STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345282	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND PINES	1404 N LAFAYETTE STREET SHELBY, NC 28150

(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
E 000	Initial Comments A recertification survey was conducted on 06/07/2021 through 06/10/2021 The facility is in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID: WNIQ11.	E 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to ensure the Minimum Data Set (MDS) was accurate for 2 of 3 residents reviewed for diagnosis and medication (Resident #6, Resident #43), 1 of 1 residents reviewed for Hospice (Resident #80) and one of one residents reviewed for Restraints (Resident #60). 1.Resident #6 was admitted to the facility on 11/04/20 with multiple diagnosis which included chronic pain and chronic neuropathy. Resident #6's quarterly Minimum Data Set (MDS) dated 05/18/21 revealed Resident #6 required limited assistance with activities of daily living (ADL) and was not coded for active diagnosis of depression. Resident #6 was coded as receiving 0 antidepressant medications during the assessment period. A nursing progress note dated 03/08/21 revealed Resident #6 had stated to a staff member that he felt like killing himself at times. He was referred to	F 641	Disclaimer: Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Cleveland Pines Nursing Center does ensure the compliance of accuracy of assessments to accurately reflect the resident's status at all times. Resident #6 MDS Assessment ARD/5/18/21 will be modified to include active diagnosis of depression in section I and use of antidepressant medication in section N. Resident #43 MDS assessment ARD 4/14/21 will be modified to include active diagnosis of both major depressive disorder and hyperlipidemia in section I and the use of antidepressant medications in section N. Resident #80 MDS assessment ARD 4/30/21 will be	7/16/21

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

Electronically Signed | 07/02/2021

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F 641	Continued From page 1 the Psych Physician for a consultation. A Physician order dated 03/10/21 revealed an order for Sertraline (antidepressant) 25 milligrams (mg) to be taken one by mouth daily due to a diagnosis of depression with anxiety with a discontinue date of 06/21/21. A Physician order dated 05/22/21 revealed an order for Sertraline 50 mg 1 daily by mouth with a discontinue date of 09/02/21 for a diagnosis of depression with anxiety. A joint interview was conducted with the MDS Nurse on 06/10/21 at 11:43 AM. Resident #6's electronic medical record revealed Resident #6 was taking an antidepressant medication during the assessment period for an active diagnosis of depression which had not been coded on the MDS. The MDS nurse stated she had just missed coding the active diagnosis and antidepressant medication by accident. An interview conducted with the MDS Corporate Consultant on 6/10/21 at 11:50 AM revealed Resident #6 was taking an antidepressant medication for an active diagnosis of depression. She stated she expected for depression to be coded on Resident #6's MDS. An interview conducted with the Director of Nursing (DON) on 06/10/21 at 4:20 PM revealed Resident #6's MDS should be accurately coded for active diagnosis. An interview conducted with the Administrator on 06/10/21 at 4:45 PM revealed there were errors on Resident #6's MDS and the resident's active diagnoses were expected to be coded correctly	F 641	modified to remove the coding of Hospice from section O of the MDS and Resident #60 MDS assessment ARD 4/27/21 will be modified to remove the coding of restraints from section P of the MDS. *All Modifications will be complete with submission and acceptance of the modifications by 7/02/21* Depression Diagnosis/Hyperlipidemia Diagnosis and Antidepressant Use: Pharmacy will provide the facility with a comprehensive list of all current residents currently receiving antidepressant and hyperlipidemia medications. Nurse Assessment Coordinators (or designee) will conduct a 100% audit of all residents receiving both antidepressant and hyperlipidemia medications to ensure those receiving the medications have accurate coding on the MDS in both sections I (I0100-I8000-Diagnosis) and section N (N0410- Medications) as applicable. This audit will be complete by 07/16/2021. Hospice Coding: The Hospice Services for Cleveland Pines Facility will provide a current list of all active residents on Hospice Services. Nurse Assessment Coordinators (or designee) will audit 100% of MDS Assessments to ensure only those residents listed as active by Hospice Services are coded as such on their most recent MDS assessment as applicable pending start/stop dates for Hospice Services. This audit will be complete by 07/16/2021.	

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F 641	Continued From page 2 on the MDS. The interview revealed the facility had no recent in-servicing on MDS coding. 2. Resident #43 was admitted to the facility on 10/06/20 with multiple diagnoses which included major depressive disorder and hyperlipidemia. The quarterly Minimum Data Set (MDS) dated 04/14/21 indicated Resident #43 required extensive assistance with activities of daily living (ADL) and was not coded for active diagnoses of major depressive disorder and hyperlipidemia. A joint interview was conducted with the MDS Nurse and MDS Corporate Consultant on 06/10/21 at 11:50 AM. Review of Resident #43's electronic medical record revealed the resident had an active diagnosis for Major Depressive Disorder dated 01/25/21. The interview further revealed the MDS Cooperate Consultant expected for depression to be coded on Resident #43's MDS. An interview conducted with the MDS Corporate Consultant on 6/10/21 at 2:30 PM revealed Resident #43 had an active diagnosis for Hyperlipidemia dated 10/23/20. It was further revealed the MDS Cooperate Consultant expected for Hyperlipidemia to be coded on Resident #43's MDS. An interview conducted with the Director of Nursing (DON) on 06/10/21 at 4:20 PM revealed Resident #43's MDS should be accurately coded for active diagnoses. An interview conducted with the Administrator on	F 641	Restraint Coding: Cleveland Pines is a Restraint free facility. Nurse Assessment Coordinators (or designee) will conduct a 100% audit using CASPER Reports and/or MDSI Reports in Cerner for section items P0100A-H to identify any potential coding errors for restraints. All errors identified will be modified immediately. This audit will be complete by 07/16/2021. Coding Depression and Hyperlipidemia Diagnosis: Both Nurse Assessment Coordinators will be re-educated by Director of Case Management and Compliance by 7/9/21 on how to properly code section I to reflect all active diagnosis pertinent to the MDS assessment as indicated in the RAI manual. This re-education will also include how to navigate the software system successfully to assist with identifying information from the medical record that will contribute to the coding of active diagnosis. Coding Antidepressant Medication Use in Section Item N0410C: Both Nurse Assessment Coordinators will be re-educated the Director of Case Management and Compliance by 7/16/21 on how to properly code antidepressant uses in section item N0410C per the RAI manual. This re-education will also include how to successfully navigate the software system successfully to assist with identifying information in the medical record that points to the need to code this item.	

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F 641	Continued From page 3 06/10/21 at 4:45 PM revealed there were errors on Resident #43's MDS and the resident's active diagnoses were expected to be coded correctly on the MDS. 3. Resident #80 was re-admitted to the facility on 02/12/21. The quarterly Minimum Data Set (MDS) dated 04/30/21 revealed Resident #80 required extensive assistance with activities of daily living (ADL) and was coded for Hospice care under special treatments, procedures, and programs. A Hospice progress note dated 01/23/21 revealed Resident #80 was discharged from Hospice care in need of no further services. A Physician order dated 02/09/21 revealed Resident #80 was ordered to be discharged from hospice care on 01/23/21. A joint interview conducted with the MDS Nurse and MDS Corporate Consultant on 06/10/21 at 11:50 AM revealed after review of Resident #80's electronic medical record the resident should have not been coded for Hospice due to being discharged before the last MDS review. An interview conducted with the Director of Nursing (DON) on 06/10/21 at 4:20 PM revealed Resident #80's MDS should have been accurate and should not have been coded with current Hospice care. An interview conducted with the Administrator on 06/10/21 at 4:45 PM revealed Resident #80 should not have been coded for Hospice care due to being discharged before the most current MDS	F 641	Hospice Coding: Both Nurse Assessment Coordinators will be re-educated by the Director of Case Management and Compliance by 7/9/21 on how to properly code for any residents utilizing Hospice Services in sections A, J and O of the MDS. Restraint Coding: Both Nurse Assessment Coordinators will be re-educated by the Director of Case Management and Compliance on how to properly code for any restraint use in section items P0100A-H. *All education will be complete by 07/09/2021* Coding Depression and Hyperlipidemia Diagnosis: Director of Case Management & Compliance (or designee) will audit the coding of these 2 diagnoses monthly from the list of all residents receiving antidepressants and hyperlipidemia medications weekly x 1 month, twice a month x 1 month and then monthly x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Coding Antidepressant Medication Use in Section Item N0410C: Director of Case Management & Compliance (or designee) will audit the coding of Section item	

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F 641	Continued From page 4 review. 4. Resident # 60 was admitted to the facility on 12/7/2020 with diagnoses of progressive neurological condition, dementia, and Parkinson's. Resident # 60's quarterly Minimum Data Set (MDS) dated 4/27/2021 revealed Resident # 60 required extensive assistance of one person for bed mobility, dressing, and personal hygiene. Resident # 60 required extensive assistance of two persons for transfers. The MDS indicated Resident # 60 required use of limb and trunk restraints. A review of Resident # 60's medical record revealed no orders or care plans for restraints. Observations of Resident # 60 on 6/6/2021 at 3:36 PM revealed she had a yellow nameplate outside her door (indicating she was a high fall risk). Resident # 60 was sitting upright with a half lap-tray on the right side of her wheelchair. Her right arm was resting on the tray. Resident # 60 was alert but did not respond appropriately to questions. The resident was observed on 6/9/2021 at 3:28 PM lying on her back in a low bed with a scoop mattress. On 6/10/2021 at 10:30 AM Resident # 60 was sitting upright in her wheelchair using her feet to mobilize in the hallway. The resident was observed to grab the wall and attempt to stand. She was observed to stand almost upright before a staff member redirected her. An interview with Nurse Aide # 1 (NA) on 6/10/2021 at 9:23 AM revealed Resident # 60 was a high fall risk. Interventions to prevent falls	F 641	N0410C against the Pharmacy list indicating all residents being treated with anti-depressants weekly x 1 month, twice a month x 1 month and then monthly x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Hospice Coding: Director of Case Management & Compliance (or designee) will use the most current list of active Hospice Residents supplied by the facility Hospice Care Services to audit for accurate coding of Hospice Services in section A, J and O of the MDS. These audits will take place weekly x 1 month, twice monthly x 1 month and then monthly x 1 month. Director of Case Management & Compliance (or designee) will audit the coding of Hospice services from the list of all residents receiving Hospice Services weekly x 1 month, twice a month x 1 month and then monthly x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Coding Restraints: Director of Case Management & Compliance (or designee) will use the MDSI Reports in the Cerner	

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F 641	Continued From page 5 included a low bed, a scoop mattress, gripper socks, room close to the nurse's station, and frequent checks. NA # 1 stated she was not aware of the use of any restraints in the facility. An interview with the MDS Nurse # 1 on 6/10/2021 at 11:54 AM revealed Resident # 60 did not utilize restraints. The Nurse stated she "clicked on restraints by accident" when completing the 4/27/2021 MDS. She stated she made the correction earlier today. An interview with the Safety Nurse (Nurse # 12) on 6/10/2021 at 2:50 PM revealed the facility was restraint-free. She stated residents who were a high falls risk were provided numerous interventions to prevent falls up to, but not including restraints. Interventions included yellow nameplates on resident doors, low beds, gripper socks, wheel locks for wheelchairs, call bells, personal items, sensory items and mobility aids (wheelchairs / walkers) all within reach and traffic paths clear of clutter. The Safety Nurse indicated Resident # 60 had a half lap-tray in place for support due to recent fracture of her right arm. As Resident # 60 can still get up, the lap-tray was not a restraint. The Safety Nurse also informed a neurologist had ordered an abdominal binder for hypotensive episodes, but the binder was only placed around the resident's abdomen and was not used to secure her to the wheelchair. An interview with the Director of Nursing on 6/10/2021 at 4:30 PM revealed the facility did not utilize restraints for any resident. She stated the MDS entry for restraints must have been completed in error. She stated her expectation of the MDS was for it to be coded correctly.	F 641	Software System to audit for any erroneous MDS coding of restraints. Director of Case Management & Compliance (or designee) will audit coding of section items P-0100A-H for the presence of any restraints, as Cleveland Pines is a restraint free facility. Audits will take place weekly x 1month, twice monthly x 1 month and monthly x 1 month. Director of Case Management & Compliance (or designee) will audit the coding of Restraints weekly x 1 month, twice a month x 1 month and then monthly x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. *All audits will begin the week of 07/12/2021. * POC Completion Date: 7/16/2021	

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F 641	Continued From page 6 An interview with the Facility Administrator on 6/10/2021 at 4:55 PM revealed the facility was restraint-free. She stated the MDS was most likely coded in error. Her expectation of the MDS was that it be coded accurately.	F 641		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to dispose of expired perishable food items in 1 of 1 cooler. Staff drinks were observed to be stored alongside resident food items in the kitchen freezer. The facility also failed to dispose of expired foods and date individual cartons of juice and bottled drinks in 1 of 2 resident nourishment rooms.	F 812	DISCLAIMER: Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal	7/16/21

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F 812	Continued From page 7 The findings included: a. An observation of the cooler was made on June 7, 2021 at 10:50 AM with the Dietary Manager (DM). The observation revealed the following: A container of tuna salad three-fourths full, with an expiration date of June 4, 2021 written on the container A container of chicken salad, full, with expiration date of May 31, 2021 written on the container b. An observation of a freezer was made on June 7, 2021 at 11:15 AM. The DM was present. The observation revealed the following: Two staff members' drinks were stored alongside food items in a freezer reserved for food for resident consumption. c. An observation of the nourishment room on the 200 hall was completed on June 9, 2021 at 11:25 AM. A staff nurse was present. The observation revealed the following: An intact box of thickened apple juice with "use by March 26, 2021" stamped on the box inside the cabinet. A bin of prune juice containers in the refrigerator with no expiration dates on the containers in the refrigerator. 3 bottled drinks with no expiration dates on the bottles in the refrigerator (Available for any resident consumption)	F 812	and State law. Cleveland Pines does ensure that food safety requirements are met daily and that food is stored, prepared, distributed, and served in accordance with professional standards for food service safety. Expired items and drink items not dated were discarded immediately. Staff drinks were discarded, and on 6/11/21, in a non-food prep area, a temporary refrigerator was added and labeled "staff only" to accommodate staff usage until the permanent refrigerator could be installed on 7/7/21. All dietary staff were in-serviced by the Dietary Manager on 6/11/21 on the topics of discarding expired food items, properly labeling and dating all food items (including drink items) and ensuring staff drinks are not mixed in with resident food items. The training included: who is responsible for monitoring for outdated products, labeling and dating standards per HACCP Plan, "first in/first out procedures. Dietary Aides will check nourishment rooms daily; Dietary Supervisor will check nourishment rooms 2 times daily to ensure that proper FIFO compliance is followed. Dietary Manger will complete audits of nourishment rooms 2 times weekly to ensure proper FIFO compliance. PM Cook will check reach -in and walk in coolers/freezers in the main kitchen daily with GM checking 2 times weekly to ensure proper FIFO compliance. Any staff members who did	

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F 812	Continued From page 8 4 containers of vanilla pudding with expiration dates of May 2021. An interview was conducted with the DM on June 7, 2021 at 11:15 AM. The DM stated the expired items in the cooler should have been disposed of at the end of the shift on the day of expiration. He stated opened items should have had the open date written on the package. The DM stated staff thermoses should not be stored alongside items for resident consumption. An interview with the Director of Nursing on June 9, 2021 at 11:55 AM revealed the nourishment rooms were checked daily by dietary staff. She stated the check included review of expiration dates. She indicated the items must have simply been missed. She stated, "all we can do now, is do better." An interview with the Administrator on June 10, 2021 at 4:50 PM revealed the food items in the kitchen cooler should have been discarded on the expiration date, the opened items should have been labeled with an opened date, and the nourishment room items should have been checked more closely and disposed of accordingly. She could not explain why personal mugs were stored in the dedicated resident freezer. She stated the DM was still very new to long-term care and would make sure corrections were made.	F 812	not receive the training by 6/11/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and will be added to the new hire orientation. Beginning 7/02/21, Kitchen Supervisor will now conduct daily checks of expired food items, dating drink items, and ensuring staff items are not located with resident food items. Beginning 6/22/21, Clinical Nutrition/DTR/RD or designee will conduct weekly audits of expired food items, dating drink items, and ensuring staff items are not located with resident food items. Clinical Nutrition /DTR/RD will check nourishment rooms 3 times a week x 1 month, 2 times a week x 1 month and then 1 x a week x 1 month with an excel spreadsheet design that will be provided to Food Service and Administration weekly as well as monthly. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator, Director of Nursing, and RD on a weekly basis and with QAPI quarterly review for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Completion Date for Tag F812 is July 16, 2021	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		7/16/21

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F 880	Continued From page 9 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §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,	F 880		

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F 880	Continued From page 10 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 record review, observations and staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 1 of 3 staff members (Staff #1) failed to discard her N95 mask and disinfect her goggles after leaving a quarantine room and before going to a non-quarantine room, 1 of 3 staff members (Staff #2) had no eye protection while in the quarantine room, and 1 of 3 staff members (Staff #3) wore a surgical mask and had no eye protection while in	F 880	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. On 6/10/21, Infection Control Nurse conducted in-service with the physician on	

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F 880	Continued From page 11 a quarantine room. These practices affected 4 of 4 residents (Resident #235, Resident #338, Resident #285 and Resident #322) reviewed for infection control. These failures occurred during a COVID-19 pandemic. The findings included: The Centers for Disease Control and Prevention (CDC) guideline entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/23/21 indicated, in part: *The Personal Protective Equipment (PPE) recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: 1. Respirator - Put on an N95 respirator (or equivalent or higher-level respirator) before entry into the patient room or care area, if not already wearing one as part of extended use strategies to optimize PPE supply. Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or re-use. Perform hand hygiene after removing the respirator or facemask. 2. Eye Protection - Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. Remove eye protection after leaving the patient room or care area, unless implementing extended use. Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to	F 880	donning and doffing of PPE and updated changes from CDC. Re-education was also given to the other 2 staff members that were identified during the survey to ensure that everyone was understanding of the current policies and procedures with PPE use. Beginning 6/11/21, Infection Control Nurse conducted in-services with all staff on donning and doffing of PPE and updated CDC guidelines for use of PPE. Any staff members who do not receive the training by 7/2/21 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. On 6/11/21, the following Practice Change Alert was issued: A new N95 must be donned prior to providing care for each resident. Procedure: Perform hand hygiene; Doff surgical mask; Perform hand hygiene; Don N95 that you are fit tested to/PAPR, and other PPE per signage; Provide resident care; Upon exit remove and discard gown and gloves, perform hand hygiene, remove and discard N95; remove and clean eye protection; Perform hand hygiene. Infection Control Nurse included the Practice Change Alert as part of the in-service education. On 07/01/21 the facility completed a Root Cause Analysis (RCA) with the assistance of the Corporate Infection Preventionist, Quality Assurance and Performance	

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F 880	Continued From page 12 manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or re-use. A review of the facility's COVID-19 policy entitled, "COVID-19 Resident/Teammate Management - COVID Outbreak Response," revised on 3/2021 indicated the following statements under PPE Enhancement: 1. Respiratory protection should be worn at all times when not eating or drinking in the facility. Eye protection for all patient care. 2. For hallways/neighborhoods with two or more cases, teammates shall wear N95 or equivalent respirator for all resident care for the duration of the outbreak. 3. If the outbreak extends beyond a single hallway/neighborhood, routine N95 use will be expanded as appropriate. The facility did not have a policy regarding PPE use and management for staff members when working in the quarantine hall designated for new admissions and re-admissions. 1. A continuous observation was made of Staff #1 on 6/9/21 from 8:14 AM to 9:08 AM during medication administration. During the observation, a sign for special droplet/contact precautions was on Resident #235's room door. While preparing Resident #235's medications in the hallway, Staff #1 was observed wearing a surgical mask and goggles. As she got ready to enter Resident #235's room, Staff #1 discarded the surgical mask, used hand sanitizer and put on	F 880	Improvement (QAPI) committee of the facility and Governing Body and developed the intervention plan. Beginning 6/22/21, Infection Control Nurse or designee will conduct weekly audit of correct PPE usage 3 times a week x 1 month, 2 times a week x 1 month, then 1 time a week x 1 month. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator and Director of Nursing on a weekly basis and with QAPI quarterly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. Completion Date for F880 is 7/16/21	

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an N95 mask on her face. She proceeded to put on a gown and gloves and entered Resident #235's room to administer her medications. Before leaving the room, Staff #1 removed her gown and gloves and washed her hands in the room sink. Staff #1 exited Resident #235's room and did not discard her N95 mask or disinfect her goggles. At 8:26 AM, Staff #1 entered Resident #338's room who was not on special droplet/contact precautions and asked Resident #338 what she wanted to drink. Staff #1 then proceeded to walk from the 400 hallway and passed through 100 hall to the nourishment room that was located on the 200 hall. After obtaining some juices out of the refrigerator, Staff #1 went back to Resident #338's room to give her medications. At 9:08 AM, Staff #1 entered Resident #285's room who was not on special droplet/contact precautions and asked Resident #285 what he wanted to drink with his medications.

An interview conducted with Staff #1 on 6/9/21 at 9:09 AM revealed she forgot and should have discarded her N95 mask when she left Resident #235's room who was on special droplet/contact precautions. Staff #1 confirmed that Resident #235 was currently the only newly admitted resident on the hall who was on special droplet/contact precautions. Staff #1 stated that she had been told to leave her goggles on the whole time she was working and to only clean it between shifts unless it was visibly soiled.

An interview with the facility's Infection Preventionist on 6/9/21 at 4:28 PM with the Administrator present revealed Staff #1 should have discarded her N95 mask and sanitized her goggles when she exited Resident #235's room.

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An interview with the organization's Infection Preventionist (IP) on 6/10/21 at 11:15 AM revealed the facility had been practicing extended use for N95 mask and eye protection. The staff members had been trained not to remove their N95 mask and goggles once they put them on, treat both PPE as part of their face and not to touch their face. The organization's IP stated they felt there was a higher chance of contamination with constantly touching their masks to remove them. She explained that the facility was following the organization's infection control policies and procedures.

An interview was conducted on 6/10/21 at 4:26 PM with the Director of Nursing (DON) who stated she did not expect Staff #1 to discard her N95 mask and disinfect her goggles after exiting a room on special droplet/contact precautions because that was not what they were trained to do. The DON stated the facility was following the organization's infection control policies and procedures which included to discard their masks and disinfect their goggles at the end of the day.

An interview with the Administrator on 6/10/21 at 4:51 PM revealed she expected Staff #1 to have done what she was trained to do related to PPE use. She added that it was hard to keep up with the CDC guidelines because they kept on changing all the time.

2. An observation was made on 06/09/21 of Staff #2 entering Resident #235's room who was on enhanced droplet contact precautions according to the sign on the resident's door. He entered Resident #235's room at 12:40 PM with an N95 mask on but no goggles or face shield. Resident #235 was admitted to the facility on 06/08/21, and

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according to her discharge summary from the hospital, was not vaccinated for COVID-19 and had refused vaccines while hospitalized so the resident was placed on enhanced droplet/contact precautions for 14 days. Staff #2 was observed approximately 2 feet from the resident while obtaining her history and exited the room at 1:21 PM.

An interview was conducted on 06/09/21 at 2:59 PM with Staff #2. He revealed he had been involved from the beginning through their Quality Assurance and Process Improvement program with COVID-19. He stated he and the Nurse Practitioner (NP) work closely together in managing the residents at the facility. He further stated they were following the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) guidance for nursing homes in caring for the residents at the facility. He mentioned the hospital organization the facility belonged to had also provided education and guidance to the facility staff on COVID-19. Staff #2 indicated he and the staff at the facility were following the protocols and were wearing all the appropriate Personal Protective Equipment (PPE) when caring for the residents.

An interview with the facility's Infection Preventionist (IP) on 06/09/21 at 4:28 PM with the Administrator present, revealed Staff #2 was expected to wear goggles when in resident rooms who were on enhanced contact/droplet precautions.

An interview with the organization's IP on 6/10/21 at 11:15 AM revealed the facility was following the organization's infection control policies and

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procedures. The organization's IP stated Staff #2 was expected to wear goggles while in resident rooms who were on enhanced contact/droplet precautions.

3. Resident #236 was admitted to the facility on 06/09/21, and according to her discharge summary from the hospital, was not vaccinated for COVID-19 and had refused vaccines while hospitalized so the resident was placed on enhanced droplet/contact precautions for 14 days. On 06/09/21 at 1:29 PM Staff #3 was observed entering Resident #236's room with gown, gloves and surgical mask on but no N95 mask and no goggles or face shield on to deliver the resident a pitcher of water. Staff #3 was observed exiting the room, doffing her gown and gloves.

An interview on 06/09/21 at 1:35 PM with Staff #3 revealed she had not paid attention to the sign on the resident's door for enhanced droplet/contact precautions and the need for an N95 when going into the room. She stated she was concentrated on getting the resident some water to drink and had not read the sign before entering the room. Staff #3 stated she had received training regarding wearing the appropriate Personal Protective Equipment (PPE) into the room of a resident on enhanced contact precautions but stated she had failed to put on an N95 mask and goggles prior to going into Resident #236's room.

An interview with the facility's Infection Preventionist on 6/9/21 at 4:28 PM with the Administrator present revealed Staff #3 should have donned an N95 mask and goggles prior to going in Resident #236's room and should have

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F 880	Continued From page 17 discarded the N95 when leaving the room and donned a surgical mask for source control. An interview with the organization's Infection Preventionist (IP) on 6/10/21 at 11:15 AM revealed the facility was following the organization's infection control policies and procedures. The organization's IP stated the staff were expected to wear an N95 and goggles while in resident rooms who were on enhanced contact/droplet precautions. The organization's IP further stated they had been practicing extended use for N95 mask and eye protection.	F 880		