STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345494	A. BUILDING ______ B. WING ______	C 09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - GASTONIA	**2780 X-RAY DRIVE** **GASTONIA, NC 28054**

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E 000	Initial Comments An unannounced onsite COVID-19 Focused Survey was conducted on 09/09/21 through 09/10/21. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# PSNR11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite COVID-19 Focused Survey and complaint investigation was conducted on 09/09/21 through 09/10/21. The facility was found out of compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. A total of 3 allegations were investigated and all of them were unsubstantiated. Event ID# PSNR11.	F 000		
F 880 SS=D	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 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		10/3/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/29/2021

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 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 2 §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 reviews, and staff interviews, the facility failed to implement their infection control policies and procedures when 1 of 14 residents positive for COVID-19 did not have signage on the door for enhanced droplet contact precautions and when 1 of 3 staff members (Nurse Aide #3) was observed not sanitizing her hands after handling dirty linen and before donning a clean gown to go into another room to answer a call light for 1 of 2 residents (Resident #17) observed for infection control practices. This occurred during a global pandemic. The findings included: The Centers for Disease Control and Prevention (CDC) guideline entitled, "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," last updated on 09/10/21 revealed the following: under the section "Infection Prevention and Control Program - Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices: Ensure Healthcare Personnel (HCP) have access to all necessary supplies including alcohol-based	F 880	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Residents affected: There were no adverse effects for Resident #13 for not having Enhanced Droplet Precaution signage on the room door. Appropriate signage was placed on resident room door on 9/9/21 by the Staff Development Coordinator/Infection Preventionist (SDC/IP). There were no adverse effects to the 10 Residents on Nurse Aide #3□s assignment for the nurse aide not performing hand hygiene when doffing personal protective equipment (PPE) before entering another resident□s room. All other residents with potential to be affected: On 9/9/21, the Staff Development Coordinator (SDC) did an audit to ensure that all residents on transmission-based precautions had appropriate signage outside their room door. There were no	

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F 880	Continued From page 3 hand sanitizer with 60-90% alcohol, personal protective equipment (PPE), and supplies for cleaning and disinfection o Put FDA-approved alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). Hand Hygiene o Require HCP to perform hand hygiene in accordance with CDC recommendations: o Immediately before touching a patient o Before performing an aseptic task o Before moving from work on a soiled body site to a clean body site on the same patient o After touching a patient or the patient ' s immediate environment o After contact with blood, body fluids or contaminated surfaces. o Immediately after glove removal o Ensure that HCP perform hand hygiene with soap and water when hands are visibly soiled. o Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered. A review of the facility's Infection Prevention and Control Program dated 05/2020 under section Transmission Based Precautions read in part: Transmission-Based Precautions shall be used when caring for resident who are documented or suspected to have communicable diseases or infections that can be transmitted to others. The facility will use current CDC guidelines for all precautions as they apply to long term care.	F 880	additional residents identified as having been adversely affected by the alleged deficient practice. On 9/9/21, one to one education was provided by the Director of Nursing (DON) to Nurse Aid #3 regarding proper hand hygiene per facility infection control policies and procedures. This education included technique after removing PPE, disposing of dirty linen when leaving a resident room and prior to entry to other resident rooms. Hand Hygiene competency was competed by Staff Development Coordinator/Infection Control Preventionist for NA #3 on 9/15/21. Systemic changes The facility policies related to infection control practices were reviewed by the administration on September 15, 2021 and no revisions and/or updates were needed All licensed Nurses will be educated that all residents on transmission-based precautions must have appropriate signage outside the resident door. This education was initiated by the Director of Nursing on 9/27/2021 and will be completed by DON and/or SDC by 10/03/2021. Any licensed nurse out on leave or PRN status will be educated by the SDC and/or DON prior to returning to their assignment. Any newly hired licensed nurse will be educated by the SDC during orientation. All facility staff/contracted staff/volunteers will be educated by the SDC and/or DON on proper hand hygiene technique. The education will be completed by October 3,	

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Continued From page 4

The facility shall make every effort to use the least restrictive approach to managing individuals with potentially communicable infections.

The categories include:
o Contact
o Droplet
o Airborne
o Enhanced Barrier Precautions (not mandated at this time)
o Enhanced Droplet-Contact Precautions

The Infection Preventionist/Director of Nursing, in collaboration with the Attending Physician, will determine the need for precautions and when precautions may be discontinued.

Upon entry to the facility on 09/09/21, during the entrance conference the Director of Nursing (DON) identified the 400 hall as the COVID-19 positive hall with the 200 hall as the COVID-19 positive overflow hall. The 100 hall was off isolation effective 09/09/21 for COVID-19.

1. a. Upon entry to the 400 hall the double doors were closed, and clean PPE supplies readily available outside the doors. There was signage on the double doors which indicated the unit required the donning of Personal Protective Equipment (PPE) prior to entering the hallway. A continuous observation was made of the 400 hall on 09/09/21 from 10:48 AM to 11:20 AM. There were 2 private rooms and 14 semi-private rooms. There were 24 residents on the unit. Resident #13 resided in room # 411-2 and was identified as unvaccinated and positive for COVID 19 without a sign on his door indicating he was on enhanced droplet-contact precautions. Staff were observed

F 880

2021. Employees out on leave or PRN status will be educated by the SDC/DON prior to returning to their assignments. Any newly hired employees will be educated by the SDC/DON during orientation.
Monitoring:
On September 21, 2021, the Quality Assurance and Performance Improvement (QAPI) Committee, consisting of the Director of Nursing, Staff Development Coordinator/Infection Preventionist, Administrator, and Administrative Staff initiated an audit tool to observe for continued compliance with the plan of correction.
The audit tool consists of the following:

" Staff performing hand hygiene appropriately after exiting room and prior to entering another residents room.

" Appropriate transmission-based precautions signage outside the resident room door

Facility will observe 5 employees weekly to include each shift and weekends for one month to ensure proper hand hygiene technique, then 5 employees bi-weekly for one month and then 5 employees monthly for one month. The Director of Nursing and/or Staff Development Coordinator/Infection Preventionist and Administrative RN will continue to audit on going.

The Quarantine/Isolation Unit will have an audit conducted three times a week to

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F 880	Continued From page 5 going in and out of rooms providing care and treatment and utilizing appropriate full PPE. An interview with the Staff Development Coordinator/Infection Preventionist (SDC/IP) on 09/09/21 at 5:03 PM revealed Resident #13 ' s door did not have a sign on it indicating he was on enhanced droplet-contact precautions. The IP stated she had overlooked putting the sign on the door and said the resident should have had a sign with PPE on his door. b. A continuous observation was made on 09/10/21 from 9:05 AM to 9:48 AM on the 400 hall. At 9:17 AM Nurse Aide (NA) #3 donned full PPE and went into a room to provide care. NA #3 was observed coming out of the room at 9:25 AM with bagged linen in her right hand. She proceeded down the hall to the dirty linen bin and placed the bagged linen in the dirty linen bin. She proceeded back up the hall and obtained a clean gown from a supply cabinet, donned the gown, and went into another room to answer the call light. NA #3 did not sanitize her hands after handling the dirty linen and before donning the gown to go into another resident room. An interview on 09/10/21 with NA #3 revealed she had been educated at the facility regarding COVID-19, signs and symptoms, protocol for wearing PPE, testing and education was provided continually with updates. NA #3 recalled not sanitizing her hands after putting the linen in the bin and before donning a new gown to go into another room. NA #3 stated she knew better and should have sanitized her hands after handling dirty linen. She further stated she had been educated to sanitize her hands after handling dirty linen and/or trash and said she must have gotten	F 880	ensure that appropriate signage is on resident room door, in addition a follow up audit will be conducted at random upon notification of any new COVID + and/or suspected resident. This audit will be conducted 3 times a week for one month and then weekly for one month and then monthly for one month. The Nursing Home Administrator will review the results of these audits weekly for three months. QAPI Findings of the audit tools will be reported by the Director of Nursing and/or Administrator to the QAPI Committee monthly for review times three months. Should it be necessary the QAPI Committee can modify this plan to ensure the facility remains in compliance. Date of completion: 10/3/2021	

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F 880	Continued From page 6 in a hurry and forgot to do it. An interview on 09/10/21 with the Director of Nursing (DON) revealed she was not aware of NA #3 not sanitizing her hands after handling dirty linen and donning a new gown and going into another room to answer a call light. The DON stated all employees were provided education on a continual basis and every employee should be aware of the need to sanitize their hands after handling dirty linen.	F 880		