STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345462	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS-BREVARD	300 MORRIS ROAD BREVARD, NC 28712

(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 uannounced COVID-19 Focused Survey was conducted on 05/21/20. 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# GV0U11.	E 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 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	F 880		6/8/20

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

Electronically Signed | 06/08/2020

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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F 880	Continued From page 1 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 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 "Infection Prevention - Hand Hygiene" policy, the facility failed to perform	F 880	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid	

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F 880	Continued From page 2 hand hygiene before or after delivering clothing items to 4 of 4 resident rooms (Rooms #405, #406. #407, #408). These failures occurred during a COVID-19 pandemic. The findings included: A review was completed of a facility policy titled, "Infection Prevention - Hand Hygiene", revised March 2019. The policy specified when hands were not visibly soiled or contaminated with blood or body fluids, an alcohol-based hand sanitizer could be used after contact with objects in the immediate vicinity of the resident. An observation was conducted on 05/21/20 at 10:50 AM of Housekeeping Aide (HA) #1 delivering clothing items to resident rooms located on the 400 Hall. HA#1 retrieved clothing items from the linen cart positioned in the middle of the resident hall, entered Room #405, opened the closet door, hung the items inside the closet, shut the closet door, and then exited the room without sanitizing her hands. HA#1 returned to the linen cart, retrieved more clothing items, entered Room #407 and completed the same process without performing hand hygiene. Residents were present in the room during the observations and hand sanitizer dispensers were observed mounted on the inside wall by the door of each resident room. An observation was conducted on 05/21/20 at 10:55 AM of HA#2 delivering clothing items to resident rooms located on the 400 Hall. HA#2 retrieved clothing items from the linen cart positioned in the middle of the resident hall, entered Room #406, opened the closet door, hung the items inside the closet, shut the closet	F 880	requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents. What Corrective action will be accomplished for the residents found to have been affected by the deficient practice? "Housekeeper Aides 1 and 2 who were responsible for delivering clothing to residents residing in rooms 405,406, 407 and 408 were educated on hand hygiene by the Clinical Competency Coordinator (CCC) on 5/29/20 and will be audited daily Monday- Friday for compliance for 2 weeks beginning 6-8-2020, then weekly for 4 weeks or until compliance is met. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? "All residents could be affected by this deficiency; therefore, all staff were educated on hand hygiene by the CCC. In addition the CCC will do audits for 1 staff member from housekeeping/laundry, dietary, and rehabilitation dept once daily	

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F 880	Continued From page 3 door, and then exited the room without sanitizing her hands. HA#2 returned to the linen cart, retrieved more clothing items, entered Room #408 and completed the same process without performing hand hygiene. Residents were present in the room during the observations and hand sanitizer dispensers were observed mounted on the inside wall by the door of each resident room. During an interview on 05/21/20 at 11:10 AM, HA#1 stated she did not normally perform hand hygiene in-between entering the resident rooms when delivering clean laundry and had not been instructed to perform hand hygiene when entering or exiting a resident's room. HA#1 confirmed she did not perform hand hygiene in-between entering the resident rooms on 400 Hall or after she placed the clean clothing in their closets and exited the resident room. During an interview on 05/21/20 at 11:15 AM, HA#2 shared she had received recent training due to the COVID-19 pandemic and was instructed to sanitize her hands when entering and exiting each resident's room. HA#2 confirmed she did not perform hand hygiene before or after entering the resident rooms on 400 Hall to place clean clothing items in their closets and added, "to be honest, I just forgot." The Housekeeping Supervisor was no longer employed and unable to be interviewed. During an interview on 05/21/20 at 1:00 PM, the Director of Nursing stated all facility staff were instructed and expected to perform hand hygiene each time they entered and exited a resident's room.	F 880	Monday- Friday beginning 6-8-20 and continuing for 4 weeks or until compliance is met. The CCC will report any occurrences to the Director of Nursing. "In addition the Infection control infectious disease monitoring tool will be done daily for 2 nursing staff to monitor for proper Hand Hygiene and infection control measures. This monitoring will begin 6/08/20 and continue for 4 weeks. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur? "The Clinical Competency Coordinator and Director of Nursing will conduct daily infection control rounds and follow each Department to ensure proper procedures are being utilized "The CCC re-educated all staff on proper Hand Hygiene on 5-29-2020 and 5-30-2020. Any staff on PTO or FMLA will not be allowed to return to work until they have been educated on hand hygiene. All new employees will be educated on hand hygiene during orientation How will the corrective action be monitored to assure that the deficient practice will not reoccur, i.e., what quality assurance program will be put in place for monitoring to assure continued compliance. "The Administrator and Director of	

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F 880	Continued From page 4 During an interview on 05/21/20 at 1:20 PM, the Administrator shared all facility staff had received education on hand hygiene and knew what they needed to do. The Administrator confirmed all facility staff were expected to perform hand hygiene every time they entered and exited a resident's room.	F 880	Nursing will be responsible for compliance of the monitoring of this plan of correction and daily audits sheets will be reviewed and signed daily for 6 weeks. " In addition, the Administrator will monitor the compliance of this POC in weekly Risk meetings for 12 weeks and QAPI meetings thereafter to ensure we have appropriate corrective action. Changes will be made to the plan by the committee as indicated to include, but not limited to, further education and/or immediate corrective action Date of Compliance: 6/8/2020	