STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING ______ B. WING ______	C 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN NURSING CARE CENTER	**903 W MAIN STREET** **YADKINVILLE, NC 27055**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted on July 12-16, 2020. 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# FIEW11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 7/12/20-7/16/20. 6 of the 25 complaint allegations were substantiated resulting in deficiencies. Event ID# FIEW11	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:	F 676		8/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2020

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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§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observations, record reviews and staff interviews, the facility failed to implement restorative services as referred by the facility's rehabilitative department to maintain or improve a resident's level to ambulate and transfer for 1 of 2 sampled residents reviewed for restorative services (Resident #12).

Findings included:

Resident #12 was admitted to the facility on 2/11/20 with diagnoses which included: displaced intertrochanter fracture of the right femur, fracture of the carpal bone, right wrist, fall, chronic atrial fibrillation, osteoporosis, and bilateral primary osteoarthritis of the knee.

The review of the Care Plan dated 2/18/20, revealed Resident #12 had an activities of daily living (ADL) self-care performance deficit related to confusion, impaired balance, limited mobility, limited range of motion (ROM), pain and right

The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F676: Activities of Daily living
The facility failed to implement restorative services as referred by the facility□s rehabilitative department to maintain or improve resident's level to ambulate and transfer for restorative services for Resident #12.

Address how corrective action will be

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wrist fracture. Interventions included: refer to physical and occupational therapies, whenever necessary; praise all efforts at self-care; and allow the resident plenty of time to complete tasks.

The quarterly minimum data set dated 5/19/20 indicated Resident #12 was severely cognitively impaired; required limited assistance with bed mobility, transfers, toileting, walking, and hygiene; had no impairments with range of motion.

The resident's Physical Therapy Discharge Summary dated 6/17/20 recommended Resident #12 continue ambulation and exercise with the facility's Restorative Program. There were two Restorative Care Referrals dated 6/17/20 indicating Resident #12 was to receive: the ROM and walking restorative services 6-times per week and contact guard for walking; and the walking and transfers restorative services 1-time per day, 5-times per week with contact guard and minimal assist. Instructions were provided to the restorative aides. Both referrals indicated these services were to begin on 6/18/20.

There was no documentation available in the resident's medical record that specified Resident #12 received restorative services from 06/18/20 to 7/13/20.

During an interview on 7/13/20 at 3:41 p.m., the Occupational Therapist (OT) stated that Resident #12 was currently receiving OT which was restarted on 5/19/20 due to her decline in self-care and would be discharged from OT on 7/14/20. The OT stated the resident received PT (physical therapy) for ambulation and was discharged on 6/17/20. The OT revealed that

F 676

accomplished for those residents found to have been affected by the deficient practice: On August 5, 2020, resident #12 was reassessed by Physical therapy staff to determine current ambulation and transfer status. Resident #12 was picked up by Physical Therapy as a result of assessment.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On August 4, 2020, the Director of Nursing and Restorative Registered Nurse (RN) reviewed 100% of all residents with current restorative programs. Of the 19 residents with current plans, 15 plans were revised, 3 were discontinued, and 1 was referred to physical or occupational therapy for reevaluation.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur : On August 5 & 6, 2020 the Director of Nursing initiated education for Restorative RN and the MDS Nurse and on July 14, 2020 the Administrator initiated education for the restorative aides on the Liberty Restorative Program that included initiation of restorative nursing services to maintain or improve a residents level of ambulation or transfer. This also included education that residents can begin a restorative plan immediately as ordered even while remaining on caseload with Physical or Occupational Therapy.

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F 676	Continued From page 3 whenever a long-term care resident completed and was discharged from therapy, the resident was referred to the facility's Restorative Program for maintenance. During an interview on 7/14/20 at 2:55 p.m., Restorative Aide (RA) #1 stated Resident #12 was currently not receiving restorative services as requested by PT on 6/17/20, because the resident continued OT. She explained that if a resident received therapy from multiple disciplines (OT, PT, ST) and was discharged from one of the therapies with a referral for restorative, the resident would not receive restorative services until the resident was discharged from all of the therapy disciplines. On 7/14/20 at 3:00 p.m. during an interview, the Administrator stated the Minimum Data Set (MDS) Coordinator oversaw the facility's Restorative Program but was not available for interview. The Administrator stated that once the rehabilitative department submitted a referral for a resident to receive restorative, her expectation was for the restorative services to begin in a timely manner. During an interview on 7/14/20 at 3:28 p.m., the Rehabilitative Manager and the facility's OT revealed the restorative referrals were discipline specific (OT, PT, or ST). Resident #12 was weightbearing as tolerated. The resident's orthopedic follow-up visit would not have delayed or impacted her start date for restorative services. During an observation on 7/14/20 at 4:00 p.m., Resident #12 was propelling herself in her wheelchair towards the nursing station from her room. The resident was verbally responsive, but	F 676	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed: On August 7, 2020 the Director of Nursing will initiate quality assurance monitoring audit of 5 residents restorative programs weekly x 4 then monthly x 3 , to include at least one new referral from the facilities therapy department if available for timely initiation of restorative program for resident restorative nursing services. QA monitoring will be reviewed during the facility QA meeting monthly for follow up. The QA meeting is attended by the Administrator, Director of Nursing, Unit managers, Dietary Manager, Minimum Data Set Registered Nurse, Environmental/Housekeeping Director, and Health information Manager.	

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F 676	Continued From page 4 with hearing difficulties. During a telephone interview on 7/15/20 at 4:33 p.m., the Administrator revealed the Director of Nursing (DON) was able to locate documentation which showed Resident #12, only received restorative services for two days (on 6/18/20 and 6/19/20). She stated that both restorative aides were re-educated on the expectation that restorative referrals were to be started with residents when referrals were recommended by the rehabilitative discipline to ensure continuity of the program as planned when discharged from therapy. During a telephone interview on 7/16/20 at 12:09 p.m., the Rehabilitative Manager stated that if a resident did not receive restorative services when and as requested by the rehabilitative department, the resident could possibly loose his/her quality and consistent distance of ambulation.	F 676		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		8/9/20

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new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, staff interviews and wound physician interview, the facility failed to provide pressure ulcer care per physician orders, assess and monitor a resident's buttocks pressure ulcer, and ensure the resident's heels were floated off the bed to relieve pressure for 2 of 5 (Resident #7 & Resident #18) sampled residents reviewed for pressure ulcers.

Findings included:

1. Resident #7 was admitted to the facility on 10/28/15 with diagnoses that included, in part, heart failure, diabetes mellitus and dementia.

A significant change Minimum Data Set (MDS) assessment dated 6/24/20 revealed Resident #7 had cognitive deficit and required one-to-two-person extensive assistance with bed mobility, transfers and toileting. Resident #7 was non-ambulatory and incontinent of bowel and bladder. The MDS documented that Resident #7 was at risk for pressure ulcers and had acquired one stage 4 pressure ulcer and two unstageable pressure ulcers during her admission to the facility.

The resident's care plan, which was updated on 6/26/20, specified Resident #7 had skin breakdown, was at risk for pressure ulcer development related to decreased mobility, incontinence, poor appetite due to poor prognosis related to my terminal illness. Care plan interventions included frequent position changes, incontinence care as needed, and staff to encourage more meal/supplement intake.

F 686

F686 Treatment / Services to Prevent/Heal Pressure Ulcer
The facility failed to provide pressure ulcer care per physician orders, assess and monitor a resident's buttocks pressure ulcer, and ensure the resident's heels were floated off the bed to relieve pressure for Resident #7 & Resident #18.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On June 30, 2020 the Director of Nursing discontinued previous treatment orders for resident #7 and reviewed current treatment orders with Wound doctor, no new orders were needed. Resident # 7 wounds were reassessed on 7/17/2020 by the Director of Nursing that Staff Development Director (RN).

On 7/17/2020 the Director of Nursing and the Staff Development Director (RN)reassessed resident #18 skin condition and ensured a pillow was in place to float heels. On July 17, 2020 the Director of Nursing documented Resident #18 current wound status .

Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On July 14, 2020 100 % of current residents skin assessments were completed by the Director of Nursing, Unit managers, two visiting wound nurses and

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A review of the physician's orders revealed a treatment order dated 6/25/20 that instructed to clean Resident #7's stage 4 sacral wound with normal saline, apply calcium alginate, Santyl, and to cover with dry dressing daily. There was also an order dated for 6/30/20 that stated to clean with normal saline, pat dry, apply dakins wet to moist to wound bed, cover with dry protective dressing, and change twice a day.

Review of the medication and treatment administration records from June 2020, revealed that staff had documented that they were completing both of the treatments ordered for Resident #7 at 2:00 PM daily.

During a dressing observation with Nurse #3 on 7/12/20 at 1:00 PM, the dressing Nurse #3 was observed to place on Resident #7's sacral wound was a dry dressing with dakins packed into the wound bed. Nurse #3 stated that she had cleansed the wound, applied Santyl and then had packed the wound with dakins wet to moist dressing. There was no calcium alginate applied to wound bed. When asked if she usually does the treatments, she stated that there is no treatment nurse, so depending on the assignment, she does them on occasion.

During an interview and review of the treatment orders on 7/13/20 at 10:50 AM with Nurse #3 there were several orders in place for the stage 4 sacral dressing. When asked to verify what she had applied to the resident's wound on 7/12/20 she stated again that she had cleansed the wound, applied Santyl with crushed Flagyl, packed with dakins, and covered with a dry dressing, there was no calcium alginate placed

F 686

Staff development RN. On July 17, 2020 all residents identified as having pressure ulcers were reviewed by the Director of Nursing and Staff Development Director (RN) to assure appropriate treatment orders and documentation were in place. All care plans for residents with pressure ulcers have been updated to reflect treatment plan and interventions.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On July 3 through July 17, 2020 the Director of Nursing, Administrator and Staff development RN began education for all staff Nurses on completion of skin assessments and importance of weekly skin documentation. On July 3 through August 7, 2020 the Staff Development RN and Director of Nursing initiated education to all nursing staff on the importance of skin care, floating heels and use of heel boots, turning and repositioning as well as reporting changes in skin condition.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed: On July 17, 2020 the Director of Nursing and Staff Development RN initiated quality assurance monitoring with audits of all residents with pressure injuries to assure weekly documentation as well as appropriate treatments and to assure interventions in place as care planned weekly x 4 then monthly x 3. QA

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F 686	Continued From page 7 during the dressing change. During an interview with the Unit Manager on 7/13/20 at 11:18 PM she stated that orders from the Wound MD were transcribed and double checked by her. When shown the multiple orders for Resident #7's dressing changes, she stated that the old treatment orders must not have been discontinued. The Unit Manager called the Wound MD and verified the correct orders that he wanted for her treatment. A new order was placed on 7/13/20 to clean Resident #7's stage 4 sacral wound with normal saline, apply calcium alginate, Santyl with crushed Flagyl to wound bed and to cover with dry dressing daily. When asked if it was possible to perform both of the dressings ordered at 2:00 PM as documented, she stated no it was not. During an interview with the Wound MD on 7/14/20 at 2:03 PM he stated that he was notified of the multiple dressings ordered and had specified to staff that he wanted Resident #7's stage 4 sacral wound cleansed with normal saline, to apply calcium alginate, Santyl with crushed Flagyl to wound bed and to cover with dry dressing daily. He stated that the dakins solution counteracts the Santyl debriding agent. When asked if this could have harmed the resident, he stated that it would not harm the resident, and added that it was his expectation that his wound treatment orders were followed and deleted when new ones were added. 2. Resident #18 was admitted to the facility on 5/22/20 with diagnoses of closed compression fracture of lumbosacral spine, and history of cancer.	F 686	monitoring will be reviewed at the facility QA meeting monthly for follow up. The QA meeting is attended by the Administrator, Director of Nursing, Unit mangers, Dietary Manager, Minimum Data Set Registered Nurse, Environmental/Housekeeping Director, and Health information Manager.	

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F 686	Continued From page 8 A record review revealed Resident #18 had a pressure ulcer risk assessment completed on 5/22/20. The resident's total score was 17, indicating she was at risk for pressure ulcer development. An admission Minimum Data Set (MDS) assessment dated 5/29/20 revealed Resident #18 had intact cognition. She required extensive assistance of 2 people with bed mobility, transfers and toileting. Resident #18 was non-ambulatory and continent of bowel and bladder. She had no current pressure ulcers and was at risk for developing pressure ulcers. The resident's care plan, which was updated on 6/15/20, specified Resident #18 had a pressure ulcer on her buttocks and was at risk for pressure ulcer development related to decreased ability to assist with repositioning. Care plan interventions included frequent position changes, encourage weight shifting and float heels on pillow when in bed. A review of the physician ' s orders revealed a treatment order dated 6/16/20 which read, clean wound with normal saline apply calcium alginate dressing and cover with foam dressing to wound. Resident #18's medical record revealed from 6/17/20 to 6/24/20 there was no information documented in the medical record regarding the condition of the pressure ulcer on the resident's buttocks. A progress note dated 6/25/20 by the physician revealed Resident #18 had developed a small open wound to her right inner buttock	F 686		

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approximately 5 centimeters by 5 centimeters with no surrounding erythema and non-draining granulation base.

Resident #18's medical record revealed from 6/26/20 to 7/14/20 there was no information documented in the medical record regarding the condition of the pressure ulcer on the resident's buttocks.

An observation on 7/14/20 at 8:20 AM revealed Resident #18 was lying in her bed. Resident #18's feet and heels were resting flat on the mattress; her heels were not floated on a pillow as specified in her care plan.

An observation of wound care on 7/14/20 at 9:15 AM revealed Resident #18 lying in her bed with her feel and heels lying flat on the mattress; her heels were not floated. Observation was made of a small open area approximately pea-sized on Resident #18's right buttock. Nurse #1 completed the treatment per the physician's order.

An interview was conducted with Nurse #1 on 7/14/20 at 9:15 AM. She stated the facility did not have a wound care nurse. She stated the nurses did their own treatments unless there was an extra nurse on staff that could perform the resident's treatments. She stated when she did the treatments, she signed off on the TAR. She stated she did not measure Resident #18's pressure ulcer and she was not being seen by wound care. Nurse #1 was unaware of who was responsible for measuring the residents pressure ulcer. She stated the Director of Nursing would have to be asked for information regarding measuring and weekly documentation of the resident's pressure ulcer because she did not

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F 686	Continued From page 10 know. An interview was conducted on 7/14/20 at 1:50 PM with Nurse Aide (NA) #1. NA #1 stated she knew Resident #1 had to have her heels floated because she tried to float all of the resident's heels. The surveyor asked NA #1 why Resident #18's heels were not floated while she was in bed during the morning of 7/14/20 NA #1 replied, "second shift puts her in bed". An interview was conducted with the Director of Nursing (DON) on 7/14/20 at approximately 3:30 PM. She stated information on wounds was in the resident charts. The surveyor requested the DON to provide information on Resident #18's pressure ulcer that was on the resident's buttocks. An interview was conducted with the DON and the Administrator on 7/15/20 at 8:28 AM. The Administrator stated they did not currently have a wound care nurse and she was aware there were concerns regarding wounds not being tracked. Email correspondence from the Administrator to the surveyor on 7/16/20 at 6:16 PM indicated the facility was unable to find any documentation of assessment or evaluation of Resident #18's buttocks pressure ulcer from 6/17/20 to 6/24/20 and from 6/26/20 to 7/14/20.	F 686		
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	F 880		8/9/20

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(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
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development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345167	A. BUILDING ______ B. WING ______	C 07/16/2020

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F 880	Continued From page 12 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the facility's Policy titled, "COVID-19 Preparation and Response," the facility failed to implement their COVID-19 policy on wearing required personal protective equipment (PPE) when 1 of 1 staff failed to wear a mask that covered her mouth and/or nose while working at an opened nursing station (Nurse #2). This failure occurred during a COVID-19 pandemic. The findings included: A Review was conducted of the facility policy Titled, "COVID-19 Preparation and Response," revised on 6/26/2020. The policy specified that all employees will wear a mask while in the facility with the only exception when in an office alone	F 880	F880; Facility failed to implement their COVID-19 policy on wearing required personal protective equipment (PPE)when 1 of 1 staff failed to wear a mask that covered her mouth and/or nose while working at an opened nursing station (Nurse #2). This failure occurred during a COVID-19 pandemic. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Nurse # 2 resigned position prior to education for failure to wear face mask while sitting at nurses station. Address how the facility will identify other	

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and while eating.

On 7/14/2020 at 10:16 a.m., Nurse #2 was observed sitting at a nursing station, that was open to the hallway, wearing a mask that was positioned below her nose. During an interview with Nurse #2 on 7/14/20 10:17 a.m., she stated her mask was too loose and slid down. The Nurse was repositioned the mask to cover her nose.

On 7/14/2020 12:32 p.m. to 12:34 p.m., Nurse #2 was observed sitting at the nursing station not wearing a mask with her nose and mouth uncovered

On 7/14/2020 at 2:02 p.m., Nurse #2 was observed sitting at the nursing station with her mask positioned below her nose. Her nose was completely uncovered.

On 7/14/2020 at 3:15 p.m., Nurse #2 was observed sitting at the nursing station with a mask properly positioned on her nose and face. At this time, an interview was conducted with the Nurse #2. She stated that infection control education was completed on the COVID-19 signs and symptoms to assess for in staff and residents. She stated that staff were educated on when to wear personal protective equipment such as gowns, mask, gloves and how to appropriately put on each item and remove the item. They were checked off by the infection control nurse on proper use. She stated that staff were trained on the COVID-19 facility policy and provided a copy to review.

On 7/15/2020 at 1:24 p.m., a telephone interview was conducted with the Administrator. The

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residents having the potential to be affected by the same deficient practice: On August 7, 2020 the Infection Control Nurse completed a walking round observation of nursing stations and other resident areas, no other staff were found to have masks off. Three staff with poorly applied face masks were observed with masks falling below nose and were re-educated on techniques to prevent masks from sliding down below nose.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On August 7, 2020 the Director of Nursing and Staff development RN completed re-education of staff on COVID 19 policy to include use and placement of PPE while working in resident areas, CMS recommended video "Keep Covid 19 Out" and a "Facemasks Do's & Don'ts handout". This included both clinical and non- clinical staff. PRN staff and staff on FMLA or vacation will not be allowed to work until re-education is completed.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On August 7, 2020 the Director of Nursing and Infection Control Nurse initiated quality assurance(QA) monitoring rounds of 5 staff members for use of personal protective equipment (PPE)to assure that it is being properly applied. This is to include observations of both clinical and non- clinical staff to validate PPE use, weekly x 4 then monthly x 3. QA

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F 880	Continued From page 14 Administrator stated that it was her expectation that all staff wear a mask in the facility in resident care areas, hallways and areas open to residents. She stated staff should only remove their mask if they were in an office alone.	F 880	monitoring will be reviewed at the facility QA meeting monthly for follow up. The QA meeting is attended by the Administrator, Director of Nursing, Unit managers, Dietary Manager, Minimum Data Set Registered Nurse, Environmental/Housekeeping Director, and Health information Manager.	