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E 000	Initial Comments An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted onsite 08/16/21 - 08/17/21 and remotely through 08/18/21. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# SFXE11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and infection control complaint investigation was conducted onsite 08/16/21 - 08/17/21 and remotely through 08/18/21. The facility was not found in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. One of one infection control complaint allegation was cited with deficient practice. Event ID # SFXE11.	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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		9/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/10/2021

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 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 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.	F 880		

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F 880	Continued From page 2 §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 the facility's Infection Control Policy to 1) ensure staff were fully screened upon entering the facility for 3 of 7 staff screening logs reviewed (Nurse #1, Activity Director #1, and Nurse Aide #1) and to ensure staff recorded a body temperature on 1 of 7 staff screening logs (Nurse Aide #1), and ensure staff were screened per faciltiy policy prior to entering the facility for 3 of 7 staff screening logs reviewed (Nurse #1, Activity Director #1, Nurse Aide #1) 2) ensure staff donned full PPE (personal protective equipment) before entering a resident's room (Resident #5) who was on Enhanced Isolation Precautions during a facility outbreak of COVID -19 when a staff member (Nurse Aide #2) was observed feeding a resident without wearing gloves, or a gown. 3) ensure staff donned and doffed PPE prior to entering and exiting resident rooms who were on Enhanced Droplet Precautions when Nurse Aide #1 was observed entering two residents rooms (Resident #4, #5) without donning the appropriate PPE and Certified Medication Aide #1 failed to remove	F 880	F880 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Element #1: The facility failed to maintain the Infection Control Policy to ensure staff were fully Covid 19 screened upon entering the facility for 3 of 7 staff screening logs reviewed and to ensure staff recorded a body temperature on 1 of 7 staff screening logs, and to ensure staff were screened per facility policy prior to entering the facility for 3 of 7 staff screening logs reviewed (Nurse #1, Activity Director #1, and Nurse Aide #1) A Fishbone/root cause analysis was conducted on 9/7/21/21 to identify root cause of the area identified in the 2567. The Root cause analysis was facilitated by the Administrator, Director of Nursing,	

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PPE prior to exiting 2 of 2 resident rooms.

Findings included:

1) A review of the facility policy titled, "Employee and Essential Healthcare Screening" effective 08/12/21 revealed staff, agency, and other essential healthcare personnel must be screened by the Infection Preventionist or designated licensed nurse on entrance or at the beginning of their assigned shift and prior to working with residents.

During a review of the staff screening log sheet for Nurse Aide #1 dated 08/14/21 - 08/16/21 revealed on 2 occasions (08/14/21 and 08/15/21) Nurse Aide #1 did not record a temperature or answer the health screening questions on the screening log prior to beginning his shift.

An interview was conducted on 08/16/21 at 5:20 PM with Nurse Aide #1. He stated no staff member was at the front desk to screen him when he arrived for his shift at 7:00 AM on 08/14/21 and 08/15/21. He reported he didn't have a screening log sheet in the notebook at that time, so he didn't complete the screening prior to starting his shift. Nurse Aide #1 indicated he did not have any symptoms and had not been exposed to COVID -19 when he arrived for work on 08/14/21 and 08/15/21.

During a review of the staff screening log sheet for Nurse #1 dated 08/13/21- 08/16/21 revealed on 3 occasions Nurse # 1 recorded a temperature on each date but failed to answer yes or no to the health screening questions. A partial line was drawn through the health questions on each date but yes or no was not recorded to indicate the

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and the District Director of Clinical Services. The Root cause analysis revealed staff did not follow our Infection control measures in place related to Covid 19 staff screening and was reviewed with the QAPI committee 9/9/21, and incorporated into the facility plan of correction below. The Directed Plan of Correction will be completed for all staff educations and inventions.

Nurse #1, Activity Director #1, and Nurse Aide #1 had no adverse outcome from not following the Infection Control policy and procedure for Covid -19 staff screening. Nurse #1, Activity Director #1 and Nurse Aide #1 were immediately educated on the Covid 19 screening process that must be completed prior to entering the facility , also to include body temperatures and completion of all screening questions 8/17/21 by the Director of Nursing.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:
Element #1: In-service education was provided by the Director of Nursing and the Interim ADON beginning 09/03/21 and will be completed by 9/7/21 on the Infection Control policy for Staff screening process for Covid 19 monitoring. An audit of all staff Covid 19 screening was completed and any noted deficient practice was identified and corrected immediately. This audit was conducted by the Director of Nursing, and the Interim ADON to ensure all Staff Covid 19

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nurse was asymptomatic or had exposure to COVID-19.

An interview was conducted on 08/16/21 at 4:54 PM with Nurse #1. She stated she was agency staff and worked at the facility since May 2021. She reported upon arriving to work she screened herself at the front entrance. She stated she answered all the questions on the screening log. She stated she checked her own temperature and if it was elevated, she would notify the nurse and go outside for a rapid COVID test. She stated she had not received training on the screening log sheets and stated she thought she was signing no to the questions all the way across and stated the partial line drawn on the screening log was her answer to the health questions. Nurse #1 agreed she did not accurately and fully complete the health screening questions.

During a review of the staff screening log sheet for Activity Director #1 revealed on 4 occasions she recorded a body temperature but did not answer yes or no to the health screening questions and no dates were recorded each day on the screening log.

An interview was conducted on 08/16/21 at 5:10 PM with Activity Director #1. She stated she screened herself upon arrival to work and didn't answer the health questions fully and completely. She stated she was in a hurry when she arrived for her shift and didn't complete the screening in full. She agreed she should have recorded dates when she checked her temperature and should have answered the health questions. The Activity Director indicated she did not have any symptoms or had not been exposed to COVID -19.

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Screenings were completed 100% for all staff allocated working on all shifts, and all days.

What measures will be put into place to ensure the deficient practice does not reoccur:
Mandatory all staff education on policies and procedures related to the Infection control policy for Covid 19 staff screening Education was initiated 09/03/21 and completed 9/7/21. All new hires and all newly assigned agency staffing will have this mandatory education prior to working on the unit.

How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance program will be put into place:

Element #1 to ensure ongoing compliance, the Director of Nursing and the Interim ADON will conduct random audits daily x ___4___ weeks to ensure 100% compliance to the Infection Control policies and procedures of Staff Covid 19 Screening. If there are any areas of concern, the appropriate education/in-servicing will be immediately provided to staff. All new hires will and newly assigned agency staff be educated on this policy and procedure during the orientation process prior to initiating work. The results of our auditing process will be reported to monthly QAPI until such time that substantial compliance has been achieved x 3 months

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An interview was conducted on 08/16/21 at 6:00 PM with the Administrator along with the Director of Nursing (DON). The DON stated staff were required to stop at the front entrance and take their temperature and complete the screening log by answering yes or no to the questions and if no signs or symptoms then sign off on it. She stated sometimes they had a staff member screening employee's as they entered but not every day and stated she reviewed the screening logs each day, but she had not reviewed the screening logs since last week. She reported if she found concerns or thought staff needed more training regarding the screening process, she would go to that staff member. The DON indicated extra screening log sheets were usually kept in the screening log notebook. The DON stated her expectation was that staff were answering the questions on the screening log completely and accurately and recording a temperature when they arrived for their shift. The DON indicated extra screening log sheets were usually kept in the screening log notebook.

2) A review of the facility's Contact Precaution Policy revised on 02/2018 for "Donning and Removal of PPE" stated gloves and a gown should be worn when entering the room and while providing care for a resident; and should be removed before leaving the resident's room.

During an interview on 08/16/21 at 10:45 AM with the Administrator, she stated the facility was in COVID-19 outbreak status and currently had 3 COVID positive residents on the 100 and 200 hall that remained in the facility. She stated all residents in the facility were on Enhanced Isolation Precautions and required full PPE

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What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Elements #2 & #3: Nursing Assistant #1 failed to Follow the Infection Control policy to ensure that staff donned full PPE before entering a resident's room (Resident #5) who was on Enhanced Droplet Precautions during a facility Outbreak of Covid – 19 when a staff member (Nurse Aide #2) was observed feeding a resident without wearing gloves, or a gown. Facility also failed to ensure that staff donned and doffed full PPE prior to entering and exiting resident rooms who were on Enhanced Droplet Precautions when (Nurse Aide #1) was observed entering 2 rooms (Resident #4 & Resident #5) without donning the appropriate PPE, and Certified Medication Aide #1 failed to remove the PPE prior to exiting 2 of 2 Resident rooms.

A Fishbone/root cause analysis was conducted on 09/07/21 to identify root cause of the area identified in the 2567.

The Root cause analysis was facilitated by the Administrator, Director of Nursing, and the District Director of Clinical Services. The Root cause analysis was reviewed with the QAPI committee 9/9/21 and incorporated into the facility plan of correction below. The Directed Plan of Correction will be completed by 09/17/21 with training conducted by the Director of Nursing and the Interim ADON.

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(personal protective equipment) before entering resident rooms.

An observation on 08/16/21 at 11:55 AM of Resident #5's room revealed a sign on the door to indicate the resident was on Enhanced Droplet Precautions. The sign indicated prior to entering the room a mask, shield, gown, and gloves must be worn.

An observation on 08/16/21 at 11:55 AM revealed Nurse Aide #2 in Resident #5's room feeding the resident without wearing gloves or a gown. At that time, the Staff Development Coordinator (SDC) was observed notifying Nurse Aide #2 that she needed to apply PPE when she entered the resident rooms.

An interview was conducted on 08/16/21 at 5:30 PM with Nurse Aide #2. She stated she was agency staff, and it was her first day working in the facility. She stated she didn't know the facility had COVID in the building, then stated she was informed later by other staff members that there were COVID positive residents. She stated she did not think she had to wear PPE in Resident #5's room because the PPE wasn't hanging on the outside of the resident's door.

An interview was conducted on 08/16/21 at 12:00 PM with the SDC nurse. She stated all residents were on Enhanced Isolation Precautions due to the COVID-19 outbreak in the facility. She stated staff were required to wear full PPE when entering resident rooms. She reported Resident #5 was not one of the COVID positive residents in the facility.

An interview was conducted on 08/16/21 at 6:00

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Element #1 & #3: Resident #4 & Resident #5 had no adverse outcomes from the staff member entering their rooms without applying the appropriate Personal Protective Equipment PPE, also no adverse outcomes from staff not removing PPE appropriately prior to exiting resident's room, and finally, no adverse outcomes from assisting a resident with a meal without wearing gloves or a gown. Resident 's #4 and #5 are long term care residents that were placed on Enhanced Droplet Precautions (TBP) due to a Covid – 19 Outbreak in the facility and placed on TBP out of an abundance of precaution, as they were Covid Negative per PCR testing. They were removed from TBP on 8/17/21 as they no longer needed to be placed on TBP precautions. The Certified Nursing assistant #1 and Certified Medication Aide #1 were immediately educated on Enhanced Droplet Precautions and the appropriate usage of donning and doffing full PPE (gloves, eyewear , gown usage, and proper feeding guidelines while on TBP on 08/16/21 by the Director of Nursing.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Element # 2 & #3: All resident that are on TBP Precautions have the potential to be affected. In-service education was provided by the Director of Nursing, and Interim ADON beginning 09/03/21 and

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PM with the Administrator along with the Director of Nursing (DON). The DON stated new employees including agency staff were made aware of COVID positive residents in the facility. She stated Nurse Aide #2 was provided an orientation packet when she arrived for her shift which included PPE use and information regarding Isolation Precaution signs on resident doors. She stated her expectation was that staff were wearing full PPE when entering resident rooms who were on Enhanced Isolation Precautions.

3) An observation of Resident #4's room on the 100 hall on 08/16/21 at 11:43 AM revealed a sign on the door to indicate the resident was on Enhanced Droplet Precautions. The sign indicated prior to entering the room a mask, shield, gown, and gloves must be worn.

An observation of Nurse Aide #1 on 08/16/21 at 11:45 AM revealed Nurse Aide #1 entered Resident #4's room with a mask and face shield only and closed the door. The Nurse Aide did not apply the required gown and gloves.

An interview was conducted with Nurse Aide #1 on 08/16/21 at 11:57 AM. Nurse Aide #1 stated he did not know what Resident #4 was on precautions for. He stated he forgot to apply the gown and gloves as required before entering the resident's room. Nurse Aide #1 stated he was not aware the resident was on precautions because when he worked over the weekend, staff could enter any room just not the COVID-19 positive rooms without PPE. Nurse Aide #1 stated he was an agency aide and received education prior to starting at the facility with regards to infection control prevention such as when to apply PPE,

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will be completed by 9/7/21 on Enhanced Droplet Precaution (TBP) requirements. To include: Proper donning and doffing of PPE when entering and exiting resident rooms and proper PPE utilization when assisting a resident with meals. A full house audit of all residents on TBP were identified and was conducted by the Director of Nursing, and Interim ADON to ensure all Enhanced Droplet Precaution rooms have direct care observations of staff entering and exiting the isolation rooms to be following our Policies and procedures regarding specific PPE requirements, and expectations for TBP precautions when assisting resident with meals.

What measures will be put into place to ensure the deficient practice does not reoccur:

Mandatory all staff education on policies and procedures related to Enhanced Droplet Precautions (TBP), appropriate utilization (donning and doffing) of PPE requirements upon entering and exiting the resident rooms on TBP, and policies and procedures related PPE guidelines while assisting a resident with meals. Education initiated 09/03/21 and completed 9/7/21. All new hires and newly assigned agency staff will have this mandatory education prior to working on the unit.

How the corrective actions will be monitored to ensure the deficient practice will not recur, and what quality assurance

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F 880	Continued From page 8 how to remove PPE, and handwashing. An observation on 08/16/21 at 12:15 PM revealed Certified Medication Aide (CMA) #1 asked Nurse #1 to set up a trash bag in the 100 hall. Nurse #1 tied the trash bag to the handrail near a resident's room. CMA #1 was observed applying the appropriate PPE including a gown, gloves, mask, and face shield prior to entering the resident's room with the lunch tray. CMA #1 was observed exiting the room with all the PPE on and was noted to discard the gown and gloves in the trash bag hanging on the handrail across the hall from the resident's room. At 12: 26 PM, she was observed applying PPE prior to entering another resident's room with the meal tray and when she exited the room, she discarded the gown and gloves in the trash bin located on the nurse's medication cart which was across the hall from the resident's room. An interview with CMA #1 at 12:42 PM on 08/16/21 revealed she thought it would be easier to dispose of the PPE in the trash bag and she discarded the PPE in the medication cart trash bin because she did not want to walk down the hall with contaminated PPE. CMA #1 reported she had been in serviced regarding donning and doffing PPE which included to removing PPE before exiting a resident's room. An observation of Nurse Aide #1 on 08/16/21 at 5:45 PM revealed Nurse Aide #1 entered a residents room on the 100 hall with a mask and face shield and asked the resident if she was done with her dinner and removed the dinner tray. He stored the dinner tray on the dietary cart. A sign on the resident's door indicated the resident was on Enhanced Droplet Precautions and prior	F 880	program will be put into place: Element #2 & #3: To ensure ongoing compliance, the Director of Nursing and the Interim ADON will conduct random audits weekly x __4___ weeks to ensure Enhanced Droplet Precautions (TBP)are being followed with the use of appropriate donning and doffing PPE when entering and exiting resident rooms, and appropriate PPE usage while assisting a resident with meals. If there are any areas of concern observed, the appropriate education/in-servicing will be immediately provided to staff. All new hires and all newly assigned agency staff will be educated on this policy and procedure during the orientation process prior to initiating work. The results of our auditing process will be reported to monthly QAPI until such time that substantial compliance has been achieved x 3 months Compliance date 9/17/21.	

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to entering the room a mask, shield, gown, and gloves must be worn.

An interview was conducted with Nurse Aide #1 at 5:47 PM. Nurse Aide #1 stated he saw the sign on the door, he just forgot to apply the PPE.

An interview was conducted with the Unit Manager (UM) on 08/16/21 at 12:10 PM. The UM stated every resident in the facility was on Enhanced Droplet Precautions at this time due to the COVID-19 breakout. The UM stated she would expect staff to apply the appropriate PPE before entering a resident's room and if they were unsure what the precaution was to ask a nurse.

An interview with the SDC nurse on 8/16/21 at 1:00 PM revealed that no staff should exit a resident's room with PPE on. The SDC Nurse stated all staff were educated to remove the PPE in the residents rooms prior to leaving the room. She stated she did not know why the CMA was exiting the room and placing the PPE in the trash bag which was noted to be on the floor in the hallway or in the trash bin on the medication cart. The SDC stated she did not know why the nurse set up a trash bag in the hall and added, that was not normal practice.

An interview was conducted on 08/16/21 at 6:00 PM with the Administrator along with the Director of Nursing (DON). The DON stated new employees including agency staff were made aware of COVID positive residents in the facility. She stated Nurse Aide #1 was provided an orientation packet when he arrived for his shift which included PPE use and information regarding Isolation Precaution signs on resident doors. She stated her expectation was that staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345150	A. BUILDING ______ B. WING ______	C 08/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENANSVILLE HEALTH & REHABILITATION CENTER	**209 BEASLEY STREET** **KENANSVILLE, NC 28349**

(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 10 were wearing full PPE when entering resident rooms who were on Enhanced Isolation Precautions and to remove their PPE prior to exiting a resident's room.	F 880		