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	345538	A. BUILDING ______ B. WING ______	C 01/11/2021

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PRUITTHEALTH-RALEIGH	**2420 LAKE WHEELER ROAD RALEIGH, NC 27603**

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E 000	Initial Comments An unannounced COVID-19 Focused Infection Control survey and complaint investigation was conducted on 12/29/2020. The survey team was onsite 12/29/2020. Additional information was obtained offsite on 12/30/2020 - 01/11/2021. Therefore, the exit date was 01/11/2021. The facility was found to be in complaince with 42 CFR 483.73 related to E-0024 (b)(6), Subpart Requirements for Long Term Care Facilities. Event ID# ZE6R11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control survey and complaint investigation were conducted on 12/29/2020. Additional information was obtained offsite on 12/30/2020-01/11/2021. Therefore the exit date was 01/11/2021. The facility was found not to be incompliance with 42CFR.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. Immediate Jeopardy was identified on 12/29/2020 at: CFR 483.80 at a scope and severity K. Immediate Jeopardy began on 12/29/2020 and was removed on 01/05/2021. Event ID# ZE6R11. One of one allegation was substantiated.	F 000		
F 880 SS=K	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	F 880		2/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/01/2021

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

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F 880	Continued From page 1 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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	F 880		

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F 880	Continued From page 2 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, staff interviews, the facility failed to implement their COVID-19 Infection Prevention and Control policies and The Centers for Disease Control and Prevention Center (CDC) COVID-19 guidelines when a nurse exited a resident ' s room who was COVID positive and failed to remove her Personal Protective Equipment (PPE) and disinfect her face mask before immediately entering the room of a resident who was COVID negative, the facility failed to have enough PPE available for staff to ensure the CDC recommended maximum number of uses of five donnings/doffings of N95 and KN95 masks were being followed, staff failed to store N95 and KN95 masks in a paper bag at the end of the work shift and the facility failed to post required enhanced droplet isolation precaution signage on the doors	F 880	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. As of 1/1/2021 all positive residents have been moved to COVID positive halls 100, 200, 300, 500, 600, and 700 halls under enhanced droplet and contact	

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to the rooms of 69 residents with new-onset or confirmed COVID-19 which specified hand hygiene, eye protection, gloves, gown and a N95 mask were required before entering the resident's room. From 12/17/20 to 12/28/2020, a total of 69 of the facility's 138 residents had tested positive for COVID-19 in the facility. This system failure occurred during the COVID-19 pandemic and had a high likelihood of affecting all residents by placing them at an increased risk of developing and transmitting COVID-19.

Immediate Jeopardy began on 12/29/2020 when observations revealed the same staff were assigned to work with residents who were COVID-19 positive and residents who were COVID-19 negative and Nurse #1 was observed in a COVID-19 positive resident ' s room at bedside and exited the room without discarding her N95 face mask or disinfecting her face shield and immediately entered a COVID-19 negative resident ' s room and approached the resident at bedside. PPE supplies, including N95s, KN95s and face shields were not observed on the 400 and 600 halls for staff to use for resident care. The facility was posting "Airborne Precaution" signage throughout the facility for suspected or confirmed COVID-19 rather than "Enhanced Droplet Contact Precautions." Staff were storing used facemasks in plastic bags instead of the CDC recommended paper bags between shifts for reuse the next day or their next assigned shift. The immediate jeopardy was removed on 01/05/2021 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate

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precautions. Rooms 710 & 709 are negative residents separated from the rest of 700 hall on the Memory Support Unit. All negative residents have been moved to the 400 hall and rooms 710 and 709 on the Memory Support Unit.

The correct signage “Enhanced Droplet Isolation and Contact Precautions” was placed on all COVID-19 rooms on 100, 200, 300, 500, 600, 700 halls as of 1/1/2021 by the Clinical team (Interim Director of Nursing , Assistant Director of Nursing, Infection Control Nurse, Unit Manager, Education Nurse, Nurse Consultants (SPICE trained and Clinical Supervisors) and will be placed on any new COVID-19 rooms as future cases occur.

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

The Nurse Navigator, Consultants, Interim Director of Nursing, Nurse Supervisors and Case Mix Director or their designees were assigned to retest all staff and residents that tested negative every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive results. The testing began 1/2/2021 and as of 1/14/2021 no new cases of COVID-19 have occurred.

-3 Address what measures will be put into place or systemic changes made to

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jeopardy) to ensure monitoring systems put into place are effective.

Findings included:
The facility's "COVID-19 Guidance on use of PPE to Conserve Supplies" dated 04/24/2020 was responsible for ensuring appropriate PPE was readily available and accessible, implementing limited re-use of medical facemasks, and PPE medical facemasks should be removed and discarded before leaving a COVID-19 resident ' s room, extended use medical facemasks will be discarded at the end of the shift and respirators are to be stored in a paper bag in between encounters.

A review of facility policy labeled Coronavirus (COVID-19) Infection Prevention and Control Practices Policy, Section "coronavirus has been identified in the facility" dated 03/06/2020 revealed the facility would implement contact and droplet precautions for all residents with suspected or confirmed flu-like symptoms and for suspected or confirmed COVID-19 and Healthcare Personnel (HCP) would wear an N95 mask upon entering the resident ' s room or when working within three feet of the resident, remove the mask when leaving the resident ' s room and dispose of the mask in a waste container.

The CDC guideline entitled Crisis Capacity Strategies updated on November 23, 2020 indicated the following statement:

*Limit the number of reuses to no more than five uses (five donnings) per device to ensure adequate respirator performance.
The CDC guideline entitled "Responding to Coronavirus (COVID-19) in Nursing Homes" last

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ensure that the deficient practice will not recur.

A) Training was conducted as follows by the Director of Health Service (DHS), Nurse Navigator , Medical Director, Administrator & Interdisciplinary Team (IDT). The IDT consists of(DHS, ADHS, Clinical Supervisors , Dietician, Dietary Manager, Maintenance Director, Social Work, Activity Director, Financial Counselor, Human Resource Director, House Keeping Supervisor, and Case Mix Director. All training was completed by 1/16/2021. Any staff that has not received training as of 1/17/2021 will not be allowed to return to work until they are trained.

•Correct use and storage of N95 and KN95 including reuse parameters per the CDC guidelines and the PruittHealth Covid19 Pandemic Isolation and Cohorting Process for Healthcare centers.

•Enhanced Droplet Isolation and Contact Precautions (including keeping doors closed for Covid 19 + residents)

•Donning and doffing of PPE per DCD guidance to include, appropriate donning and doffing of PPE between Covid 19 positive residents and non Covid 19 residents, donning's of KN95/N95 for 5 donning's only (taking the mask off to eat and/or drink fluids counts toward the total number of donning's).

•Disinfecting process for face

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reviewed and updated on 04/30/2020 indicated the following statements:
*Place signage at the entrance to the COVID-19 unit that instructs (HCP) they must wear eye protection and an N95 or higher-level respirator (or facemask if respirator is not available) at all times while on the COVID-19 unit. Gown and gloves should be added when entering resident rooms.
*All recommended COVID-19 PPE should be worn during the care of residents under observation which includes use of N95 or higher-level respirator (or facemask if respirator is not available), eye protection, (goggles or a disposable face shield that covers the front and sides of the face), gloves and gown.

Observation during a facility tour on 12/29/2020 at 10:46AM to 12:23 PM revealed COVID-19 positive resident ' s rooms were among COVID-19 negative resident ' s rooms on the 400 and 600 halls outside of a COVID-19 designated area or unit located on the 300 and 500 hallways. Each COVID-19 positive resident ' s room within the 400 and 600 halls had an "Airborne Infection Isolation Precautions" sign on the door, 12 doors in total. The Airborne Infection Isolation Precautions signage instructed staff to perform hand hygiene before entering and before leaving the room, wear an N95 respirator when entering the room and keep the door closed. The 400 hall had five of 11 doors with signage that read Airborne Infection Isolation Precautions. The 400 hall had eight COVID-19 positive residents and 12 COVID-19 negative residents, and positive and negative rooms were scattered throughout the hall. The 600 hall had seven of 12 doors with signage that read Airborne Infection Isolation Precautions. The 600 hall had seven COVID-19

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shield/goggles.
•Proper room placement for Covid 19 positive residents and Covid 19 negative residents.
•Proper storage of N95 and KN95 masks in paper bags and the designated area to store them.

B) The following process/systemic changes were made:

•A revised policy titled “Covid-19 Use of PPE to Conserve Supplies” was provided by PruittHealth Corporate and implemented 1/5/2021. The policy includes the language found in Centers of Disease Control (CDC) guidelines for “Crisis Strategies” updated November 23, 2020 (specific to the number of facemask reuses).

•The Dietary Manager was designated 1/2/2021 to supply the paper bags needed for staff to store their N95 and KN95 masks. The Ante Room was the designated area in which the bags will be stored.

•1/3/2021 - The Maintenance Director and his designee(s) is/are responsible for ensuring there is adequate masks and personal protective equipment (PPE) available at the donning tables and nurses’ station daily.

•1/3/2021 - The Maintenance Director and/or designee will utilize an inventory tracker to maintain par levels for each station. They will order supplies on a

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positive residents and eight COVID-19 negative residents, and positive and negative residents were scattered throughout the hall. The signage of Airborne Infection Isolation Precautions was observed throughout the facility, including on the COVID-19 unit.

Resident #1's medical record revealed Resident #1 was admitted on 12/09/2020 and tested positive for COVID-19 on 12/28/2020. The facility's census sheet revealed Resident #1 resided on the 600 hall and was in a semi-private room with a roommate, Resident #2.

Resident #2 ' s medical record revealed Resident #2 was admitted 12/09/2020 and tested positive for COVID-19 on 12/28/2020 The facility ' s census sheet revealed Resident #2 resided on the 600 hall in a semi-private room with Resident #1.

Resident #3 ' s medical record revealed Resident #3 was admitted on 12/02/2020 and tested negative for COVID-19 on 12/28/2020. The facility ' s census sheet revealed Resident #3 resided on the 600 hall.

Observation on 12/29/20 at 10:53 AM revealed Resident #1 was in a semi-private room on the 600 hall with an Airborne Infection Isolation Precautions sign posted on the door, the door was open, and Nurse #1 was at bedside. Before exiting Resident #1 ' s room, Nurse #1 discarded a yellow gown and a pair of gloves in Resident #1 ' s waste basket, washed her hands inside the room and stepped outside of the room. There were no PPE supplies available outside of the door of Resident #1 ' s room or the hallway. Upon exiting Resident #1 ' s room, Nurse #1 did

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weekly basis as needed.

•The process for having personal protective equipment (PPE) supplies was reviewed by the Administrative and Clinical Leadership team , the Administrative and Clinical leadership team is. Interim DHS , Nurse Navigator , MDS Case Mix Director , Dietician, Nurse Navigator, Dietary Manager, Housekeeping Supervisor, Activity Director, Administrator, Clinical Coordinators, Medical Records, AVP and Nurse Consultants. Each hall has two donning/supply stations with PPE. The exception to this is the 400 hall that is a non-Covid hall, therefore it has only one donning/supply station.

•PruittHealth Corporation updates the policies and procedures from CDC guidance on Infection Control/Covid-19 and once the policy/procedure is updated the policy is released to the facilities. The Administrator will check daily for updates and educate Department Managers on the updates who will then educate their department.

C)(i)A root cause analysis was completed by the: Infection Preventionist (Nurse Navigator) that is Spice Trained, the Quality Assurance and Performance Improvement (QAPI) committee, and Governing Body and reviewed by the Contracted Consultant. The analysis was incorporated into the plan of correction/intervention plan.

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not disinfect her face shield or discard her facemask. After Nurse #1 exited Resident #1 ' s room into the hallway, she was observed using alcohol-based hand sanitizer and immediately entered Resident #3 ' s room and approached Resident #3 at bedside and began speaking with Resident #3 and reached to turn off the call light. Resident #3 did not have precaution signage posted on the door.

A phone interview with Nurse #1 on 12/29/2020 at 3:39 PM revealed she was assigned to the 600 hall on 12/29/2020 from 7:00 am to 7:00 pm and her assignment included both COVID-19 positive and COVID-19 negative residents. She added she often cared for residents who were COVID positive and COVID negative during her shifts at the facility. Nurse #1 stated she did not remove her facemask or disinfect her face shield in between providing care for Resident #1 and Resident #3 on 12/29/20 because she was unaware that she was required to and supplies, specifically N95s and KN95s, were not readily available upon exiting a COVID-19 room to allow for donning a new facemask. Nurse #1 confirmed she typically wore the same N95 and face shield during her entire shifts and did not disinfect her face shield in-between caring for COVID positive and COVID negative residents. She stated she was aware the door for COVID-19 residents should be closed and was not sure why some of the doors for COVID-19 rooms on the 600 hall were open. She also stated she wore her facemask for five to seven shifts depending on if she wore an N95 (five days) or KN95 (seven days) unless it became soiled or damaged before that time. Nurse #1 stated N95s were given to her by the Administrator in a plastic bag every five days for N95s and every seven days for KN95s

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(ii) The LTC Infection Control Assessment completed 4/6/20 was reviewed by the: Medical Director, Infection Preventionist, and QAPI Committee members and the Contracted Consultant 1/28/21.

(iii) Facility has contracted with a Consultant who has completed specialized training in Infection Prevention and Control effective date 1/28/2021 for a duration of six (6) months to assist in 1) in-services specific to the issues cited if needed 2) assist with root cause analysis 3) Assist with development of the plan of correction 4) assist with development/review of the facility Infection Control assessment 5) routine visits to assist with monitoring infection prevention/control practices 6) written report with findings, recommendations if any will be provided following each visit.

- 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

The following areas will be audited to ensure the education and process changes were effective. These audit tools will be conducted 6 times daily for ten days and then 30 times weekly for the next thirty days, and then 15 times weekly for the next thirty days, and then 7 times weekly for the next twenty days. These audits will be conducted by the interdisciplinary team including DHS,

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F 880	Continued From page 8 and she could ask the Administrator for a new facemask if hers became soiled or damaged. Nurse #1 stated if he was not available, she could ask the nurse supervisor on duty. Nurse #1 stated that, at the end of her shift, she either took her mask with her when she left the facility either in a plastic bag or she may not have put it in a bag at all. A phone interview with Nurse #2 on 12/29/2020 at 3:51 pm revealed she was assigned to the 400 hall from 7:00 am to 7:00 pm on 12/28/2020 and 12/29/2020. Nurse #2 stated her assignment included both COVID-19 positive and COVID-19 negative residents over the last several weeks. Nurse #2 stated gowns and gloves, but not N95s or KN95s, were stored at the door of some of the COVID-19 positive rooms. Nurse #2 confirmed she wore the same N95 and face shield her entire shift and did not sanitize the shield during her shift. Nurse #2 revealed she had not been changing her facemask after providing care to a COVID-19 positive resident and before providing care to a COVID-19 negative resident because she had not been given enough facemasks by the facility to do so. Nurse #2 stated she was only issued one facemask every week and it was very hard to ask for another one if she needed it because they are stored in the Administrator ' s office. Nurse #2 revealed she had been changing her gown and gloves and washing her hands after providing care for a COVID-19 positive resident and before providing care for a COVID-19 negative resident, but did not disinfect her face shield unless it became soiled or dirty during her shift. Nurse #2 stated she was aware the Airborne Precaution signs were not the correct ones and stated she reported it to the Infection Preventionist, but the signs remained on	F 880	ADHS Nurse Navigator, MDS Case Mix Director, Dietician, Dietary Manager, Housekeeping Supervisor, Activity Director, Administrator, Maintenance Director, Clinical Coordinators, Medical Records, or their designees. •Observations of staff entering and exiting the Covid-19 positive rooms. resident rooms and adhering to the personal protective equipment policy appropriately, this includes the date, staff member being observed, personal protective equipment applied/removed correctly, KN95/N95 5 donning's and storage, face shield sanitized, and a comment section and observers initials. The results will be recorded on an audit tool. This audit tool is titled "Surveillance of Staff". •Observation of halls and rooms for appropriate personal protective equipment and Isolation Signs. This tool includes the date, the hall observed, personal protective equipment availability, Covid19 Doors closed, appropriate signs for Enhanced Droplet Isolation and Contact Precautions, a comment section, and observers' initials. . Results will be recorded on an audit tool titled "surveillance of PPE Areas". Results will be presented by the Director of Health Services to the Quality Assurance Performance Improvement Committee meetings monthly for 90 days then quarterly thereafter. The Quality Assurance Committee will assess and modify the action plan as needed to	

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F 880	Continued From page 9 the doors until the afternoon of 12/29/2020. Nurse #2 stated she keeps her used facemask in a plastic bag provided by the facility and takes it with her upon leaving at the end of her shift and brings it back the next day or shift until it is time for her to receive a new one. A phone interview with Nurse #3 on 12/29/2020 at 4:08 pm revealed she was not working at the facility on 12/29/2020 but has previously worked on the 400 and 600 halls, and her past assignments have included both COVID-19 positive and COVID-19 negative residents during the same shift. Nurse #3 stated she was issued a KN95 facemask once every seven days and revealed she had looked for additional facemasks at times during her shifts after hers became damaged and had to contact the Administrator because there were no extra masks on the supply carts. Nurse #3 stated she did not change her facemask or disinfect her face shield in between taking care of COVID-19 positive and COVID-19 negative residents because she didn ' t know she was required to, and she wouldn ' t have had enough facemasks to do so. Nurse #3 stated she wore gloves and a gown when providing care to a COVID-19 positive resident, discarded them and washed her hands before leaving the resident ' s room. Nurse #3 stated she does not store her used facemask in any type of bag and takes it with her when she leaves the facility at the end of her shift. Nurse #3 revealed she would identify a COVID-19 positive resident ' s room at the facility because she had been told by the Infection Preventionist the doors of COVID-19 positive residents had an Airborne Infection Isolation Precaution signs posted on each door. A phone interview with NA #1 on 12/30/2020 at 2:20 pm revealed most of her assignments at the	F 880	ensure continued compliance. Completion date: 2/4/2021.	

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facility occur on the 400 and 600 halls and her past assignments have included caring for both COVID-19 positive and COVID-19 negative residents during the same shift. NA #1 stated she was not working at the facility on 12/29/2020. NA #1 revealed she was issued a facemask an N95 or a KN95 about every seven days by the facility Administrator. NA #1 stated when she provided care to a COVID-19 positive resident, she wore a gown, facemask, face shield and gloves. NA #1 stated she did not change her facemask or disinfect her face shield after providing care to a COVID-19 positive resident because she was unaware that she needed to and stated she wouldn ' t have had enough facemasks to do that. NA #1 revealed supplies such as gowns and gloves were available on the 400 and 600 halls, but N95s and KN95s were not readily available. NA #1 stated the COVID-19 positive rooms were identified on the 400 and 600 halls by the Airborne Infection Isolation Precautions signs posted on them. NA #1 revealed she asked the facility Infection Preventionist if the Airborne Precautions were the correct precautions for COVID-19 positive residents, but the Infection Preventionist did not provide an answer for her. NA #1 added her normal practice does not include disinfecting her face shield or exchanging her mask after providing care to a COVID-19 positive resident and before providing care to a COVID-19 negative resident.

An interview with the Infection Preventionist on 12/29/2020 at 12:35 PM revealed Airborne Infection Isolation Precautions signage was used throughout the facility for COVID-19 positive residents and room doors were to be closed. She stated the facility was using Airborne

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Infection Isolation Precautions signage because the Enhanced Droplet/Contact Precaution signs stated staff must be fit tested for N95 masks to enter the COVID-19 rooms, and none of the facility staff had been fit tested. She added she had received the newest CDC Enhanced Droplet Precaution signage a month or so ago but had not posted them for this reason. In addition, she revealed staff should discard gown, gloves and facemasks, wash hands with soap and water and sanitize face shields when exiting a COVID-19 positive resident ' s room and before providing care to a COVID-19 negative resident. She also stated facility staff had been educated using an online module on the topic of generalized Infection Control-Coronavirus (COVID-19). Continued attempts were made to contact the Infection Preventionist by the facility Administrator and Surveyor for further interviews on 12/30/2020, 12/31/2020 and 01/01/2021 but were unsuccessful.

An interview with the Director of Nursing (DON) on 12/29/2020 at 10:46 AM revealed as a result of the facility's number of COVID-19 positive residents and the designated COVID-19 unit being full, COVID-19 positive residents were housed on the 400 and 600 halls which also housed COVID-19 negative residents. She added the COVID-19 positive resident rooms could be identified throughout the two halls in no specific order and by the signage of Airborne Infection Isolation Precautions posted on the doors along with the doors to these resident's room would also be closed. She revealed the facility did not have a negative pressure room and she was not sure why signage of Airborne Infection Isolation Precaution had been posted by the Infection Preventionist. An additional phone

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F 880	Continued From page 12 interview with the DON on 12/30/2020 at 8:48 AM revealed staff should remove all PPE, including gowns, gloves, and face masks, wash hands with soap and water and sanitize face shields each time when exiting the COVID-19 positive resident ' s room and before providing care to a COVID-19 negative resident. She added all employees were educated on this process via online module between the dates of 10/11/2020 to 11/17/2020. An additional interview with the DON on 12/30/2020 at 4:07 PM revealed PPE such as gowns and gloves were available for COVID-19 positive residents inside the specific COVID-19 rooms and supply carts could be found on certain hallways. She stated staff, including herself, used plastic bags to store their used facemasks for the next assigned shift and stated she took her used facemask with her when she left the facility at the end of the work day and brought it back the next day. She stated the Administrator provided the instruction to her to place her facemask in a plastic bag at the end of her day/shift. She added the Administrator issues N95 masks every 5 days and KN95s every 7 days and supplies of these facemasks were stored in his office and if he was not available, staff could request additional facemasks through the nurse supervisor if needed. An additional phone interview on 01/02/2020 at 12:14 pm revealed that additional gowns and gloves, as well as facemasks, could be found up and down hallways on carts that resemble bedside tables and added she did not know the exact number of carts that were on hallways throughout the facility and a few additional masks could be found on a nurse ' s cart on the 400 & 600 halls. She added she was not sure why she or the staff were using plastic bags instead of paper bags as required per facility policy, but stated she preferred plastic	F 880		

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F 880	Continued From page 13 bags as she felt they were a little bit safer. An interview with the Administrator on 12/29/2020 at 12:48 PM revealed all residents who were COVID-19 positive were to have doors closed and there were residents on the 400 and 600 halls who were COVID-19 positive and COVID-19 negative. A phone interview with the Administrator on 12/30/2020 at 9:10 AM revealed signage of Enhanced Droplet Contact Precautions should have been posted on the outside of all COVID-19 positive resident ' s rooms throughout the facility, including the COVID-19 unit. During an additional phone interview on 01/01/2021 at 11:07 AM, the Administrator confirmed the COVID-19 positive residents residing on the 400 and 600 halls on 12/29/2020 had tested positive on 12/28/2020 and were not immediately moved the same day away from COVID-19 negative residents because of not having enough staff to deep clean rooms and other residents needed to be moved around to make room for the COVID-19 positive residents. He added he felt it was not humanly possible to move the COVID-19 positive residents on 12/28/2020 on the day they tested positive. He continued and stated COVID-19 positive residents on the 400 and 600 halls were moved to the 100, 200, 300 and 500 halls of the facility during the late afternoon/evening of 12/29/2020 and Airborne Infection Isolation Precaution signage had been replaced with Enhanced Droplet Contact Precaution signage for COVID-19 positive residents throughout the facility. He stated the Airborne Precaution signs had been used throughout the facility for COVID-19 positive residents because the Infection Preventionist had informed him the Enhanced Droplet Contact Precaution signs used verbiage that staff must be fit tested to enter the	F 880		

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F 880	Continued From page 14 COVID-19 positive rooms. He added the remaining residents on the 400 and 600 halls were COVID-19 negative with Enhanced Droplet Contact Precautions signage posted on the doors. He added the facility had not been low on PPE supplies, including N95s and KN95s, and he distributes KN95 facemasks to staff every seven shifts and N95 facemasks every five shifts and instructed staff to store their masks (KN95s or N95s) in a plastic bag until it is needed for the next shift -- and most staff take it with them when they leave the facility at the end of their shift and bring it back for their next assigned shift. An additional phone interview on 12/31/2020 at 11:17 AM revealed he was not aware of the CDC guideline of Crisis Capacity Strategies updated on November 23, 2020 that recommended limiting the number of facemask reuses to no more than five uses (five donnings) per device to ensure adequate respirator performance. An additional interview on 01/01/2021 at 11:07 AM revealed the reason the facility staff were using plastic bags instead of paper bags per facility policy was due to not having an abundance of paper bags. He stated the facility was using low-density, resealable plastic bags to store used N95s and KN95s. A phone interview on 12/31/2020 at 10:11 AM revealed staff should remove PPE, including facemasks, and sanitize face shields in between providing care for COVID-19 positive and COVID-19 negative residents. He stated facemasks had been made available through the nursing supervisor, at nursing stations and carts on hallways. A phone interview with the Nurse Navigator/Liaison on 01/05/2020 at 11:32 AM revealed her working schedule on 12/28/2020 was from 8am-5pm and was assigned to help with employee COVID-19 testing. She stated she	F 880		

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assisted staff at times during the day shift hours if needed and added she did not remember receiving a call from staff asking for a replacement face mask during the hours she was at the facility on 12/29/2020. She stated if she had received a call from staff requesting a new facemask, she would have asked the Administrator to issue one for the requested staff member. She added facemask supplies, such as N95s and KN95s, as of 12/29/2020 were kept in the Administrator ' s office.

An interview with the Environmental Maintenance Director on 01/05/2020 at 2:14 pm revealed there had not been any PPE shortages throughout the COVID-19 pandemic and shipments had arrived regularly. He added he was responsible for ordering and receiving PPE supplies.

On 01/01/2021 at 6:11 PM, the Administrator was notified of the immediate jeopardy by phone.

The facility's credible allegation of immediate jeopardy removal for F-880 Infection Prevention and Control included the following:

1.) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the non-compliance.

All residents have the potential to be affected by the infection control breaches.
Observations on 12/29/20 on the 400 and 600 halls revealed the doors to all 12 rooms with COVID-19 positive residents were not closed and all rooms with COVID-19 positive residents throughout the facility had signage for Airborne Precautions, which does not include the verbiage to don gown and gloves prior to entering the

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room. Staff were not changing personal protective equipment (PPE) specifically facemasks (N95 and KN95 respirator masks) and disinfecting face shields/goggles per The Centers for Disease Control and Prevention (CDC) guidance between positive and negative residents. Staff were not storing respirator masks in paper bags per the facility policy and reported during interviews they wore the same facemask for five to seven days.
Interviews with staff revealed they did not have access to additional N95 or KN95 respirator masks for changing between COVID-19 positive and COVID-19 negative residents.
The Administrator and Director of Nursing were not aware of the CDC guideline of Crisis Capacity Strategies updated on November 23, 2020 recommended limiting the number of facemask reuses to no more than five uses (five donning ' s) per device to ensure adequate respirator performance.
As of 12/29/20, 69 of 138 residents have tested positive for COVID-19 for the December outbreak.

2.) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

All positive residents have been moved as of 01/01/2021 to COVID positive halls 100, 200, 300, 500, 600, and 700 hall. Rooms 710 & 709 are negative residents separated from the rest of 700 hall on the Memory Support Unit.
All negative residents have been moved to the 400 hall and rooms 710 and 709 on the Memory Support Unit. Residents that test positive will be moved to a COVID-19 positive hall. If there is not

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a room on a COVID-19 positive hall, they will be placed in a private room under enhanced droplet contact precautions.

The Nurse Navigator, Consultants, Interim DON, Nurse Supervisors and Case Mix Director have been assigned to retest all staff and residents that tested negative every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive results.

On 01/02/2021, The Nurse Navigator, Consultants, Interim DON, Nurse Supervisors, and Case Mix Director were educated on the CMS guidance on testing for Facilities with a new COVID-19 positive case. They were also assigned to testing and moving residents.

The correct signage of Enhanced Droplet Isolation and Contact Precautions signage has been placed on all COVID-19 rooms on 100, 200, 300, 500, 600, 700 halls as of 01/01/2021, and will be placed on any new COVID-19 rooms as needed. The Clinical team (Interim DON, ADON, Infection Control Nurse, Unit Manager, Education Nurse, Nurse Consultants (SPICE trained and Clinical Supervisors) is responsible for placing the signage on each positive room. The Clinical Team including the Interim DON and Consultants (SPICE Trained) were notified of this assignment on 01/01/2021.

The Area Vice President educated the Administrator and Director of Nursing on 12/29/2020, the use and storage of N95 and KN95 and reuse of mask per the CDC guidelines utilizing the PruittHealth COVID-19 Pandemic

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F 880	Continued From page 18 Isolation and Cohorting Process for Healthcare Centers. Corporate sent a revised policy on 01/05/2021 to provide the language directly in relation to CDC guideline of Crisis Capacity Strategies updated on November 23, 2020 recommending limiting the number of facemask reuses to no more than five uses (five donning's) per device to ensure adequate respirator. This change was made for quick reference on the policy related to the five donning's, but the policy did have the link to the Crisis Capacity Strategies referenced on original policy (effective 4/24/20). The Clinical Team (DHS, ADHS, Interim DHS, Consultants, Nurse Navigator, Nurse Supervisors) started education for all 180 staff in departments on 12/29/2020 regarding these areas: Enhanced Droplet Isolation and Contact Precautions, keeping doors closed for COVID-19 positive residents, donning and doffing of PPE per CDC guidance to include, appropriate donning and doffing of PPE between COVID-19 positive residents and non COVID-19 residents, donning ' s of KN95/N95 for 5 donning ' s only (taking the mask off to eat and/or drink fluids counts toward the total number of donning ' s), cohorting of positive residents with positive residents and negative residents with negative residents and face shield/goggle disinfecting process. Staff that has not been educated by 01/04/2021 will not be allowed to work until they have been in-serviced. The Interim Director of Nursing and her clinical team will ensure that the education is completed by staff. There is an Interim DON that has been appointed and a Nurse Consultant have been assigned to assist this facility that will provide Infection Control	F 880		

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Monitoring and to assist the Interim DON.
On 01/02/2021, education began for all staff on the process of keeping paper bags in the facility to store their KN95 & N95 after their shift. The masks are stored in the Ante Room at the top of 100 Hall. There is an Isolation Cart that will be used to store masks in paper bags that each staff member will leave after their shift. They will label their bag with their name and they are able to wear for five donning ' s. It was explained to staff each time they don their mask during a shift counts toward the five total donning ' s. This would include doffing and donning a N95 or KN95 for any reason, including eating and drinking. After a mask has been donned five times, staff are responsible to getting a new mask at the PPE stations. They will replace with a clean surgical mask to exit the building. When staff enter the building, they will receive a clean surgical mask and proceed to the ante room and retrieve their mask before their shift. Staff that have not been educated as of 01/04/2021 will not be allowed to work until they complete this education prior to their next shift.

The Dietary Manager was notified he will supply the paper bags and be responsible for storing them in the ante room, on 01/02/2021.

The Maintenance Director and his designee(s) is/are responsible for ensuring there are adequate masks and PPE available at the donning tables and nurses' station daily. The Maintenance Director and/or designee will utilize an inventory tracker to maintain par levels for each station. The Maintenance Director and his designees were educated on this process on 01/03/2021. The storage of the bulk of the PPE items are in the facility warehouse on property

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site. The Maintenance Director will order supplies based on needs weekly through our corporate vendor.

Each hall has two donning/supply stations with PPE. The exception to this is the 400 hall, which is a non-COVID-19 hall. This area has one donning/supply station.

On 01/02/2021, the Interdisciplinary (IDT) Team met and reviewed the Surveillance forms that were created to ensure the education below is being followed. Infection Control surveillance as it applies to PPE available at hall stations, signage appropriate for COVID-19 Rooms, and COVID-19 doors closed surveillance rounds. The second Surveillance Form identifies staff observed applying and removing PPE, KN95 and N95 Mask Storage, and Face Shield/Goggles disinfecting. Each audit tool will be conducted at least six times per day by members of the IDT to ensure these policies are being followed and implemented appropriately, per the credible allegation. This was assigned on 01/03/2021. On each Audit tool there is a comment section, as well. Additional education will be provided for not following policy and or disciplinary actions for staff members that have been educated and unable to or not willing to follow the policies. The Interdisciplinary Team includes, but is not limited to, Interim DON, ADON, Nurse Navigator, Administrator, Dietician, Clinical Consultants, Social Worker, and Activity Director.

PruittHealth Corporation updates the policies and procedures from the CDC guidance and once the policy/procedure is updated the policy is released to the facilities. The Administrator will check daily for updates and pull the newly released policies

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F 880	Continued From page 21 and educate Department Managers who will educate their departments on newly released policies/procedures. The Corporate office is responsible for updating policies and procedures. PruittHealth Raleigh alleges the removal of Immediate Jeopardy on 01/05/2021. On 01/11/2021 at 9:27 AM, the facility ' s credible allegation for immediate jeopardy removal was validated by the following: -observation of the facility's COVID-19 residents to ensure doors were closed and Enhanced Droplet Isolation Contact signage was posted -observation of staff assigned to COVID-19 residents to verify use of PPE according to the CDC guidelines and facility 's policy -observation of staff wearing appropriate PPE, donning/doffing stations throughout each hall, -review of COVID-19 positive and COVID-19 negative residents to ensure room assignments in the facility were according to their COVID-19 test results and/or respiratory signs and symptoms. -review of testing schedule for new cases of COVID-19 staff or residents for a period of at least 14 days since the most recent positive results. -review of education logs for The Nurse Navigator, Consultants, Interim DON, Nurse Supervisors, and Case Mix Director on the CMS guidance on testing for Facilities with a new COVID-19 positive case. -review of education log for the Administrator and Director of Nursing on the use and storage of N95 and KN95 and reuse of mask per the CDC guidelines utilizing the PruittHealth Covid19 Pandemic Isolation and Cohorting Process for Healthcare Centers.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345538	A. BUILDING ______ B. WING ______	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-RALEIGH	2420 LAKE WHEELER ROAD RALEIGH, NC 27603

(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 22 - Multiple staff were interviewed and verified they had received education of COVID-19 to include the importance of donning and doffing N95s and K95s a maximum of five times, recognizing Enhanced Droplet/Contact Isolation signage and storing used masks in a paper bag in between encounters and when not at the facility. The facility's date of immediate jeopardy removal of 01/05/2021 was validated.	F 880		