STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345319	A. BUILDING _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

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E 000	Initial Comments An unannounced Recertification survey was conducted on 10/25/21 through 10/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1GX911	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 10/25/21 through 10/28/21. Event ID# 1GX911.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		11/23/21

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

Electronically Signed | 11/19/2021

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F 583	Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect the private health information for 1 of 1 sampled resident (Resident #274) by leaving confidential medical information unattended and exposed in an area accessible to the public. The findings included: Resident #274 was admitted to the facility on 10/20/21. A continuous observation was made on 10/26/21 from 1:28 PM through 1:36 PM of an unattended medication cart next to the nurse station on the 500 Hall. Nurse #4 left the medication cart with the Medication Administration Record (MAR) of Resident #274 visible on the medication cart's computer screen when she was away taking lunch break. The screen showed the name and the picture of Resident #274. The surveyor could easily access to information related to her current medications and other private health information. The unattended computer was accessible by anyone near the medication cart. During an interview with Nurse #4 on10/26/21 at 1:46 PM she explained while she was reviewing medication for Residents #274, she had to	F 583	Nurse # 4 immediately activated the privacy screen on the computerized Medication Administration record for Resident #274. The Director of Nursing immediately upon notification of the privacy of record issue observed medication administration records on all other medication carts to assure they were either in attendance by a nurse or the privacy screen activated. All other medication administration records had the privacy screen activated. All licensed nurses including agency nurses were educated by Director of Nursing on 10/26/2021 to activate the privacy screen on the medication administration record while not in attendance to protect the resident□s private health information from exposure to the public. The Director of Nursing and/or his/her Designee will observe medication administration records during routine	

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F 583	Continued From page 2 answer a call light triggered by one of the Residents in 500 Hall. She was distracted and had forgotten to turn on the privacy protection screen before leaving the medication cart. She took the lunch break after she had completed patient care for the Resident. She stated it was an oversight and acknowledged that it was inappropriate to leave the MAR screen unattended. She indicated that she had received the Health Insurance Portability and Accountability Act (HIPAA) training from the facility during orientation. In an interview conducted on 10/26/21 at 2:08 PM, the Director of Nursing (DON) expected the nurse to turn on the privacy protection screen before leaving the medication cart to protect Resident's confidential personal and medical information. It was her expectation for all the staff to follow the HIPAA guidelines when working in the facility. Interview on 10/27/21 at 10:45 AM with the Administrator revealed all the staff had received training in HIPAA. She stated the nurse had to secure the computer before leaving it unattended. It was her expectation for all the staff to follow HIPAA guidelines all the times.	F 583	rounds to assure the privacy screen is activated when not in direct attendance by the licensed nurse. This audit will be completed daily for 1 week then weekly for 2 weeks. Results will be recorded on an audit tool titled MAR Privacy. The Director of Nursing or Designee will observe medication administration records during routine rounds to assure the privacy screen is activated when in not directed attendance by licensed nurse. This audit will be completed daily for 1 week and then weekly for 2 weeks. Results will be reported to the QAPI team and reviewed by the team including Administrator and Medical Director during the November meeting. All QAPI team recommendations will be followed.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		11/29/21

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F 656	Continued From page 3 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan for weight loss for 2 of 8 residents reviewed for nutrition (Residents #56 and #72).	F 656	Plan of Correction Tag: F-279 Develop Comprehensive Care Plans It is the facility□s philosophy and normal	

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F 656	Continued From page 4 The findings included: 1. Resident #56 was readmitted to the facility on 5/6/21 with diagnoses that included dementia, dysphagia, and history of tracheostomy status. The quarterly Minimum Data Set (MDS) dated 6/11/21 assessed Resident #56's cognition as being severely impaired and functional status as needing limited assistance of 1 staff person with eating. Resident #56 was coded for significant weight loss not on prescribed weight-loss regimen and significant weight gain on physician-prescribed weight-gain regimen. He weighed 156 pounds with a height of 71 inches. The significant change Minimum Data Set (MDS) dated 9/11/21 assessed Resident #56's cognition as being severely impaired and functional status as needing limited assistance of 1 staff person with eating. He weighed 172 pounds with a height of 71 inches. Resident #56's care plan revealed there was no plan developed for nutritional status or weight changes. Review of nutrition/dietary notes from May through October 2021 the Registered Dietitian (RD) revealed on 5/10/21 Resident #56 had significant weight loss of 5.1% within 1 month. She associated the weight loss to cancer and recommended a high-calorie/high-protein liquid nutritional supplement twice daily. During an interview on 10/27/21 at 3:42 PM the MDS Coordinator stated she was responsible for creating and updating the care plans for all	F 656	practice to use the results of the assessment to develop, review and revise the resident□s comprehensive plan of care. The facility has in place developed written policies and procedures. Interdisciplinary Care Plans are developed for each resident, and are designed to address potential problems, and offer approaches designed to meet specific goals. The facility will continue to endeavor to implement and update care plans as changes occur. ¿ Resident # 56 and Resident # 72 plans of care was amended on 10/27/21 by the MDS Coordinator to address weight loss and nutrition. ¿ On 10/27/2021 the MDS coordinator reviewed the October 2021 Weight Report to determine if any other resident□s had experienced weight loss and if so the weight loss and nutrition was included in the resident care plan by the MDS Nurse. There were no other residents identified during the review. ¿ The facility will change our procedure and require the MDS coordinator to begin attending the weekly risk meetings effective 11/03/2021 where resident□s weights are reviewed for weight loss/gains. ¿ The new procedure will also be for the MDS nurse to review and revise care plans following the meeting for resident□s who have experienced significant weight loss or gain to include nutritional	

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F 656	Continued From page 5	F 656		

residents. If a resident was triggered for weight loss, she stated she would have revised the care plan and notified the Assistant Director of Nursing (ADON) and Director of Nursing (DON). The MDS coordinator indicated Resident #56's care plan was last revised 9/17/21 and weight loss was not included as a focus but should have been.

During an interview on 10/28/21 at 9:15 AM the Director of Nursing revealed her expectation was that care plans be reviewed and revised as needed.

The Administrator was interviewed on 10/28/21 at 11:31 AM. She stated her expectation was that the care plans should reflect the resident and the care the resident required.

2. Resident #72 was admitted to the facility on 6/11/21 with diagnoses that included dementia, congestive heart failure and diabetes.

The admission Minimum Data Set (MDS) dated 6/24/21 assessed Resident #72's cognition as being moderately impaired and functional status as independent with eating with setup help only from staff. Resident #72 weighed 189 pounds with a height of 70 inches. The Care Area Assessment (CAA) for nutrition was triggered but not marked as addressed in the care plan.

On 8/24/21, Resident #72 weighed 168.2 pounds per the medical record and was the last recorded weight before 10/08/2021.

The quarterly Minimum Data Set (MDS) dated 10/8/21 assessed Resident #72's cognition as being severely impaired and functional status as independent with eating with setup help only from

interventions if not already revised prior to the meeting.

¿ The MDS nurse was educated on this process change by the Director of Nursing on 10/27/2021.

¿ The Nurse Consultant will provide re-education to the MDS Nurse before 11/17/2021 on the need to review resident□s care plan after each assessment, except discharge assessments, and revise the care plan based on changing goals, preferences and needs of the resident and/or triggered items on the MDS assessment and/or Care Area Assessments that may be completed.

¿ Director of Nursing and/or designee will audit the care plans of resident□s experiencing weight loss to assure nutritional interventions are evident on the care plan. This will be audited weekly for a month and then once a month for 3 months.

¿ Results will be reported to the Quality Assurance Performance Committee by the Director of Nursing monthly and results reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.

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F 656	Continued From page 6	F 656		

staff. Resident #72 was coded for significant weight loss not on prescribed weight-loss regimen. He weighed 189 pounds with a height of 70 inches, which was not the most recent weight value at the time of this assessment.

Resident #72's care plan revealed there was no plan developed for nutritional status or weight changes.

Review of the nutrition/dietary notes from June through October 2021 the Registered Dietitian (RD) noted on 8/10/21 Resident #72 had significant weight loss of 10.1% within 1 month. The RD recommended a protein nutritional supplement twice daily, weekly weights for 3 weeks and the Dietary Manager to revisit Resident #72's food preferences. With the most recent weight value on 8/17/21 showing an additional loss, the RD wrote a follow-up note on 8/21/21 and recommended an additional high-calorie/high-protein liquid nutritional supplement once daily for 30 days.

During an interview on 10/27/21 at 2:11 PM the MDS Coordinator stated if a resident's MDS triggered significant weight loss, she would revise the care plan and notify the Assistant Director of Nursing (ADON) and Director of Nursing (DON). She stated she did not notice Resident #72's significant weight loss coded in the most recent MDS assessment.

During an interview on 10/27/21 at 2:48 PM the Director of Nursing revealed Resident #72 has had weight loss during his entire admission. The DON stated the care plan should have been revised to include weight loss along with a care plan intervention. The DON indicated this lack of

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F 656	Continued From page 7 care plan revision to include weight loss may have been an oversight. The Administrator was interviewed on 10/28/21 at 11:31 AM. She stated her expectation was that the care plans should reflect the resident and the care the resident required.	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to administer supplemental oxygen with a physician's order and failed to develop a plan of care for the care of a tracheostomy for 1 of 6 residents reviewed for oxygen (Resident #30). The findings included: Resident #30 was originally admitted to the facility on 4/27/21 and readmitted on 9/8/21 after a hospitalization. Review of the medical record revealed diagnoses which included chronic respiratory failure and tracheostomy status. The admission Minimum Data Set (MDS) assessment for Resident #30 dated 9/9/21	F 695	F695 Respiratory Care It is the policy of this facility to provide respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan, the resident resident□s goals and preferences. Resident # 30□s Physician gave an order for 3.5 liters of oxygen via tracheostomy immediately on 10/27/2021. A list of all residents using oxygen and the liters of oxygen ordered was compiled. The list was then used to review the	11/29/21

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F 695	Continued From page 8 revealed she was severely cognitively impaired and was coded for oxygen use/tracheostomy while a resident and while not a resident. Review of the care plan last revised on 9/20/21 revealed Resident #30 was not care planned for either oxygen therapy or tracheostomy status. Observations of Resident #30 receiving oxygen therapy in her room with an oxygen concentrator via the tracheostomy occurred on 10/25/21 at 9:53 AM and during tracheostomy care on 10/27/21 at 2:34 PM. Observations of Resident #85 receiving oxygen therapy in her room with an oxygen concentrator set at 3.5 liters via the tracheostomy occurred on 10/28/21 at 10:19 AM. Review of the medical record for Resident #30 revealed oxygen saturations were checked at least once a shift and all oxygen saturations were 90% or above. Review of the physician orders for Resident #30 revealed there was no order for oxygen therapy. Interview with Nurse #1 on 10/28/21 at 10:37 AM revealed Resident #30 was on oxygen since her initial admission and a physician order was required to administer oxygen. Nurse #1 stated there should have been an order for oxygen therapy for Resident #30, but that there was no order for oxygen therapy present in the medical record. On 10/28/21 at 11:17 AM the MDS Nurse was interviewed, and she revealed tracheostomy care and oxygen therapy were services that were not	F 695	medical records to determine if a Physician□s order was written for the oxygen therapy and the liters that were ordered were being delivered. This was completed on 11/03/2021 by the Director of Nursing. No other residents were identified in the review. The MDS coordinator will review all new admissions to see if they are receiving oxygen and verify the order is in the record during the 48 hour meeting that occurs after admission. The MDS Coordinator was re-education by nursing consultant on 11/17/21. The Director of Nursing will train the nurses on new admission procedure by 11/17/21. " The Director of Nursing and/or Registered Nurse Supervisors will monitor all residents using oxygen to ensure there is an accompanying Physician order for the oxygen therapy. This will be completed weekly for 4 weeks. " Results will be reported to the Quality Assurance Performance Committee by the Director of Nursing monthly and results reviewed and discussed. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 695	Continued From page 9 included in Resident #30's care plan. She stated the care plan was last revised on 9/20/21 and the tracheostomy care and oxygen therapy should have been included. The MDS Nurse indicated she was not sure why they were not included in Resident #30's care plan. Interview with the Director of Nursing (DON) on 10/28/21 at 10:37 AM revealed she confirmed Resident #30 did not have an order for oxygen therapy. The DON stated her expectation was for Resident #30 to have an oxygen therapy order, which included liters and titration, for her current oxygen use. On 10/28/21 at 11:21 AM, the DON stated her expectation was that Resident #30's care plan should have included the tracheostomy care and oxygen therapy. Interview with the Medical Director (MD) on 20/38/21 at 11:04 M revealed Resident #30 had been on oxygen since her initial admission. The MD confirmed there was no current order for oxygen therapy for Resident #30, and she stated there should have been a physician's order for any resident receiving oxygen therapy. Interview with the Administrator on 10/28/21 at 11:31 AM revealed if a resident was on long-term oxygen therapy, there should have been a physician's order. On 10/28/21 at 11:31 AM, the Administrator stated the care plans should reflect the care the resident required.	F 695		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry	F 801		11/29/21

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F 801	Continued From page 10 out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F 801		

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F 801	Continued From page 11 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on record review and staff and previous consultant Dietitian interviews, the facility failed to employ a qualified dietitian or clinically qualified nutritional professional on a full time, part-time or consultant basis. This affected the need for nutritional assessment for 77 of 77 residents. The findings included:	F 801	A Registered Dietician was hired by the Administrator through a Consultant Dietician Firm on 10/28/21 with her first day of work scheduled for 11/03/21.The Registered Dietician was hired as Consultant for dietary with a minimum of 16 hours per month and more if needed based on the needs of the facility.	

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	345319	A. BUILDING _____ B. WING _____	10/28/2021

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F 801	Continued From page 12 On 10/25/21, the Administrator provided contact information for the interim Dietitian for the facility (Registered Dietitian #1). The Administrator reported that the most recent Dietitian (Registered Dietitian #2) was no longer working for the facility. During an interview with the interim Registered Dietitian #1 (RD) on 10/27/21 at 9:50 AM, she stated she had not worked for the facility for more than a few years and relinquished her RD license in January of 2020. The Medical Director (MD) was interviewed on 10/27/21 at 12:46 PM and revealed she had not received any recommendations from a qualified nutritional professional within the last 30 days. The MD stated she was currently managing the nutritional status of all residents. During an interview with the Administrator on 10/27/21 at 9:55 AM, she revealed the previous RD #2's last day of work was 9/17/21. The Administrator stated she was contacting the interim RD #1 for advice and help finding a new RD. She further stated the MD was overseeing the nutritional status of the residents at this time. On 10/28/21 at 10:04 AM, the Administrator stated she was just contacted by a consultant dietitian firm that morning with an available RD, and she was awaiting their signature on a new working contract.	F 801	All residents have the potential to be affected. " A plan was developed to assure nutritional evaluations were completed as quickly as possible by the new Registered Dietician. The new Dietitian will be trained by the Dietary Manager and the Director of Nursing and Administrator on 11/3/21 and on going on the facility procedures and policies. The plan is as follows: " Residents□ with nutritional issues and/or weight loss/gain that was not planned were reviewed on 11/03/2021 by the new Dietitian. " The remaining resident□s charts were reviewed to determine the date the previous Registered Dietician completed an evaluation. Resident's reviewed by the prior Registered Dietician will be evaluated priortorizing from oldest review date to most current. New Dietitian visited again 11/17/21 and reviewed all residents□ nutritional status that were not current. " The new Registered Dietician will begin a routine schedule of evaluating resident□s nutritional status on 11/03/2021 and will be reviewing resident□s nutritional status on routine visits that will occur bi-monthly or sooner if needed to meet resident□s nutritional need. " The new Registered Dietician is also available via phone, email for any Consultation needed between routine visits. " The facility signed an agreement with a company to provide Dietitian services	

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F 801	Continued From page 13	F 801	and not an individual to prevent the facility from being dependent on an individual. We now have the resources of a large company. " The Director of Nursing and/or her Designee will monitor 5 resident records bi-monthly to ensure a Nutritional Consult has been provided by the Registered Dietitian. " The Director of Nursing and/ or her designee will review 10 resident records monthly to assure a Nutritional Consult has been provided by the Registered Dietician. " The Director of Nursing will report her findings to the QAPI team in the November meeting. The recommendations of the QAPI team including the Administrator and the Medical Director will be followed.	
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		11/26/21

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F 880	Continued From page 14 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 15 §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 and, review of the facility policy and review of the CDC guidelines, the facility failed to follow CDC guidelines when staff failed to wear eye protection while performing wound care (Resident #5) and tracheostomy care (Resident #30) for 2 of 2 residents observed. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 9/10/21 indicated the following information under the section "Implement Universal Use of Personal Protective Equipment for HCP (Healthcare Personnel): *If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP working in facilities located in counties with substantial or high transmission should also use PPE (Personal Protective Equipment) as described below including: Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters.	F 880	• Nurse # 2 was re-educated by Administrator and Medical Director immediately on 10/27/2021 regarding the need to wear eye protection during all patient care encounters while under county high transmission Covid rates. • All residents have the potential to be affected during patient care. • A root cause analysis was completed involving the Infection Preventionist, Director of Nursing, Administrator, and Assistant Director of Nursing on 11/17/21. Following root cause analysis, it was determined that lack of knowledge of the county high transmission rate and staff oversight to appropriately wear eye protection during the dressing change led to this deficiency. • All staff including agency staff were re-educated by the Infection Preventionist and/or her Designee on the need to wear eye protection during all patient care	

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F 880	Continued From page 16 Per the CDC website, https://covid.cdc.gov/covid-data-tracker/#county-view, Madison County remained in a high transmission rate 10/25/21 through 10/28/21. Review of the facility policy, "Standard Precautions" read in part, "Barriers indicated in standard precautions ...eyewear protection over the eyes should be worn during procedures that are likely to generate droplets of blood/body fluids." On 10/27/21 at 1:39 PM wound care to Resident #5's left heel was observed. Nurse #2 performed the wound care without wearing eye protection. She cleaned the left heel with normal saline, applied betadine and wrapped with kerlex. Nurse #2 stated she did not realize the facility was in a high transmission county and that she should have worn eye protection when providing the wound care. On 10/27/21 at 2:45PM the Director of Nursing (DON) stated she thought the reason Nurse #1 failed to wear eye protection while performing wound care was due to human error. The DON stated Nurse #1 she should have worn eye protection while performing wound care. On 10/27/21 at 2:34pm, an observation and interview was conducted of tracheostomy care performed on Resident #30 by Nurse #3, assisted by the DON. Nurse #2 wore eye protection, however the DON failed to wear eye protection while she assisted with the tracheostomy care. Resident #30 coughed several times while care was performed. The DON stated she thought her glasses would serve as eye protection. She	F 880	encounters when the county Covid transmission rates remained high. New hires can not work until they are trained by Director of Nursing of IP nurse or her Designee. • After reviewing our policy, a change was made to the policy on 11/18/21.The change was that eye protection will be worn during all patient care regardless of transmission rate in the county. • The Director of Nursing and the Infection Preventionist and/or her Designee will do daily observations for 5 days and 3 times weekly for 2 weeks to ensure staff including any agency staff are wearing eye protection during patient care. • The director of Nursing will report the findings to the QAPI team in the November meeting. • The QAPI team including the Administrator and Medical Director will make recommendations based on the findings of the observations. The recommendations of the QAPI team will be monitored for 30 days. Completion date: 11/26/2021	

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F 880	Continued From page 17 further stated she should have worn eye protection that covered the sides of her face during the tracheostomy care.	F 880		