STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345089	A. BUILDING _____ B. WING _____	C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALNUT COVE HEALTH AND REHABILITATION CENTER	**511 WINDMILL STREET WALNUT COVE, NC 27052**

(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 Survey was conducted on 09/09/2020-09/10/2020. 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# RG2K11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 09/09/2020 through 09/10/2020. The facility was found not in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 1 of the 8 complaint allegation(s) was/were substantiated resulting in deficiencies.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		10/10/20

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

Electronically Signed | 10/05/2020

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F 880	Continued From page 1 §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. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 2 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 "COVID 19 Plan and Protocols" policy, the facility failed to implement their COVID-19 policy when: 1) two visitors were not screened upon entry to the facility and were going to be allowed into resident care areas. 2) Two staff members were observed wearing a face mask below their nose in a resident care area (Nursing Assistant #1 and the Minimum Data Set Coordinator). 3) 2 of 2 staff failed to perform hand hygiene when assisting residents during designated smoke breaks (Nursing Assistant #2 and Nurse #1) 4) Additionally, the facility failed to develop a policy to clean and disinfect the facility's designated smoking area and staff failed to clean and sanitize shared ashtrays and smoking aprons between resident uses. These failures occurred during a COVID-19 pandemic. The findings included: A review was conducted of the facility policy titled "COVID 19 Plan and Protocols." The policy specified that anyone who enters the facility will be required to pass a screening at the front entry,	F 880	The surveyors were checked in upon notification of oversight on 9/9/20 by the Director of Nursing. Nursing Assistant #1 and the Minimum Data Set Coordinator were educated on proper use of mask on 9/11/20 Nursing Assistant #2 and Nurse #1 were educated by the Director of Nursing to perform hand hygiene when assisting residents during designated smoke breaks on 9/11/20. The smoke area, to include ashtrays and smoke aprons, were sanitized on 9/11/20 by housekeeping staff. The Pandemic Plan was updated on 9/25/20 to include sanitizing the smoke break area after use. The Root/Cause Analysis was completed by the Regional Vice President of Operations, the Regional Director of Clinical Services, the Executive Director and the Director of Nursing on 9/25/20. The Executive Director conducted a quality review of infection control practices	

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F 880	Continued From page 3 wear a face mask while in resident care areas, perform hand hygiene before and after resident contact and will limit resident to resident contact and/or gatherings. 1. On 9/9/2020 at 10:00 a.m., two surveyors entered the facility's front entrance at the same time as the Director of Nursing (DON). The surveyors were not screened for the COVID-19 virus when they entered the facility. The Director of Nursing directed the surveyors to follow her out of the front lobby area to an office where an entrance conference was conducted with the DON, and Staff #1 entered the office to provide computer set up. The DON did not to screen the surveyors for the COVID19 virus. On 09/09/20 at 10:57 a.m. prior to walking into resident care areas, one surveyor informed the DON and the Corporate nurse consultant that she would now be going to resident care areas to make observations. The DON stated, "ok." The surveyor then informed the DON and the nurse consultant that the two surveyors had not been screened by staff and were being allowed enter a resident care area. An interview was conducted with the DON on 09/09/2020 at 10:57 a.m., regarding the two surveyors not being screened when they entered the facility. She stated, "I had thought someone else screened you." She stated it was the company's policy that all visitors be screened prior to entering the building. The DON stated a staff member was assigned to complete the screening task when visitors entered the facility's front lobby. But she asked this employee to perform another task at the time the surveyors entered the building.	F 880	as related to the screening of staff/visitors/vendors/health care providers on 9/14/20. The Director of Nursing/Unit Managers conducted a quality review of infection control practices as related proper utilization of masks, proper sanitizing between patients on smoke breaks and sanitizing the ash trays, smoke aprons and the smoke area on 9/11/20. Follow up based on findings. The Regional Vice President of Operations with the Regional Director of Clinical Services educated the Executive Director and the Director of regarding to screening of staff/visitors/vendors/healthcare providers when they enter the building, the need to keep face mask covering both mouth & nose, the need to hand sanitize whenever the mask or any potentially contaminated surface is touched, the updated pandemic plan and infection control practices related to supervising the smoke breaks along with sanitation of smoke aprons, ashtrays and the smoke area also on 9/25/20. The Director of Nursing provided re-education to staff regarding to screening of staff/visitors/vendors/healthcare providers when they enter the building, the need to keep face mask covering both mouth & nose, the need to hand sanitize whenever the mask or any potentially contaminated surface is touched, the updated pandemic plan and infection control practices related to supervising the smoke breaks along	

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F 880	Continued From page 4 On 09/09/2020 at 11:01 a.m. the two surveyors were screened for COVID-19 signs, symptoms and exposure, by the DON. 2. On 09/09/2020 at 11:20 a.m. an observation was made of nursing assistant (NA) #1, walking on the South hall with her mask below her nose, past Resident #3. Resident #3 was sitting in her wheelchair in the hall with her mask below her nose. On 09/09/2020 at 11:25 a.m. an observation was made of the Minimum Data Set (MDS) Coordinator as he walked down the 100 hall, an area with resident rooms, with his face mask below his nose. He was observed to adjust his mask and pulled it over his nose but failed to perform hand hygiene prior to walking into the front office and handing a folder to a staff member. On 09/10/2020 at 8:30 a.m., an interview was conducted with the DON. She stated it was her expectation that all staff wear a face mask that covers their nose and mouth while in a resident care area. 3. On 09/09/2020 at 2:00 p.m., an observation was made of the facility's courtyard smoking area, during the 2:00 p.m. resident smoke break. Six residents and two staff members were present (NA #1 and nurse #1). Five ashtrays were available on tables for residents to use in the smoking area. More than ten used cigarette butts were observed in the five available ashtrays. The residents were observed sharing ash trays and no hand hygiene was being performed by the staff or residents in the smoking area. Nurse #1 was observed, at 2:05 p.m., to touch the cigarette	F 880	with sanitation of smoke aprons, ashtrays and the smoke area also by 10/9/20. The Executive Director will conduct random Quality Improvement Monitoring of checking in vendors, staff and health care providers 3 times weekly for 4 weeks, then weekly times 8 weeks, then monthly to ensure staff are following infection control practices during entrance of staff/visitors/vendors/healthcare providers. Monitoring schedule modified based on findings. The results of the stated Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee by the Executive Director monthly. The Director of Nursing/Unit Managers will conduct random Quality Improvement Monitoring of staff properly wearing face masks, 3 times a week for 4 weeks, then weekly times 8 weeks, then monthly to ensure staff are following infection control practices regarding wearing face masks. The monitoring schedule will be modified as needed based on the findings. The results of the stated Quality Monitoring will be presented to the Quality Assurance Performance Improvement Committee monthly by the Director of Nursing. Director of Nursing/Unit Manager/Executive Director to conduct random Quality Improvement Monitoring during smoke break 3 times weekly for 4 weeks, then weekly times 8 weeks to include sanitizing between residents as well as sanitation of the ashtrays, smoke aprons and smoke area. The results of the above Quality Monitoring will be	

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F 880	Continued From page 5 storage container and to pull out the individually labeled bags without performing hand hygiene. An interview was conducted with nurse #1 on 09/09/2020 at 2:15 p.m., while she monitored the 2:00 PM resident smoke break. She confirmed during the smoke break five ashtrays were present that were being shared by the six residents present in the smoking area and used cigarette butts were in the ash trays. UM #1 stated, residents used the same ashtrays from one scheduled smoking break to the next and the ash trays were not cleaned in between scheduled smoke breaks. UN #1 stated there were more than ten residents in the facility who were approved for supervised smoking. An observation was made on 09/09/2020 at 4:47 p.m. of the courtyard smoking area, five ashtrays were on tables in the courtyard. Nursing assistant (NA) #2, who was in the courtyard. NA #2 was observed to remove an ashtray from Resident #4's hands and sit it on the table. NA #2 did not perform hand hygiene after removing the ashtray from the resident's hands. There was no hand sanitizer observed to be available in the courtyard. NA #2 then picked up a large sized bag, that contained smaller bags of cigarettes, that were individually labeled with resident's names, and she sealed the bag. NA #2 then walked to Resident #5, removed the smoking apron the resident was wearing and placed the smoking apron on a hook. NA #2 did not clean or disinfect the smoking apron and did not perform hand hygiene. NA #2 was observed to push Resident #5 in her wheelchair from the courtyard to the building. NA #2 pushed a button which opened a door to the facility and NA #2 assisted Resident #5 into the building. On 09/09/2020 at	F 880	presented to the Quality Assurance Performance Improvement Committee by the Director of Nursing monthly. Compliance Date: 10/10/20	

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F 880	Continued From page 6	F 880		

5:11 p.m. NA #2 was observed to utilize hand sanitizer at the first available hand sanitizer dispenser and offered hand sanitizer to Resident #5.

An interview was conducted with NA #2 on 09/09/2020 at 5:00 p.m. She stated she did not clean the ashtrays or smoking aprons after a resident used and touched them. She confirmed hand hygiene was not conducted outside in the courtyard during smoke breaks by staff or residents. NA #2 stated hand hygiene was performed by staff and residents, once they were inside the building after the smoking break.

An interview was conducted with the Director of Nursing (DON) on 09/10/2020 at 8:30 a.m. She stated it was her expectation that staff perform hand hygiene between contact with each resident during a smoke break. She stated 100% of staff had received education to perform hand hygiene during smoke breaks prior to the facility allowing residents to resume smoke breaks. She said that staff were not cleaning the ashtrays in between smoke breaks or at regular intervals. The DON stated the staff had not been providing individual ashtrays for residents to use, if more than five residents were present during smoke break. She stated hand sanitizer would be provided outside immediately in the courtyard for staff and residents to perform hand hygiene. The DON explained the facility would develop and implement a policy for cleaning the facility's smoking area including; shared ashtrays and smoking apron.