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	345133	A. BUILDING _____ B. WING _____	C 12/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

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E 000	Initial Comments The survey team enter the facility on 12/17/20 to conduct an unannounced COVID-19 Focused Infection Control Survey and complaint investigation and exited on 12/17/20. Additional information was obtained through 12/21/20. Therefore, the exit date was changed to 12/21/20. 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: W3J811.	E 000		
F 000	INITIAL COMMENTS The survey team enter the facility on 12/17/20 to conduct an unannounced COVID-19 Focused Infection Control Survey and complaint investigation and exited on 12/17/20. Additional information was obtained through 12/21/20. Therefore, the exit date was changed to 12/21/20. The facility was found out of 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. There was one complaint intake investigated and it was substantiated. Event ID#W3J811.	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.	F 880		12/25/20

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

Electronically Signed | 01/15/2021

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F 880	Continued From page 1 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 2 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement infection control policies and Centers for Disease Control and Prevention (CDC) guidelines when two nursing assistants (NAs) failed to don and doff PPE (Personal Protective Equipment) and failed to perform hand hygiene before entering or after contact with a resident or objects in a resident's room for 4 of 4 sampled residents who resided on the COVID-19 care units and were on Enhanced Droplet Isolation Precautions (Residents #1, #2, #3, #4).These failures in infection control practices occurred during a global COVID-19 pandemic. Findings included: An undated facility policy titled "Handwashing/ Hand Hygiene" indicated the facility considered hand hygiene the primary means to prevent the	F 880	F880 Root cause analysis was conducted on 12/17/20 and completed on 12/21/20 to identify the root cause of the facility's failure to ensure staff implementation of infection control policies and CDC Guidelines when two nursing assistants failed to don and doff PPE and failed to perform hand hygiene before entering their room and after contact with a resident or objects for 4 of 4 residents who resided on the COVID Unit and was on Enhanced Droplet Precautions. These infection control failures occurred during a global COVID-19 pandemic. The root cause analysis determination was led by the Administrator with input from the Director of Nursing, Assistant Director of Nursing/ Infection Preventionist and Unit Manager. The results of the root cause	

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spread of infection. Alcohol based hand rub must be used before and after direct contact with residents, before and after entering isolation precaution settings, and before and after assisting a resident with meals. Hand hygiene is the final step after removing and disposing of personal protective equipment

A review of a facility document titled Isolation-Categories of Transmission-Based Precautions revised 03/01/20 revealed standard precautions shall be used when caring for all residents regardless of their suspected or confirmed infectious status. Transmission-Based Precautions will be implemented for a resident who is documented or suspected to have a communicable disease or infection that can be transmitted to others. Resident confirmed positive for COVID-19 and persons under investigation (PUI) shall be placed on Enhanced Droplet Isolation Precautions in addition to standard precautions and signage placed that illustrated the use of a gown, face mask, eye wear and gloves.

According to the CDC website dated 12/04/20 HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved N-95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection.

During an initial entrance of the facility on 12/17/20 beginning at 9:30 AM the Director of Nursing (DON) and the Administrator revealed the facility was in a COVID-19 outbreak status

analysis were reviewed by the QAPI Committee on 12/24/20 and incorporated into the facility's plan of correction.

Resident #s 1, 2, 3 and 4 were all assessed by the Unit Manager on 12/21/20 with no ill effects from staff not wearing appropriate PPE before entering their room and after contact with a resident or objects were observed or noted.

All residents have the potential to be affected, therefore staff was immediately retrained with competency validations initiated on 12/22/20 and completed by 12/25/20, to ensure knowledge and compliance with procedures and ensuring the appropriate use of PPE, as well as when and where to use it. Any newly hired staff after 12/25/20 have received training with donning and doffing validations and handwashing competencies completed which remain ongoing.

Staff were educated beginning on 12/21/20 by the Director of Nursing on Infection Control practices to include donning and doffing of PPE, requirements for what types of PPE to use and handwashing procedures. 100% of staff completion was accomplished by 12/24/20. Competencies were completed with 100% of currently employed staff on PPE competency validations and handwashing competencies per the Assistant Director of Nursing or Director of Nursing starting on 12/22/20 with

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F 880	Continued From page 4 and had designated rooms 100- 129 for residents with known COVID-19 positive test results. The DON stated a total of 34 residents and 4 staff members were currently confirmed as positive for COVID-19 as of 12/17/20. An observation of Rooms 100-129 in the COVID-19 resident care unit on 12/17/20 from 11:55 AM to 12:55 PM revealed all residents to have signage displayed on the outside of the door to their rooms that indicated each resident was on "Enhanced Droplet Isolation Precautions." The signage contained both written and a graphic illustration to show the need for hand hygiene and indicated PPE to include a gown, gloves, face mask, and eye wear were needed in the resident rooms. 1. An observation was made on 12/17/20 beginning at 12:00 PM and ending at 12:05 PM revealed NA #1 open a soiled utility closet on the COVID-19 care unit to retrieve a soiled linen barrel which contained multiple plastic bags of soiled laundry. NA #1was not wearing a gown or gloves when she wheeled the soiled linen barrel from the soiled utility closet towards the exit door of the COVID-19 care unit located at the side of the facility. NA #1 removed the plastic bags and placed them outside the facility exit door along with other bags containing soiled laundry, then returned the barrel to the soiled linen closet, closed the door and proceeded to collect a bag containing clean linen/resident personal clothing from NA #2 who was standing in the hallway and walk up the hallway to deliver them to Resident #1's room. NA #1 entered Resident #1's room to deliver clean linen/resident personal clothing items. NA #1 was wearing a face mask and eye wear, but was not observed to perform hand	F 880	completion on 12/25/20. To ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirement the Administrator and/or Director of Nursing will oversee weekly QAPI meetings to discuss all findings, and/or any changes to the plan that are needed. Meetings will include the Administrator, Director of Nursing, Assistant Director of Nursing and Unit Manager at minimum. An Audit Tool was developed and will be used to document any findings. Result of findings and/or corrections will be discussed weekly x4, then monthly x3 to include addressed during the quarterly QAPI meeting. At that time frequency will be determined by the team for continued monitoring needs as well as input from the Medical Director.	

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hygiene, don gloves or a gown before she entered Resident #1's room which contained signage of Enhanced Droplet Isolation precautions which listed hand hygiene was needed before and after exiting the room and PPE was needed to include a gown, gloves, face mask, and eyewear when in the room. NA #1 then exited the room holding an empty plastic bag which the clothes had been located, closed the door to the room, and walked to a nearby blue cart located in the hallway to dispose of the plastic bag and retrieve another plastic bags containing clothing and proceeded to another resident's room which was not in the line of sight . NA #2 was not observed to perform hand hygiene after exiting Resident #1's room or before collecting items belonging to another resident.

An interview on 12/17/20 at 12:32 PM with NA #1 revealed she had been assigned to work in the COVID-19 care unit on day shift. NA #1 indicated she had been taught to wear gloves when removing soiled linen from the unit and to wear a gown when direct contact with soiled linen might occur with linens on the COVID-19 care unit. NA #1 indicated she had removed a barrel containing soiled linen from the soiled utility closet located on the unit and took it to the exit door and placed the bags on the sidewalk outside the door for the laundry department to pick-up for processing. NA #1 revealed the bags of laundry contained both resident personal items and facility linens and that some of the bags which were outside to be picked up were not tied off to prevent potential exposure to soiled linens containing blood borne pathogens. NA #1 stated she was not sure why she had not donned PPE before contact with the soiled linens or performed hand hygiene before she had contact with the clean linens of Resident

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#1 nor why she did not don a gown and gloves before entering the room of Resident #1 who resided on the COVID-19 care unit. NA #1 had been educated to apply full PPE to include a gown, gloves, face mask, and eye wear every time she entered a resident room on the COVID-19 care unit.

An interview on 12/17/20 at 12:55 PM with the Infection Control Nurse (IC), Director of Nursing (DON) and the Administrator revealed staff had been educated monthly on all updates with COVID-19 since September 2020 and these in-service trainings included the use of personal protective equipment needed on the COVID-19 care unit. The DON indicated she had performed some audits initially prior to the outbreak and noticed some breeches in Infection Control and provided education and disciplinary actions at that time and she had not saw any further concerns. She stated the facility had adopted a no tolerance policy for infection control breeches. The DON indicated a staff member had been placed on the COVID unit to monitor the staff for infection control practices. The Unit Supervisor was not visible during this observation.

An interview on 12/21/20 at 3:05 PM with the DON and Administrator revealed both the DON and Administrator indicated NA #1 had been educated to wear a face mask and eye wear at all times when on the COVID-19 care unit. NA #1 should have donned gloves before removing the soiled linen barrel from the soiled utility closet to empty outside for laundry; however, if there were any open bags of linen in the barrel, NA #1 should have donned a gown in addition to gloves to remove the soiled laundry from the barrel for laundry and indicated all bags should be tied off

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before placing in the linen barrel the hand washing should be performed before performing any further tasks on the COVID-19 care unit. The Administrator stated the facility had an adequate supply of PPE and had not had difficulty obtaining enough gown or gloves so there was no reason why NA #1 should not have worn the proper PPE.

2. An observation on 12/17/20 at 12:18 PM revealed NA #1 and NA #2 to enter the room of Resident #2 and Resident #3 who were roommates in a room located at the end of the hall on the COVID-19 care unit. Both NA #1 and NA #2 were wearing a face mask and eyewear and had donned a gown prior to entering the room to deliver the lunch meal. NA #2 was observed to sit the tray down on the bedside table of Resident #3 and began to set the tray up for Resident #3 to eat when NA #1 asked for the assistance of NA #2. NA #1 asked NA #2 to help her pull Resident #3 up in the bed so she could eat her lunch. NA #2 left the bedside of Resident #2 and proceeded around the end of the bed and approached Resident #3's bedside. NA #1 and NA #2 then proceeded to pull up Resident #3 in bed. NA #1 then sat up Resident #3's meal tray and NA #2 returned to the bedside of Resident #2 and continued to setup her lunch meal tray. NA #1 was not observed to wear gloves when in the room of Resident #2 and #3; however, NA #1 was observed to perform hand hygiene when she exited the room. NA #2 was not observed to wear gloves while in the room of Resident #2 and #3 nor perform hand hygiene between contact with Resident #2 and #3 during lunch meal delivery. NA #2 was observed to perform hand hygiene when she exited the room.

An interview on 12/17/20 at 12:32 PM with NA #1

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revealed she was assigned to work the COVID-19 care unit on day shift. NA #1 acknowledged she entered Resident #2 and #3's room without donning gloves. NA #1 stated she put on her gown and forgot to put the gloves on before she approached Resident #3's bed with her meal tray. NA #1 indicated she asked NA #2 for assistance in bed mobility for Resident #3 when she realized she was not positioned in the bed adequately to eat her lunch meal. NA #1 does not recall if NA #2 performed hand hygiene or had on gloves when she came to assist her. NA #1 stated she should have put on gloves to go into the room of a resident on Enhanced Droplet Isolation Precautions because she had been taught full PPE to include a gown, gloves, a face mask, and eye wear were to be worn each time she entered a room on the COVID-19 care unit.

An interview on 12/17/20 at 12:38 PM with NA #2 revealed she was assigned to work the COVID-19 care unit on day shift. NA #2 voiced she had been taught to wear full PPE to include a gown, gloves, face mask, and eye wear each time she entered the room of a resident on the COVID-19 care unit. NA #2 acknowledged she entered Resident #2 and #3's room without donning gloves. NA #2 stated she remembered to don a gown but failed to don a pair of gloves before she approached Resident #2's bed to set up her lunch meal tray. NA #2 indicated she was asked by NA #1 to assist in bed mobility for Resident #3 who was slouched down in the bed. NA #2 stated she stopped setting up the tray for Resident #2 and went over to help NA #1. NA #2 explained she had not thought about hand hygiene when she left Resident #2 and approached Resident #3 or before returning to Resident #2.

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An interview on 12/17/20 at 12:55 PM with the Infection Control Nurse (IC), Director of Nursing (DON) and the Administrator revealed staff had been educated monthly on all updates with COVID-19 since September 2020 and these in-service trainings included the use of personal protective equipment needed on the COVID-19 care unit. The DON indicated she had performed some audits initially prior to the outbreak and noticed some breeches in Infection Control and provided education and disciplinary actions at that time and she had not saw any further concerns. She stated the facility had adopted a no tolerance policy for infection control breeches. The DON indicated a staff member had been placed on the COVID unit to monitor the staff for infection control practices. The Unit Manager was not visible during this observation.

An interview on 12/21/20 at 3:05 PM with the DON and Administrator revealed both the DON and Administrator indicated NA #1 had been educated to wear a face mask and eye wear at all times when on the COVID-19 care unit. They both stated that NA #2 had been taught that a gown and gloves in addition to the face mask and eye wear were to be worn each time they crossed the threshold of a resident door on the COVID-19 care unit and that hand hygiene should be performed before and after donning of PPE and before contact potentially contaminated environmental surface. The Administrator stated the facility had an adequate supply of PPE and had not had difficulty obtaining enough gown or gloves so there was no reason why NA #1 should not have worn the proper PPE. The DON stated NA #2 should have also her PPE used when in contact with Resident #2, performed hand

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hygiene, and donned clean PPE before proceeding to assist NA #1 in pulling up Resident #3 in the bed, then doffed her PPE, performed hand hygiene, and donned clean PPE before returning to care for Resident #2.

3. An observation on 12/17/20 at 12:30 PM, on the COVID 19 care unit, revealed Resident #4 was wheeling herself in her wheelchair in the hallway holding a pair of pants in her lap. Resident #4 had a face mask on, but the mask was pulled down around her chin. Resident #4 explained she wanted her to put on her pants. NA #2 approached Resident #4 from behind her, put her hands on the back of the wheelchair, leaned over towards Resident #4's left cheek and began encouraging Resident #4 to allow her to assist her with dressing. With much encouragement, Resident #4 allowed NA #2 to push her to her room. NA #2 pushed Resident #4 inside her room and to the bathroom which was located inside Resident #4's room and began assisting Resident #4 with dressing. Resident #4's door displayed signage that indicated Resident #4 was on Enhanced Droplet Isolation Precautions which indicated hand hygiene was required before and after entering the room and PPE to include a gown, gloves, face mask, and eye wear were required to enter the room. NA #2 was observed to wear a face mask and eyewear when she entered the room. NA #2 was not observed to wear a gown or gloves when she entered Resident #4's room to assist with dressing.

An interview on 12/17/20 at 12:38 PM with NA #2 revealed she was assigned to work the COVID-19 care unit on day shift. NA #2 voiced she had been taught to wear full PPE to include a gown, gloves, face mask, and eye wear each

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time she entered the room of a resident on the COVID-19 care unit. NA #2 explained she entered Resident #4's room to assist with dressing. NA #2 acknowledged she did not don a gown or gloves before entering the room and did not close the door to the room before beginning to assist Resident #4 to dress.

An interview on 12/17/20 at 12:55 PM with the Infection Control Nurse (IC), Director of Nursing (DON) and the Administrator revealed staff had been educated monthly on all updates with COVID-19 since September 2020 and these in-service trainings included the use of personal protective equipment needed on the COVID-19 care unit. The DON indicated she had performed some audits initially prior to the outbreak and noticed some breeches in Infection Control and provided education and disciplinary actions at that time and she had not saw any further concerns. She stated the facility had adopted a no tolerance policy for infection control breeches. The DON indicated a staff member had been placed on the COVID unit to monitor the staff for infection control practices. The Unit Manager was not visible during the observation.

An interview on 12/21/20 at 3:05 PM with the DON and Administrator revealed both the DON and Administrator indicated NA #2 had been educated to wear a face mask and eye wear at all times when on the COVID-19 care unit. They both stated that NA #2 had been taught that a gown and gloves in addition to the face mask and eye wear were to be worn each time she crossed the threshold of a resident door on the COVID-19 care unit and that hand hygiene should be performed before and after donning of PPE and before contact potentially contaminated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 12/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

(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 environmental surface. The DON indicated NA #2 should have donned appropriate PPE and closed the door before beginning to dress Resident #4. The Administrator stated the facility had an adequate supply of PPE and had not had difficulty obtaining enough gown or gloves so there was no reason why NA #2 should not have worn the proper PPE.	F 880		