STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345508	A. BUILDING _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNC REX REHAB & NURSING CARE CENTER OF APEX	911 SOUTH HUGHES STREET APEX, NC 27502

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 7/13/22. 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# 9N5511.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 7/13/22. The facility was found to be out of compliance with 42 CFR §483.80 infection control regulations regarding implementing the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event 9N5511	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 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		8/1/22

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

Electronically Signed | 07/25/2022

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F 880	Continued From page 1	F 880		

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.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 2 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to assure staff wore eye protection as source control for COVID-19 during a time period when the county COVID-19 transmission rate was high on one (Hall 100) of four halls. This occurred during a coronavirus pandemic. The findings included: Review of the facility's "Infection Control, Prevention and Surveillance Program," last revised on 10/29/19 revealed, "The center's infection control includes, but is not limited, to the following components: a: Implementing policies and procedures to prevent the spread of infections that include promoting consistent adherence to standard precautions and other infection control practices." At the end of the program details, it was noted, "Resources Center for Disease Control (CDC) http://www.CDC.gov." Under the "facility's COVID-19 protocol," last updated on 4/18/22 it was noted, "Staff will wear a mask at all times when on halls or in resident/patient rooms. When providing direct patient care with high risk patients, staff member must wear protective eye coverings (face shield, goggles, ... prescription glasses do not qualify as protective eye coverings) along with a mask." Review of CDC guidelines for Infection Prevention and Control Recommendations for	F 880	The corrective action will be accomplished through facility-wide training for all clinical groups. The Infection Preventionist, along with other members of leadership, will provide training on wearing protective eye covering for source control when providing care to patients when community transmission rates are high or substantial. Training will be conducted through monthly staff meetings, staff huddles, and one-on-one education sessions. Training will be completed by August 1st, 2022. Widespread training will ensure no residents or patients in the facility, including residents #1-#5 in the Resident Roster for Survey, are affected by deficient source control. To ensure the deficient practice will not recur, the following will be implemented: Eye protection, including goggles and face shields, will be made easily accessible to all clinical groups prior to starting their shift. During daily rounds, members of the leadership team will monitor the use of protective eyewear by all clinical groups on the halls. Positive reinforcement will be	

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F 880	Continued From page 3 Healthcare Personnel (HCP) during the Coronavirus Disease 2019 Pandemic, last updated on 2/2/2022, revealed HCP working in facilities located in counties with substantial or high transmission should use eye protection during all patient (resident) encounters. A review of CDC's Data Tracker of COVID-19 transmission rates for the facility's county revealed the rate of transmission was high for the current date of 7/13/22 and all the dates with data from 6/6/22 through 7/13/22. Review of the facility's infection control tracking records revealed there were no residents on the 100 hall who were in need of transmission-based precautions for COVID or other infections on the date of 7/13/22. On 7/13/22 at 9:02 AM Student NA (Nurse Aide) # 1 was observed going in and out of Room 101 where a resident resided. After she exited the room, she was interviewed about the use of eye protection and stated she did know anything about using goggles and no one else was wearing them on the unit. NA # 2 was observed on 9:07 AM on the 100-hall. She was observed to have glasses but no eye protection. NA # 2 was interviewed about this and stated there were no COVID cases and therefore she did not wear eye protection when caring for residents. Resident # 4, who was coded cognitively intact on her quarterly 6/8/22 Minimum Data Set assessment, was interviewed on 7/13/22 at 9:10 AM. Resident # 4 resided on the 100-hall. Resident # 4 reported she saw staff wear masks,	F 880	given to staff who are wearing eye protection appropriately. On-the-spot education will be provided to those who may not be wearing eye protection as instructed. Staff compliance with eye protection will be monitored daily. Corrective action will be completed by August 1st, 2022. This directed plan of correction is not an admission that any deficiency existed at the time of the survey, or of the accuracy of any of the allegations contained in the CMS 2567 survey report. This plan of correction is the facility's allegation of compliance with all applicable state and federal requirements and is being submitted to meet requirements of state and federal law for skilled nursing facilities.	

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F 880	Continued From page 4 but she did not see them wear goggles or face shields when they cared for her. The facility's Infection Preventionist was interviewed on 7/13/22 at 11:55 AM and reported the 100-hall was where long-term residents resided. She had interpreted that eye coverings needed to be worn when there was an internal risk for high transmission, and she evaluated the risk of the 100-hall as not high since the residents did not come and go. Therefore, she had not instructed the staff to use eye protection on the 100-hall. The facility's IP stated she had interpreted the guidance incorrectly and based on the CDC guidelines the staff should have been wearing eye protection as source control on the 100-hall. According to the facility's IP she was aware that the CDC data tracker had both the county positivity rate and the transmission rate, but the tracker page could be confusing at times in that the positivity rate always stood out at the top of the online statistical page and that is what she had been most often referencing.	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to:	F 886		8/1/22

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F 886	Continued From page 5 (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing	F 886		

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F 886	Continued From page 6 services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to base their routine staff testing schedule for COVID-19 on the level of community COVID-19 transmission reported in the past week. This was for one of four employees reviewed for COVID-19 testing. The findings included: Review of the facility's COVID-19 Protocols, last updated on 4/18/22, revealed the facility would test staff per the county transmission rate per CDC guidelines (Centers for Disease Control). Review of the facility's Staff Vaccination Status Roster revealed Staff Member # 1 was vaccinated but not up to date with boosters. Review of routine testing for the last four weeks for Staff Member # 1 revealed four COVID-19 tests had been performed. These were on the following dates: 6/20/22; 6/28/22; 7/6/22; and 7/12/22. A review of CDC's Data Tracker of COVID-19 transmission rates for the facility's county revealed the rate of transmission was high for all the dates with data from 6/6/22 through 7/13/22. These included the dates of 6/6/22 to 6/17/22 and	F 886	The Director of Nursing, Haylian York, provided training to the Infection Preventionist, Pamela Rowell, that routine testing should be based on county transmission rate. This training was completed on 7/18/2022. Attached is a copy of the signed training and attestation. Training of the Infection Preventionist will ensure no residents or patients in the facility, including residents #1-#5 in the Resident Roster for Survey, are affected by deficient staff testing practices. To ensure the deficient practice will not recur, the following will be implemented: The Infection Preventionist has created a testing list of all staff who are not up-to-date with Covid-19 vaccinations. This list will be updated and disseminated weekly to all members of leadership. RN Supervisors will utilize this list to determine who must be tested and ensure those individuals are routinely tested. At the end of the week, the list will be returned to the Infection Preventionist to ensure completion.	

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F 886	Continued From page 7 6/21/22 to 7/13/22. The facility's Infection Preventionist (IP) was interviewed on 7/13/22 at 12:50 PM. At this time the CDC's data tracker was also reviewed with her. The IP pointed to the rate of community level for the facility's county; which was medium. She stated she had been basing her routine testing for all employees who were not up to date with COVID-19 on the county positivity rate and not the transmission rate. According to the facility IP she had misunderstood the guidance about where to find the transmission rate on the tracker and thought by testing according to the positivity rate she had been doing it correctly. The facility IP stated she should have been testing the not up to date staff twice per week according to policy and procedures since the transmission rate was high. Review of facility COVID-19 resident cases revealed there were no current resident cases. The last resident COVID case was listed as 6/14/22.	F 886	The frequency of testing will be based on the current county transmission rate. Compliance with testing for those not up-to-date with Covid-19 vaccinations is monitored weekly. Corrective action will be completed by August 1st, 2022. This directed plan of correction is not an admission that any deficiency existed at the time of the survey, or of the accuracy of any of the allegations contained in the CMS 2567 survey report. This plan of correction is the facility's allegation of compliance with all applicable state and federal requirements and is being submitted to meet requirements of state and federal law for skilled nursing facilities.	