droplet Isolation. The sign read, Before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and gloves when entering room. The sign contained a picture to explain each piece of PPE. There was a cart right outside of the room that had 3 drawers and contained surgical mask and gown. No eye protection was noted. Resident #11 was moaning out. The Speech Therapist (ST) was observed to approach Resident #11's room and apply a surgical mask, gown, and gloves and enter the room. No eye protection was donned. The ST went to Resident #11's bedside and began adjusting her oxygen tubing that seemed to be bothering her. She adjusted the covers and held her hand for comfort. When the ST had completed her task, she removed her PPE and exited the room and performed hand hygiene.</p> <p>An observation was made on 10/27/20 at 8:53 AM of Resident #11. The door to Resident #11's room was closed. There was a sign on the door that read Enhanced Droplet Isolation: Before entering this room, follow the instruction below: universal masking: N95 (if available) if not surgical mask acceptable and must fully cover the nose, mouth, and chin. N95 or higher-level respirator (must be fit tested) needed when performing aerosolized procedures. Private room and keep door closed. Eye Protection with patient encounters. Perform hand hygiene, gown, and</p>	F 880			

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F 880	<p>Continued From page 24</p> <p>gloves when entering room. The sign contained a picture to explain each piece of PPE. NA #4 was observed to approach Resident #11's room and don a gown, gloves, and surgical mask. NA #4 then entered the room. Once inside the room she was met by the Hospice Nurse (HN) who was donned in a gown, gloves, and mask. Neither NA #4 nor the HN donned eye protection. NA #4 and the HN were observed to be at bedside holding Resident #11's hand for comfort. The HN adjusted the oxygen tubing and replaced the covers over Resident #11 to ensure she was warm enough.</p> <p>An interview was conducted with the Hospice Nurse (HN) on 10/27/20 at 9:37 AM. The HN stated she did not wear eye protection because she did not believe that Resident #11 still needed to be on isolation because it has been longer than 14 days since her readmission.</p> <p>An interview was conducted with NA #4 on 10/27/20 at 10:37 AM. NA #4 stated that she had not been educated in the facility about PPE but had receive the education at other facilities she worked out. She stated that the sign on the door instructed her of what PPE she needed to apply before entering the room. NA #4 stated that she did not read the sign on the door but stated when she went to the PPE cart to obtain her gown and gloves there were no goggles or face shield in there. She added she did not have time to run from supply room to supply room looking for the things that she needed. NA #4 added that she applied what was available to her at the time she went into the room. She stated that this was the first time she had heard that she needed to wear goggles in an isolation room, and she was under the assumption they would not use goggles</p>	F 880			

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F 880	<p>Continued From page 25</p> <p>unless the facility had positive cases of COVID-19.</p> <p>An interview was conducted with the ST on 10/27/20 at 12:56 PM. The ST confirmed that she did not have on eye protection when she assisted Resident #11 on 10/26/20. She stated that when residents readmit from the hospital, they were COVID-19 negative but they stayed on isolation for 14 days and during that 14-day window she would wear the eye protection. The ST stated that Resident #11 had been back in the facility for longer then 14 days and was asymptomatic and so she did not wear the eye protection. She stated that she was aware of the Enhanced Droplet isolation sign on the door but stated that the hall staff just had not kept up with her 14-day window. The ST stated that it was not unusual for the carts to not have the eye protection and she does not see a lot of staff wearing them. She added there was "no emphasis" placed on eye protection.</p> <p>An interview was conducted with the Unit Manager (UM) on 10/27/20 at 12:21 PM. The UM stated that staff should be following the sign on the door of what PPE to apply before entering the room. She stated that the former infection control nurse supplied face shield and goggles to staff and the staff should be following the sign on the door and applying the correct PPE before entering the room.</p> <p>An interview was conducted with the DON on 10/27/20 at 2:44 PM. The DON stated that she had recently done a mass education to all staff in all departments on infection control and donning and doffing the correct PPE. Following the education, she was doing audits to ensure that all</p>	F 880			

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F 880	<p>Continued From page 26</p> <p>staff were doing what they had been trained to do, and those were going very well and overall, she believed the staff were doing a good job of donning and doffing the correct PPE. The DON stated that the signs on the isolation doors explained exactly what PPE was required to enter the room. The DON further explained that Resident #11 had been back in the facility for greater than 14 days and she did not know of any other reason why she was on isolation. She added that she had missed the opportunity to remove the sign on 10/16/20 but stated the staff should have been following the signage on the door. She added that she had only been at the facility for a couple of months and when she came to the facility the staff were not in a habit of wearing the eye protection, but stated they ordered the PPE including eye protection and it was available to the staff to wear. The DON stated she expected all staff to wear the appropriate PPE when they enter a room that had an isolation sign on the door. The DON further stated that she had read and was familiar with all the CDC guidelines and had not had the time to place the signage that was required on the door of the COVID-19 unit. As to the moving of Resident #13 to the COVID-19 unit she had a previous version of the facility policy and that was what she used to determine the need to move Resident #13 to the COVID-19 unit despite the fact that he had a negative test.</p> <p>An interview was conducted with the Administrator on 10/27/20 at 5:56 PM. The Administrator stated that if the eye protection was on the isolation sign then he would expect the staff to wear the eye protection. He added that they thought since Resident #13 had been exposed then it was fine to move him to move</p>	F 880			

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F 880	<p>Continued From page 27</p> <p>him to the COVID-19 unit. The Administrator was not aware that the DON had the wrong policy to determine the course of action to take when determining whether to move both Resident #12 and Resident #13.</p> <p>An interview was conducted with the Central Supply Clerk (CSK) on 10/29/20 at 12:49 PM. The CSK stated he routinely ordered supplies and stocked them at the facility. He explained that he had a par number to go by and when the supply was getting close to that number, he would order the item. Once the item arrived at the facility, he would stock the item within the facility. As far as the PPE supplies the CSK stated that he did a daily count of the gown, gloves, mask, and eye wear and provided those to the Administrator and DON. He stated that they sent the numbers to the corporate office who then in turn would send the needed PPE based on the number provided to them. The CSK stated that once the PPE arrived at the facility, he would stock the PPE carts outside of the rooms that required the PPE. He added that some days he stocked the carts 2-3 times a day, but it depended on how many other tasks he had to do. He explained that he also drove the facility van and with the easing of restrictions the residents had more appointments and he was driving more often. The CSK stated that he left his office unlocked with supplies in it and the storage shed out back was also unlocked so staff always had access to the supplies even if he was not there to stock the carts. He stated it was not just his responsibility but everyone 's responsibility to stock the supplies that the staff needed. The CSK stated that the facility had plenty of PPE supplies and they were always available to staff who needed them. On 10/26/20 the CSK explained he had been on a transport</p>	F 880			

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F 880	Continued From page 28 and was not able to stock the PPE carts until he returned to the facility later in the day.	F 880			