STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345205	A. BUILDING _____ B. WING _____	C 08/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

(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 07/28/2020. 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# 12SB11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 07/28/20 with exit from the facility. Additional information was obtained through 08/07/2020. On 8/17/20 the extended survey was completed and the credible allegation of compliance was vaildated. Therefore, The exit date was changed to 8/17/2020. 2 of the 6 complaint allegations were substantiated and cited. Event ID# 12SB11. Immediate Jeopardy (IJ) was identified at CFR 483.12 at tag F880 at a scope and severity of K. Immediate Jeopardy (IJ) began on 07/28/20 and was removed on 08/11/20. An extended survey was conducted on 8/17/20.	F 000		
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	F 695		9/7/20

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

Electronically Signed | 09/02/2020

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F 695	Continued From page 1 by: Based on staff interview and record review, the facility failed to obtain an order for oxygen therapy for an oxygen dependent resident while in the facility and failed to ensure oxygen therapy was provided to meet the needs of an oxygen dependent resident at discharge for 1 of 1 residents reviewed for respiratory care (Resident #52). Findings included: Resident #52's emergency room history and physical dated 07/06/20 revealed she required continuous oxygen at 6 liters per minute via nasal canula (O2 6L/NC) for chronic respiratory failure with hypoxia and the oxygen should be continued. Resident #52 was admitted on 07/07/20 with diagnoses that included interstitial pulmonary disease, cor pulmonale (right sided heart failure), and acute and chronic respiratory failure with hypercapnia/hypoxia (lung conditions that affect breathing). Resident #52's respiratory care plan dated 07/07/20 indicated she had potential for ineffective breathing pattern with interventions that included oxygen therapy and monitoring for signs and symptoms of insufficient breathing pattern, shortness of breath, and blueness of the lips. A progress notes written by the nurse practitioner dated 07/08/20, 07/09/20, 07/13/20, and 07/14/20 revealed Resident #52 was oxygen dependent. A 5-day Minimum Data Set (MDS) assessment dated 07/13/20 indicated Resident #52 was	F 695	Westwood Hills Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Westwood Hills Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Resident # 52 was provided oxygen before discharge. Residents #52 is no longer a resident at the facility. All oxygen dependent residents have been identified through review of physician orders, if a resident is identified as oxygen dependent the unit manager or nursing supervisor will place the resident on review for the Cardinal IDT meeting. Upon discharge, any oxygen dependent resident will be identified per the Discharge Instructions and Plan of Care, by the RN unit manager or designee. The	

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F 695	Continued From page 2 cognitively intact. It further noted Resident #52 had received oxygen therapy and experienced no shortness of breath. A nurses' discharge progress note written on 07/18/20 at 09:48 AM revealed Resident #52 had been discharged on oxygen via NC. A review of the monthly physician orders dated July 2020 revealed no orders for oxygen use. A review of the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) dated July 2020 revealed there were no orders for oxygen or nurse signatures of usage. An interview was conducted with Nurse Aide (NA) #3 on 08/05/20 at 3:46 PM. The NA indicated she had been aware of Resident #52's oxygen dependence. She stated she had transported Resident #52 via wheelchair outside to the family member's car for discharge and had not placed her on oxygen during the transport. She stated Resident #52 had developed shortness of breath and had been brought back into the lobby. The NA reported she left Resident #52 in the lobby while she ran back to Resident #52's room to look for her personal O2 tank. When she returned to Resident #52 two or three minutes later, her lips were pale, and the color improved after the oxygen was put on. She stated she had forgotten to report this to the nurse. An interview was conducted with Nurse #7 on 08/04/20 at 12:31 PM. The nurse revealed that she had discharged Resident #52. She recalled Resident #52 had been oxygen dependent and required continuous oxygen. Nurse #7 stated it had been after the discharge that she had been	F 695	discharging nurse will meet with the resident and their responsible party to review the discharge instructions and plan of care. The nurse will provide the resident with oxygen to use for transport out of the facility. The nurse will then instruct the certified nursing assistant to help the resident and responsible party to the car. The CNA will report back to the nurse how the resident tolerated the transportation out of the facility. A 100% audit oxygen dependent residents have been audited for physician orders by the Director of Nursing and or designee. This was completed on 8/31/2020. Two nurses will verify all new admissions for complete orders, including oxygen, on the Admission Audit Tool. The Social Worker will notify the facility through the facility morning meetings of any upcoming discharges; she will make the team aware if the resident will require oxygen at discharge. The Discharge Instructions and Plan of Care form will include oxygen administration instructions per the physician orders, which will be completed by the discharging nurse, and the social worker will complete the section for Education and Equipment, which will give the name of the durable medical equipment company along with contact information providing the oxygen. If the resident has their own oxygen tank and company it will be noted on the Discharge instruction and plan of care form. The Cardinal IDT Interdisciplinary Team will review all new admissions, using the Admission and Discharge Forms. MD orders for oxygen will be validated at this	

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F 695	Continued From page 3 made aware of Resident #52's symptoms and that she had not been placed on oxygen during transport. Nurse #7 also explained a physician order for oxygen therapy was required and usage should be documented on the MAR each shift. An interview was conducted with the day shift supervisor (Nurse # 8) on 08/04/20 at 5:10 PM. Nurse #8 stated she recalled Resident #52 being oxygen dependent. Nurse #8 also revealed staff were to place an oxygen dependent resident on portable oxygen anytime they were being transported. Nurse #8 further elaborated that all residents requiring oxygen should have a physician's order and usage should be documented on the MAR every shift. An interview with the Director of Nursing (DON) was conducted on 08/05/20 at 1:51 PM. The DON stated she was aware Resident #52 had been oxygen dependent and had required continuous oxygen but she had been unaware of any concerns at the time of discharge. The DON explained that a physician order should have been be written for oxygen therapy. An interview with the Administrator was conducted on 08/13/20 at 4:07 PM. The Administrator explained the discharging nurse should have ensured Resident #52's oxygen was in place, the NA should not have transported the resident without oxygen, and she should have brought the resident back to the nurse for assessment. The Administrator further explained that physician orders should be verified upon admission.	F 695	time. All licensed nursing staff will be in serviced regarding MD orders for oxygen and discharge instructions and plan of care. The certified nursing assistances will be in-serviced on residents with oxygen and how to report to the nurse any changes in condition, discharge procedures for residents identified as needing oxygen while being transporting out of the facility and to report back to the nurse how the resident tolerated the procedure. These procedures will be trained during orientation of all new staff and agency. This training will be completed by the Director of Nursing and or designee by 9/7/2020. The Respiratory policy and procedure for oxygen therapy was reviewed and validated that the Admission Audit Tool and the Discharge Audit Tool are included. The Admission checklist is a tool developed by the facility to aide in providing guidance for the admission nurse to ensure all admission orders are completed. The Discharge Instructions and Plan of Care form is an assessment in the resident’s chart. The DON or designee will audit oxygen dependent residents weekly, utilizing the Oxygen Order Validation Tool, for current physician orders x 4 weeks, then monthly x2. The Findings of the audits from the Oxygen Order Validation Tool will be reviewed by QAPI monthly. The DON or designee will audit discharged residents weekly for appropriate Plan of Care, via the Oxygen Order Validation Tool x 4 weeks, then	

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F 695	Continued From page 4	F 695	monthly x 2. All discharged resident files will be reviewed in Cardinal IDT meetings to ensure residents that are on oxygen were discharged appropriately. Findings of the audits from the Oxygen Order Validation Tool will be reviewed by QAPI monthly.	
F 880 SS=K	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	F 880		9/7/20

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F 880	Continued From page 5 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 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, record review, staff interviews, review of the signage labeled "Droplet	F 880	Westwood Hills Nursing and Rehabilitation acknowledges receipt of the	

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F 880	Continued From page 6 Precautions" and review of the facilities infection control policies, the facility staff failed to don and doff PPE (Personal Protective Equipment) per CDC guidelines for residents under transmission based precautions, failed to display Enhanced Droplet Contact Precautions signage for confirmed and possible COVID-19 exposure resident rooms, and failed to perform hand hygiene before entering or after contact with a resident or objects in a residents room who were under isolation precautions. The facility failed to develop and implement a policy for Enhanced Droplet Contact Precautions for suspected and quarantined residents. These failures in infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents in the facility through the transmission of COVID-19. A total of 37 residents were confirmed as positive for COVID-19 as of 08/03/20. Immediate Jeopardy began on 07/28/20, when the facility failed to identify residents with potential exposure of COVID-19 by not placing them on Enhanced Droplet Contact Precautions, failed to implement basic infection control practices, and failed to prevent cross over of staff from the quarantine hall to the general population. Immediate Jeopardy was removed on 08/11/20 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility remained out of compliance at a lower scope and severity level of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. The findings included:	F 880	Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Westwood Hills Nursing and Rehabilitation's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Westwood Hills Nursing and Rehabilitation reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Residents #1, 3, 4, and 10 are no longer residents of this facility. Residents # 8 signage to included Enhanced Droplet-Contact Precautions was placed on the resident door on 8/10/2020. All staff will be able to see the new signage as they enter the room. Residents # 9 signage to included Enhanced Droplet-Contact Precautions was placed on the resident door on 8/10/2020. All staff will be able to see the new signage as they enter the room. Resident # 11 signage to included Enhanced Droplet-Contact Precautions was placed on each resident door on 8/10/2020. All staff will be able to see the new signage	

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F 880	Continued From page 7 According to the facility policy titled "Standard and Transmission-Based Precautions" dated 03/10/20 indicated in part: Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in healthcare facilities and standard precautions are used for the care of all residents. Handwashing should be performed after touching contaminated items whether gloves are worn or not, immediately after gloves are removed, between residents, and when otherwise necessary to avoid transfer of microorganisms to other residents or the environment. Good hygiene is essential and in the absence of an outbreak either soap and water or alcohol-based sanitizer may be utilized. Gloves are to be worn when touching contaminated items. Remove gloves promptly before touching non-contaminated items and environmental surfaces and before going to another resident. It further indicated in part under the heading titled sharps that care is to be taken to prevent injuries when using needles, scalpels, and other sharp objects or devices, when handling sharp instruments after procedures, when cleaning instruments, and when disposing of needles. The policy details contact, droplet and airborne precautions, but does not address the CDC's recommended isolation precaution of Enhanced Droplet Contact Precautions for the COVID-19 pandemic. During the entrance conference on 07/28/20 at 10:45 AM, the Director of Nursing (DON) identified the 600 hall was designated as the New Admission/ Observation quarantine hall. Observations on the 600 hall on 07/28/20 began	F 880	as they enter the room. Resident # 12 signage to included Enhanced Droplet-Contact Precautions was placed on the resident door on 8/10/2020. All staff will be able to see the new signage as they enter the room. Resident # 13 signage to included Enhanced Droplet-Contact Precautions was placed on the resident door on 8/10/2020. All staff will be able to see the new signage as they enter the room. Resident #14 signage to included Enhanced Droplet-Contact Precautions was placed on the resident door on 8/10/2020. All staff will be able to see the new signage as they enter the room. Residents #1 ,3, 4 and 10 are no longer residents of this facility. For residents #2 100% of staff in all departments were retrained in proper hand hygiene, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Resident #8 100% of staff in all departments were retrained in proper hand hygiene, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Resident #9 100% of staff in all departments were retrained in proper hand hygiene, beginning on 7/28/2020. Additional in servicing was given on	

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F 880	Continued From page 8 at 10:52 AM and ended at 2:20 PM and revealed Nurse #1, Nurse #2, Nurse Aide (NA) #1, NA #3, NA#6, and Housekeeper #1 were working on the facility's quarantine unit. The following observations were made: A review of the Droplet Precaution signage displayed in the 600 hall revealed a visual illustration that indicated staff were to wear a mask, perform hand hygiene before and after entering the room, and dietary was not permitted in these care areas. A review of the Contact Precaution signage displayed in the 600 hall revealed a visual illustration that indicated staff were to wear a gown and gloves, perform hand hygiene before and after entering the room, and to use single use equipment or sanitize multi-use equipment between patients. a. An observation on 07/28/20 at 10:56 AM revealed Housekeeper #1 wore a gown as she exited Resident #1's room and carried a mop, a soiled cloth, and a bottle of sanitizing spray. Signage on Resident #1's door indicated Droplet Precautions. Housekeeper #1, with her gloved hands, opened the lid of her cart using a key located on a lanyard around her neck. She placed the spray bottle in the cart, disposed of the used rag, and removed the soiled mop pad from the mop handle. Housekeeper #1 placed the mop pad in a plastic bag attached to the cart and disposed of her gloves. Housekeeper #1 then pushed her cart to Resident #2's room and did not perform hand hygiene. Resident #2's door revealed signage that indicated Droplet Precautions. When she approached Resident #2's room, she donned clean gloves, picked up	F 880	7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Resident #10 100% of staff in all departments were retrained in proper hand hygiene, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Resident # 11 100% of staff in all departments were retrained in proper hand hygiene, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Resident #12 100% of staff in all departments were retrained in proper hand hygiene, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Resident #13 100% of staff in all departments were retrained in proper hand hygiene, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Resident #14 100% of staff in all departments were retrained in proper	

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F 880	Continued From page 9 the bottle of disinfectant and other items from the cart and locked the cart with the key around her neck. She then entered Resident #2's room and closed the door. An interview with Housekeeper #1 on 07/28/20 at 11:38 AM revealed Housekeeper #1 had worn a gown, mask, face shield, and gloves in Resident #1's room to clean. Housekeeper #1 indicated she should have performed hand hygiene when she removed her gloves. Housekeeper #1 acknowledged she touched items on the cart with both dirty gloves and clean hands and that the cart and items should have been sanitized to prevent cross contamination and she should have performed hand hygiene, and donned clean gloves before she entered Resident #2's room. Housekeeper #1 revealed she was educated to don PPE in the front lobby and she wore her gown for the duration of her shift and was not educated to change gowns when she left the 600 hall New Admission/observation quarantine unit and went to other areas in the facility. An interview with the Housekeeping Supervisor on 08/04/20 at 1:51 PM revealed she was the Supervisor for Housekeeper #1. She stated Housekeeper #1 should have placed the items on the outside of the cart while she removed her gloves, performed hand hygiene, and donned clean gloves and wiped off the bottle of sanitizer used in Resident #1's room who was on Droplet Precautions. She stated after she sanitized the bottle, Housekeeper #1 should have removed her gloves and performed hand hygiene again before she proceeded to Resident #2's room. b. An observation on 07/28/20 at 12:23 PM revealed Nurse Aide (NA) #3 entered Resident	F 880	hand hygiene, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. Residents #1 ,3, 4 and 10 are no longer residents of this facility. For residents #2 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. For residents #8 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. For residents #9 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. For residents #10 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was	

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F 880	Continued From page 10 #8's room which had signage on the door that indicated Droplet Precautions. NA #3 picked up a knife from the room and exited the room with the knife in her bare hand. NA #3 carried the knife to the 600 hall nourishment room and closed the door. NA #3 exited the nourishment room carrying the knife soiled with visual residue in her hand and walked down the hall and she entered a room labeled employees only located behind the nurses' station. NA #3 was not observed to wear gloves when she entered Resident #8's room nor while she held a contaminated knife from inside of Resident #8's room. An interview with NA #3 on 7/31/20 at 10:14 AM revealed she routinely worked the 600 New Admission/observation quarantine hall on day shift. She stated she was required to wear full PPE on that unit which included a gown, mask, and face shield, and gloves and she did not change her gown during her shift. She stated she was unaware that a resident on her unit had signage that indicated Contact Precautions and she would be required to change her PPE when she cared for that resident. She stated she changed gloves between residents but did not think she needed to don gloves when she entered to retrieve an object in Resident #8's room. She acknowledged Resident #8 was on Droplet Precautions and she should have worn gloves when in the room and performed hand hygiene when she exited Resident #8's room. She stated she should not have entered the nourishment room, or the room labeled employees only behind the nurses' station while she held the potentially contaminated knife from Resident #8's room. NA #3 acknowledged those areas should have been sanitized after she touched them because she potentially spread infection to other surfaces. NA	F 880	given on 7/30/2020 and 8/11/2020. The training will continue for all departments by Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. For residents #11 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. For residents #12 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. For residents #13 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant. For residents #14 100% of staff in all departments were retrained in proper donning and doffing of PPE, beginning on 7/28/2020. Additional in servicing was given on 7/30/2020 and 8/11/2020. The training will continue for all departments by the Staff Facilitator, Director of Nursing, Assistant Director of Nursing, and the Facility Consultant.	

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F 880	Continued From page 11 #3 indicated she was required to assist on the adjacent 400 hall (general population) and did not change her PPE when she exited the 600 hall. She acknowledged there were no signs on the 400 hall that indicated any resident was on isolation precautions. c. An observation on 07/28/20 at 12:25 PM revealed Nurse #2 entered the room of Resident #9 and she held a medication cup in her bare hand. Resident #9's door indicated Contact Precautions. Nurse #2 administered the cup of medications then exited the room and returned to the medication cart in the hallway. Nurse #2 was not observed to don clean PPE to include a gown, gloves, mask, and face shield when she entered Resident #9's room nor doff her gown and gloves or perform hand hygiene before she returned to the medication cart. Nurse #2 spoke to Nurse #1 at the medication cart, Nurse #1 handed Nurse #2 a cup of medications and Nurse #2 left the medication cart and entered the room of Resident #10 and #11 and did not don clean PPE that included a gown, gloves, mask, and face shield. Signage on Resident #10 and #11's door indicated Droplet Precautions. Nurse #2 administered the cup of medications and exited the room and was not observed to perform hand hygiene when she exited Resident #10 and #11's room. An interview with Nurse #2 on 07/28/20 at 1:15 PM revealed she worked on the 600 hall New Admission/observation quarantine unit. Nurse #2 revealed she was required to wear full PPE when she worked on this unit that included a gown, mask, face shield, and gloves. Nurse #2 stated she thought all residents on that unit were under Droplet Precautions and she had not noticed the	F 880	The current practices of the facility had the potential to affect all residents during the Covid Pandemic. To prevent these areas identified of alleged deficient practice the Staff Facilitator and the RN education nurse are conducting 5 day a week hand washing and proper use of PPE validations and audits on all staff. The Staff Facilitator and the RN education nurse are also conducting audits of signage and infection control practices throughout the facility. The findings are then given to the QAPI team for review and possible need for additional education. The Guidelines for Admissions and Readmissions During Covid was reviewed to reflect the use of Droplet-Contact Precautions on 8/11/2020 and will be on-going, 100% of all staff were retrained on the guidelines and proper signage, hand hygiene and donning and doffing of the PPE on 8/11/2020 and will be on-going, by the Director of Nursing and her designees. During orientation of all new staff and agency the guidelines for proper signage, hand hygiene and donning and doffing of the PPE will be educated. The policy and direction from Principle LTC our corporate governing body will now include verbiage on the use of Droplet and Contact Precautions. Audits of correct signage will continue weekly x 8, then monthly by the DON and or designee, utilizing the Infection control signage tool. These were started on 8/12/2020. Monthly QAPI will include	

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F 880	Continued From page 12 Contact Precaution sign before she entered Resident #9's room to administer her medications and failed to perform hand hygiene when she exited. She further revealed because she had not realized Resident #9 was on a different isolation precaution than the other residents on the unit, she had not changed her PPE after she exited Resident #9's room. d. An observation on 07/28/20 at 12:28 PM revealed Nurse #1 entered the room of Resident #12. As she entered the room, she pushed Resident #12's wheelchair out of the way with her bare hands as she approached the bed and answered the call light. Signage on Resident #12's door indicated Droplet Precautions. Nurse #1 was not observed to perform hand hygiene before she left Resident #12's room. An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed Nurse #1 admitted she had not worn gloves in Resident #12's room when she entered and moved the wheelchair out of the way while she approached the bed to see what Resident #12 needed. She stated she went in the room to answer the call light and did not think about Resident #12's Droplet Precautions. Nurse #1 revealed she entered the room and did not don gloves nor wash her hands when she left the room. e. An observation on 07/28/20 at 12:30 PM revealed Nurse Aide #6 enter the room of Resident #9 and carried a lunch meal tray with her bare hands. Signage on Resident #9's room indicated Contact Precautions. NA #6 sat the meal tray down on the overbed table and set the tray up then exited the room. NA #6 was not observed to wear gloves nor perform hand	F 880	findings from the infection control signage tool. Corporate Trigger calls conducted 5 times a week require, completion of a root cause analysis of current, present, and past COVID infections for residents and staff. The Directed Plan of Care will require close monitoring from a contracted consultant, facility consultant, regional vice president, corporate clinical director and additional corporate follow up. Audits of proper hand hygiene and donning and doffing will be conducted with 5 employees 3 x weekly by the DON and or designee, for one month, then weekly for 2 months, utilizing the Hand Hygiene Competency tool and the PPE Competency tool North Carolina SPICE program. This was started on 8/12/2020. Monthly QAPI will include findings from these Competency tools. Corporate Trigger calls conducted 5 times a week require, completion of a root cause analysis of current, present, and past COVID infections for residents and staff. The Directed Plan of Care will require close monitoring from a contracted consultant, facility consultant, regional vice president, corporate clinical director and additional corporate follow up.	

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hygiene before she returned to the meal tray cart located in the hallway. At 12:33 PM, NA #6 entered the room of Resident #13 and Resident #14. Signage on the door indicated Droplet Precautions. NA #6 placed the tray on the bedside table of Resident #13 and exited the room. NA #6 was not observed to don gloves nor perform hand hygiene while she delivered a lunch meal tray to Resident #13.

An interview with NA #6 on 07/31/20 at 6:54 PM revealed NA #6 worked the 600 hall New Admission/observation quarantine unit on day shift. NA #6 stated she was required to wear full PPE that included a gown, mask, and face shield always and wore gloves when she provided incontinence care. NA #6 indicated she had not change PPE during her shift and was required to wear the same gown for the duration of her shift unless it became visibly soiled. NA #6 stated she was unaware that Resident # 9's door contained signage that indicated Contact Precautions and she had not changed her PPE or perform hand hygiene when she exited the room of Resident #9 after she delivered the meal tray. NA #6 revealed she did not don gloves when she retrieved Resident #13's tray from the meal tray cart and delivered it to Resident #13. NA #6 stated she should have worn gloves and performed hand hygiene when in Resident #13's room that indicated Droplet Precautions. NA #6 indicated she was required to help on the 400 hall, but she was not educated that PPE must be changed between units. She stated she did not recall any signage on the 400 hall to indicate any resident was on isolation precautions.

f. An observation on 07/28/20 at 12:35 PM revealed Nurse #2 entered the room of Resident

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#3 and carried a cup of medications in her bare hand. Signage on the door indicated Droplet Precautions. Nurse #2 was not observed to wear gloves or to perform hand hygiene after contact with Resident #3 during medication administration. Nurse #2 exited the room and approached Nurse #1 at the medication cart, then she obtained a box of tissues from the top of the nurses' station, and re-entered Resident #3's room as she carried the box of tissues and handed the box to Resident #3. Nurse #2 was not observed to perform hand hygiene after she exited Resident #3's room the second time. Resident #3's lab results dated 07/28/20 indicated a positive COVID-19 detected test.

An interview with Nurse #2 on 07/28/20 at 1:15 PM revealed Nurse #2 stated she acknowledged Resident #3 was on Droplet Precautions, but she failed to don gloves before she entered the room or perform hand hygiene after she exited the room. She stated she should have performed hand hygiene before she touched items at the nurses' station and donned clean gloves before she returned to Resident #3's room to give her the tissues.

g. An observation on 07/28/20 at 12:40 PM revealed Nurse #1 entered the room of Resident #12 and carried a glucometer, test strip, and an alcohol prep pad in her bare hands. Signage on the door indicated Droplet Precautions. She donned gloves and obtained Resident #12's blood sugar. Nurse #1 then exited the room and wore gloves on both hands, placed the glucometer on a tissue on the top of the cart. Nurse #1 then opened the drawer of the cart and obtained a pouch that held a wipe and placed the wipe over the glucometer. She then turned to the

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laptop on the medication cart and entered the medical record of Resident #12 as she used her right gloved hand. Nurse #1 then opened the drawer of the medication cart and retrieved a bottle of insulin and a syringe and drew the insulin in the syringe and laid the syringe on the top of the cart. She opened the drawer on the right side of the medication cart and dispensed a medication into a cup and placed the cup on top of the cart. Nurse #1 picked up the medication cup and the insulin syringe and re-entered Resident #12's room. She administered the medication and the insulin, removed and discarded her gloves, and exited the room and held the used syringe in her bare hand. She placed the insulin syringe in the sharps box on the medication cart and was observed to continue to type on the laptop. Nurse #1 was not observed to perform hand hygiene before or after contact with Resident #12.

An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed she wore gloves while she obtained the blood sugar for Resident #12, but she should have removed the test strip from the glucometer, removed her gloves, and performed hand hygiene before she touched items on the medication cart. Nurse #1 stated she should have pulled the oral medications from the medication cart first, drew up the insulin into the syringe, then applied clean gloves before she re-entered Resident #12's room to administer the medications. She should have removed the glove from one hand, carried the syringe in the gloved hand and discarded it in the sharps container on the cart, then removed her other glove and performed hand hygiene before she touched items on the medication cart such as the laptop. Nurse #1 acknowledged Resident #12 was on

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Droplet Precautions.

h. An observation on 07/28/20 at 12:46 PM revealed Nurse Aide #2 worked the 200 hall carried a meal tray to the 600 hall New Admission/observation quarantine unit with her bare hands. NA #2 wore a gown, a mask, and a face shield when she entered the unit. She carried the meal tray to Resident #3's room, setup the tray, and exited the room. She was not observed to doff the PPE worn in the quarantine unit, perform hand hygiene, and don clean PPE after she left Resident #3's room or before she exited the unit.

An interview with NA #2 on 08/05/20 at 4:55 PM revealed NA #2 worked the 200 hall where residents who had been exposed to COVID-19 from a previous roommate resided. NA #2 stated she was instructed to wear full PPE that included a gown, mask, and face shield for the duration of her shift unless they became visibly soiled and gloves were to be worn in all resident rooms. She further elaborated she had not worn gloves to deliver meal trays on her unit and therefore, had not thought she needed to apply gloves when she delivered Resident #3's tray to the 600 hall which was designated as a New Admission/ observation quarantine unit and she had not noticed the signage on Resident #3's door which indicated she was on Droplet Precautions. She stated she setup the meal tray and exited the room to return to her unit. She stated she had not changed her PPE between units when she delivered the meal tray.

i. An observation on 07/28/20 at 12:50 PM revealed Nurse #1 entered the room of Resident #8 on the 600 hall New Admission/observation

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quarantine unit and she held a glucometer, alcohol prep pad, and a test strip in her bare hand. Signage on the door indicated Droplet Precautions. Nurse #1 donned gloves and obtained Resident #8's blood sugar. At 12:52 PM, Nurse #1 then exited the room with her gloved hands and carried the glucometer with the test strip attached and sat it on a tissue on the top of the medication cart. Nurse #1 then opened the drawer of the medication cart and obtained a bottle of insulin and a syringe and drew the insulin into the syringe. She then re-entered Resident #8's room. She carried the syringe and administered the insulin. Nurse #1 removed and discarded her gloves and exited the room and she carried a used syringe in her bare hand. She placed the syringe in the sharps box on the medication cart and began to type on the laptop located on the medication cart.

An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed she wore gloves and carried supplies to obtain Resident #8's blood sugar. Nurse #1 stated after she obtained Resident #8's blood sugar, she should have discarded the test strip, removed her gloves, and performed hand hygiene before she touched items on the medication cart. Nurse #1 stated she should have pulled the oral medications first, drew up the insulin into the syringe, then applied clean gloves before she re-entered Resident #8's room to administer the medications. Then she should have removed the glove from one hand, carried the syringe in the gloved hand and discarded it in the sharps container on the cart, then she should have removed her other glove and performed hand hygiene before she touched the items on the medication cart such as the laptop. Nurse #1 acknowledged Resident #8 was on Droplet

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Precautions.

j. An observation on 07/28/20 at 12:56 PM revealed Nurse #1 exited the room of Resident #13 and #14 she carried a glucometer with her gloved hands. Signage on the door indicated Droplet Precautions. She placed the glucometer on a tissue on top of the medication cart, obtained a bottle of alcohol spray from the side of the medication cart, sprayed the glucometer, removed her gloves and discarded them. Nurse #1 then wiped the glucometer with a tissue and her ungloved hands. Nurse #1 was not observed to perform hand hygiene after she exited Resident #13 and #14's room or after she cleaned the glucometer with the alcohol spray.

An interview on 07/28/20 at 1:05 PM with Nurse #1 revealed she had removed her gloves before she cleaned the glucometer after she had exited the room of Resident #13 and #14 with signage that indicated Droplet Precautions but she should have worn gloves to clean the glucometer and then performed hand hygiene. She stated she worked on the New admission/observation quarantine unit and full PPE that included a mask, gown, face shield and gloves are always required when in rooms with residents on isolation precautions. She also stated gloves should be changed between residents to include meal delivery.

k. An observation on 07/28/20 at 2:20 PM revealed Nurse #1 was on the lower end of 400 hall adjacent to the 600 hall. She had pulled medications for medication administration and she wore a mask, face shield, and a gown in the hallway.

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An interview with Nurse #1 on 08/04/20 at 3:30 PM revealed when she worked the 600 hall New Admission/observation quarantine unit she was also responsible for medication administration for residents in rooms 406-410 on the adjacent unit. She acknowledged there were no residents on the 400 hall under any form of isolation precautions. Nurse #1 stated she had been instructed to wear the same gown during her entire shift and did not change it unless it was soiled until the date of the survey but did change gloves between patients on the 400 hall.

An interview with Nurse #1 on 08/04/20 at 3:30 PM revealed when she worked the 600 hall New Admission/observation quarantine unit she was also responsible for medication administration for residents in rooms 406-410 on the adjacent unit. She acknowledged there were no residents on the 400 hall under any form of transmission based precautions. Nurse #1 stated she had been instructed to wear the same gown during her entire shift and did not change it unless it was soiled until the date of the survey but did change gloves between patients on the 400 hall.

An interview with Nurse #4 on 07/31/20 at 1:48 PM revealed Nurse #4 was the nurse on the 600 hall New Admission/observation quarantine unit on the evening shift. Nurse #4 stated he was required to wear full PPE which included a gown, gloves, mask, and a face shield when on duty and he donned the PPE in the front lobby of the facility. Nurse #4 reported he was educated to wear the same gown for the duration of the shift unless it became visibly contaminated. Nurse #4 indicated he thought all the residents on the 600 hall unit were on Droplet Precautions and had not noticed the signage on Resident #9's door that

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indicated Contact Precautions and had not changed PPE when he cared for Resident #9. Nurse #4 stated the 600 hall nurse was also responsible for medication administration on a portion of the rooms on the end of 400 hall which he recalled were rooms 406-410. Nurse #4 revealed there was no signage on the doors of any residents on the 400 hall that indicated they were on any form of transmission based precautions. He stated he was not educated to change PPE between units when he cared for the residents on the 600 hall quarantine unit and residents on the 400 hall where there had been no known COVID-19 exposures.

An interview with the IC Nurse and DON on 07/28/20 at 3:30 PM revealed neither had thought about the potential for cross contamination when staff wore the same PPE between the 600 hall and the 400 hall units.

I. An observation on 07/28/20 at 10:59 AM in the 500 hall secured memory care unit revealed 9 residents sitting in the day room and Resident #20 had ambulated and stood in the hallway outside the room. Nurse Aide #1 was observed to wear a gown, mask, and face shield while she pushed the soiled linen/trash receptacles through the double doors to leave the unit. She had not worn gloves as she pushed the cart through the double doors on the memory care secured unit.

An interview with Nurse Aide #1 on 08/05/20 at 3:39 PM revealed NA #1 worked the secured memory care unit. She stated she was required to wear full PPE to include gown, mask, and face shield during her entire shift and she did not change gowns unless it becomes soiled. She stated she left the unit for break when she was

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observed to push the soiled linen/trash receptacle out the double doors of the unit. She further elaborated she should have worn a glove to push the contaminated cart to the laundry room
.
An interview with Nurse #3 on 07/28/20 at 11:05 AM revealed NA #1 should have worn a glove to push the cart to the laundry room.
The following observations were made on the 100/200 halls which were identified by the Director of Nursing and the Infection Control Nurse as potential exposure halls during the entrance conference on 07/28/20.

m. Observations of the 100/ 200 hall on 07/28/20 between 11:08 AM and 11:19AM revealed no signage which indicated any form of transmission based precautions to include Enhanced Droplet Contact Precautions on the doors of residents who had potentially been exposed to COVID-19 by their former roommates.

An interview with NA #2 on 08/05/20 at 4:55 PM revealed NA #2 worked the 200 hall where residents who had potential exposure to COVID-19 from a previous roommate resided. She stated she was instructed to wear full PPE which included a gown, mask, and face shield for the duration of her shift unless they became visibly soiled and gloves were to be worn in all resident rooms She stated there was no visible signage to indicate Enhanced Droplet Contact Precautions on the doors of the rooms where residents with potential exposures resided to alert her that her PPE should be changed when she exited that room and therefore she did not know which residents were considered exposed and/or potentially contagious.

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An interview with NA #8 on 8/4/20 at 9:48 AM revealed she works the 200 hall on day shift. NA #8 explained she was required to wear full PPE to include a gown, mask, and face shield always when in the facility. She stated she was educated that gloves are to be worn with resident care and hand hygiene is to be performed before and after gloves are used. She reported she has recently worked both 100 and 200 hall unit on the same shift and she had not been educated to change gowns between the units. She was instructed to wear the same gown the entire shift unless it tore or was soiled. She stated there was no signage on either the 100 or 200 hall units that indicated any residents were on isolation precautions and no signage to indicate any resident on either unit had Enhanced Droplet Contact Precaution signage to alert staff PPE should be changed when they cared for that resident.

An interview with NA #4 on 07/31/20 at 12:23 PM revealed NA #4 worked the 100 and 700 hall units in the facility on day shift. NA #4 stated she was required to wear full PPE to include a gown, mask, and face shield the duration of her shift and she wore gloves when she performed incontinence care, and she performed hand hygiene between residents. She indicated she was educated to wear the same gown for the duration of her shift and only change gowns if it became visibly soiled. She revealed there were no signage on the doors on her unit that indicated any resident was on isolation precautions and no signage that indicated Enhanced Droplet Contact Precautions that required her to change PPE when she cared for that resident. She stated she was unaware if any residents on her hall may have been potentially exposed to COVID-19. NA #4 explained she had not worn gloves when she

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delivered meal trays on her unit.

An interview with NA #5 on 07/31/20 at 6:33 PM revealed NA #5 worked 12 hours shifts on the 100 and 700 hall units in the facility on day shift. NA #5 stated she was unaware of any resident on her unit that had signage that indicated any form of isolation precautions and there was no signage that indicated Enhanced Droplet Contact Precautions that would alert her that her PPE should be changed when she cared for a resident on her unit. NA #4 indicated she had been educated to wear her PPE to include gown, mask, and face shield for the duration of her shift unless it became visibly soiled and she donned all PPE in the front lobby of the facility at the start of her shift. She stated she cleans her face shield when she goes on break and at the end of the shift and occasionally must change her gown when it becomes wet with sweat. She stated she had not been educated that she needed to wear gloves when she delivered meal trays on her unit or that she needed to change gowns if she went to other areas of the facility.

An interview with NA #9 on 08/04/20 at 10:19 AM revealed NA #9 worked the 100 hall unit on day shift. NA #9 reported she was unaware of any resident on the 100 hall who was on any form of transmission-based precautions and had not seen any signage posted that indicated Enhanced Droplet Contact Precautions on resident doors to indicate PPE should be changed when she cared for the resident on her unit. NA #9 indicated she had been educated to wear full PPE which included a gown, mask, and face shield for the duration of her shift unless it becomes soiled. NA #9 explained she had not been educated to change gowns when she left the unit or went to

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other areas within the facility. NA #9 further indicated she had not worn gloves when she delivered meal trays on her unit.

n. An observation on 07/28/20 at 11:15 AM revealed Housekeeper #2 was mopping the room of Resident #4 and #5 had not worn gloves. Housekeeper #2 wore a gown and a mask. Housekeeper #2 exited the room and removed the mop pad from the mop with her bare hands and placed it in a bag attached to the cart. She then picked up a bottle of cleaner and re-entered the room and began to clean the sink.
An interview on 07/28/20 at 11:18 AM revealed Housekeeper #2 was in Resident #3 and #4's room. She was mopping the floor and wore a gown and mask. Housekeeper #2 stated she had not replaced her face shield yet and had not been educated that she needed to wear gloves when she mopped the floor or when she removed the soiled mop pad from the handle. Housekeeper #2 stated she was unaware if any residents on the 200 hall had a potential exposure to COVID-19 but there was no signage on any resident door on the unit that indicated Enhanced Droplet Contact Precautions to show her she needed to take extra precautions in that room or that she should change her PPE when she exited the room.

An interview with the Housekeeping Supervisor on 08/04/20 at 1:51 PM revealed she was the Supervisor for Housekeeper #2. She stated Housekeeper #2 had not been educated to wear gloves when she mopped in a resident's room; however, she acknowledged gloves should have been worn to remove the mop pad from the handle. The Housekeeping Supervisor stated Housekeeper #2 may not have known which rooms had potentially exposed residents because

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there was no signage that indicated any residents on the 200 hall were on isolation precautions and Housekeeper #2 had not been educated to change PPE when in rooms of the potentially exposed residents.

An interview with Nurse #8 on 08/04/20 at 5:10 PM revealed Nurse #8 was the day shift supervisor and was responsible to oversee all the halls in the facility. Nurse #8 stated she was aware the first cases of COVID-19 in the facility were residents who had resided on the 100/200 hall units and the roommates of those residents had been relocated to other rooms on these units. Nurse #8 explained she had not recalled any signage on the doors of any resident rooms on 100/200 hall that indicated a resident was on isolation precautions and there were no signs that indicated Enhanced Droplet Contact Precautions that would alert staff that PPE should be changed when they cared for the residents in those rooms. Nurse #8 indicated she wore full PPE which included a gown, mask, and face shield always. Nurse #8 voiced she had been educated to wear her gown for the entire shift unless it was soiled, and she said all PPE is donned in the front lobby of the facility after staff was screened at the start of the shift. Nurse #8 expressed staff had recently been educated to wear gloves to pass out trays and to change gowns if they went on another hall although she could not recall the exact date this change had occurred.

An interview with Nurse #5 (Infection Control Nurse and Staff Facilitator) and the Director of Nursing (DON) on 07/28/20 at 3:30 PM revealed they each indicated all new admissions and those under observations were placed on the 600 hall New Admission/observation quarantine unit.

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Nurse #5 explained all new admissions were placed on Droplet Precautions for 14 days from the date of admission and the resident was observed for signs and symptoms of COVID-19 due to a recent hospitalization or recent leave from the facility such as a doctor appointment or court appearance. Nurse #5 voiced she had not educated facility staff to wear gloves when they cared for residents who were on Droplet Precautions. She elaborated gloves were not required to be used in Droplet Precaution isolation and she provided a copy of the Droplet Precautions signage that did not include an illustration that glove use was required, but staff had been educated to perform hand hygiene between each resident on the 600 hall. Nurse #5 and the DON each indicated they were unaware signage titled Enhanced Droplet Contact Precautions was the proper signage for COVID-19 per the CDC guidelines and included PPE usage such as a gown, mask, face shield, and gloves and therefore had not included this form of isolation precaution in the facilities infection control policies for transmission-based precautions. Both the DON and Nurse #5 explained they believed everyone on the 600 hall was on Droplet Precautions and had not been made aware that Resident #9 had signage that indicated Contact Precautions on her door. Nurse #5 revealed she had not educated staff that full PPE must be changed when they traveled from two separate forms of isolation such as Contact to Droplet precaution resident rooms. The DON and Nurse #5 voiced that Nurse #1 should not have removed her mask when on the hallway, should not have worn gloves in the hallway and touched items on the medication cart without performing hand hygiene, and should not have carried a used syringe in her bare hand.

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An additional interview with Nurse #5 on 08/07/20 at 8:58 AM revealed she was told she should not to place signage on the doors of residents rooms on the 100/200 hall who had been potentially exposed to COVID-19 by their former roommate because it was a Health Insurance Portability and Accountability Act (HIPPA) violation although she was unable to recall the name of the person who provided that instruction. Nurse #5 elaborated that she believed the 100/200 hall staff should have known if they had a new resident or a resident was not in their original room that it was because of a potential exposure without having to be told. Nurse #5 voiced if staff were not aware the information should be provided the updates from the hall nurse. Nurse #5 further revealed she was unsure which residents were moved into private rooms or if some were placed in rooms with non-exposed residents. Nurse #5 indicated staff should wear full PPE to include a gown, mask, face shield, and gloves when working on 100/200 hall and should not have worn the same PPE in rooms with known potential exposures that is worn in resident rooms with no known COVID-19 exposure. Nurse #5 stated after she thought about it, staff should have been educated that the same PPE should not be worn in a residents room who had a potential exposure as a resident with no known exposure to COVID-19, gloves should be worn for meal tray delivery, resident activities of daily living (ADL) care, and to touch objects in the residents room.

An additional interview with the DON on 08/07/20 at 9:37 AM revealed the facility had their first positive case for COVID-19 on 07/18/20 and facility-wide testing was initiated on 7/20/20 which resulted in 13 cases of residents' positive for

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COVID-19. The 13 residents with positive test results were transferred to a designated COVID-19 facility on 07/22/20 and the roommates of these residents were relocated to other rooms on the 100/200 hall. The DON was unable to recall if any residents were placed in a room with a resident who had no known exposure to COVID-19 and stated the home office had assisted with a room transfer plan due to the facility had experienced a bed lock on the 600 hall New Admissions/observation quarantine unit. The DON indicated all staff to include administrative personnel were to wear full PPE for the duration of their shift and it was donned in the lobby immediately after an employee was screened at the start of the shift. The DON explained the facility had not experienced a shortage of PPE during the pandemic and had initiated gown and face shield use after the first known positive case. The DON stated staff had not been educated to change gowns when in resident rooms who had a potential exposure to COVID-19 although staff should have received instruction to change PPE when they exited a resident room with a previous potential exposure and to perform hand hygiene to prevent cross contamination to other non-exposed residents. The DON elaborated she was uncertain why isolation signage was not placed on the doors of these rooms and voiced that signage placement would not be a concern for a HIPPA violation.

An interview with the Administrator on 08/13/20 at 4:07 PM she was not in the facility on the date of the survey, but she expressed these breaches of infection control were not acceptable practice and posed an increase risk to the resident's well-being.

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The Administrator was notified by phone of the Immediate Jeopardy on 08/11/20 at 11:26 AM. On 08/13/20 at 3:14 PM, the facility provided the following credible allegation of Immediate Jeopardy removal:

Recipients who have suffered or are likely to suffer a serious adverse outcome as a result of non-compliance.

On 7/28/2020 Nurse Aide #3 picked up a knife from Resident #8 room and exited the room carrying the knife in her bare hands. Resident #8 was on droplet precautions which require donning of gloves prior to entering the room. Nurse Aide # 3 went into other areas of the facility with the knife that was carried out of Resident #8 room and was not observed to be wearing gloves during the observation.

Resident # 8 had exposure to COVID-19 via a positive roommate and was on the quarantine unit 7/28/2020, the resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020. Resident remains stable and asymptomatic.

On 7/28/2020 Nurse #2 entered Resident #9 room holding a medication cup, resident #9 was on contact precautions. Nurse #2 administered the medication and returned to the medications cart. Nurse #2 did not don gloves prior to entering Resident #9 room or was not observed to wash her hands prior to exiting the room. Nurse #2 then enter Resident #10 and #11 without gloves and both residents were on droplet precautions which would require donning of gloves prior to entering the room and hand hygiene prior to exit of room.

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On 7/28/2020 Resident #9 was on the Quarantine unit, on 8/6/2020 was moved to a regular room. The Resident was tested for COVID-19 on 8/3/2020 with results on 8/6/2020 and remains negative. Resident has no signs or symptoms at this time.

On 7/28/2020 Resident #10 was on the quarantine unit on 8/3/2020 the resident was tested for COVID-19, with a negative result on 8/6/2020. Resident discharged home on 8/9/2020 in stable condition and remained asymptomatic.

On 7/28/2020 Resident #11 was on the quarantine unit. Resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020, resident was moved to a regular room on 8/6/2020. Resident has no signs or symptoms at this time.

On 7/28/2020 Nurse #1 entered Resident #12 room and pushed the wheelchair out to the way so she could reach the call light. Resident #12 was on droplet precautions, Nurse #1 did not don gloves prior to entering the room and did not perform hand hygiene following touching contaminated items within the room.

On 7/28/2020 Resident #12 was on the quarantine unit. Resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020, resident was moved to a regular room 8/6/2020. Resident has not signs or symptoms at this time.

On 7/28/2020 Aide #6 entered Resident #9 room with a meal tray and proceeded to place the meal

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tray on the bedside table and exited the room, the resident was on contact precautions. Aide #6 then went into resident #13 and #14 room to deliver a meal tray, there residents were on droplet precautions. The aide did not don gloves or perform hand hygiene when entering any of the rooms or exiting.

On 7/28/2020 Resident #9 was on the Quarantine unit, on 8/6/2020 was moved to a regular room. The Resident was tested for COVID-19 on 8/3/2020 with results on 8/6/2020 and remains negative. Resident has no signs or symptoms at this time.

Resident # 13 was on the quarantine unit on 7/28/2020 had exposure to COVID-19 via a positive roommate, the resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020. Resident remains stable and asymptomatic.

On 7/28/2020 Resident #14 was on the quarantine unit due to exposure to COVID-19 via a positive roommate, the resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020. Resident remains stable and asymptomatic.

On 7/28/2020 Nurse #2 entered resident #3 room with a medication cup, the resident was on droplet precautions. Nurse #2 then exited the room and obtained a box of Kleenex from Nurse #1 medication cart and re-entered Resident #3 room. Nurse #2 did not don gloves prior to entering the room or perform hand hygiene prior to exit either time of entry or exit. Resident #3 tested positive for COVID on 7/28/2020.

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WESTWOOD HILLS NURSING AND REHABILITATION CENTER	1016 FLETCHER STREET WILKESBORO, NC 28697

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Resident #3 was on the quarantine unit 7/28/2020. Resident was tested for COVID-19 on 7/27/2020 with a positive result on 7/28/2020, resident was transferred to the Special Care COVID unit at a sister facility on 7/28/2020.

On 7/28/2020 Nurse #1 entered Residents #12 room, she donned gloves and took the resident blood sugar. Nurse #1 then exited the room without doffing her gloves and obtained some items from her medication cart and documented on the lab top on the medication cart. Nurse #1 re-entered the resident's room to administer insulin, then doffed her gloves and carried the syringe in her ungloved hand. She then put the syringe in the sharps container and continued charting on the lab to. Resident #12 was on droplet precautions requiring gloves to be doffed and hand hygiene preformed prior to exiting the room and gloved donned prior to re-entry.

On 7/28/2020 Resident #12 was on the quarantine unit. Resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020, resident was moved to a regular room 8/6/2020. Resident has not signs or symptoms at this time.

On 7/28/2020 Nurse Aide #2 worked on 200 hall and delivered a meal tray to resident #3 without donning gloves. Aide #2 did not perform hand hygiene prior to exit of the room or prior to leaving the quarantine unit. Resident #3 was on droplet precautions which required gloves to be donned prior to entering the room and doffed and hand hygiene preformed prior to exit of room.

Resident #3 was on the quarantine unit 7/28/2020. Resident was tested for COVID-19 on

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7/27/2020 with a positive result on 7/28/2020, resident was transferred to the Special Care COVID unit at a sister facility on 7/28/2020.

On 7/28/2020 Nurse #1 entered Resident #8 room holding a glucometer, alcohol, prep pad and test strip in her bare hands. Resident #8 was on droplet precautions. Nurse #1 donned gloves in the room and obtained the residents blood sugar, she then exited without doffing her gloves and obtained items from the medication cart. Nurse #1 then re-entered the resident's room and administered the insulin. Nurse #1 then doffed her gloves and carried the syringe out of the room in her bare hands. She then discarded the syringe in the sharps container and proceeded to document on her lap top.

Resident # 8 had exposure to COVID-19 via a positive roommate and was on the quarantine unit 7/28/2020, the resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020. Resident remains stable and asymptomatic.

On 7/28/2020 Nurse #1 exited the room of residents #13 and #14 with a glucometer with gloves on both hands. Nurse #1 sprayed the glucometer, removed her gloves and wiped the glucometer off with ungloved hands.

Resident # 13 was on the quarantine unit on 7/28/2020 had exposure to COVID-19 via a positive roommate, the resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020. Resident remains stable and asymptomatic.

On 7/28/2020 Resident #14 was on the

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quarantine unit due to exposure to COVID-19 via a positive roommate, the resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020. Resident remains stable and asymptomatic.

On 7/28/2020 100 hall had no signage indication any form of isolation precautions on the door of resident #16 who had been exposed to COVID-19 by her roommate. Nurse Aides #4 and #5, and Nurse #6 entered and exited the room without changing gowns. Gowns should be change between caring for exposed vs unexposed residents.

On 7/28/2020 Resident #16 was on the quarantine unit due to being exposed to COVID-19 via a positive roommate. Resident was tested for COVID-19 on 8/3/2020 with a negative result on 8/6/2020. Resident was retested on 8/7/2020 with negative results 8/11/20. Resident was moved to a regular room 8/12/2020. Resident is stable and has not signs or symptoms at this time.

On 7/28/2020 200 hall had no signage indication the form of isolation precautions on the doors of resident #18 or #28's room. Both residents had been exposed to COVID-19 by their roommates. Nurse Aide #2 entered and exited the rooms without changing gowns.

Resident #18 was tested for COVID-19 on 7/20/2020 with a positive result on 7/22/20202. Resident was transferred to a Special Care COVID unit at a sister facility and remains in stable condition.

Resident #28 was tested for COVID-19 on

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7/27/2020 with a positive result on 7/29/2020. Resident was transferred to the Special Care COVID Unit at a sister facility on 7/29/2020 and remains in stable condition.

On 8/10/2020 the Admissions Assistant placed CDC "Use Personal Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19" in all Isolation and Quarantine units. The CDC "Use Personal Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19" was already posted in multiple areas throughout the facility prior to and on 7/28/2020. The CDC "Use Personal Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19" covers use of gloves, gowns, face shields, downing, doffing, and hand hygiene Instructions included on this posting are performing hand hygiene, application of a gown, application of facemask, placement of face shield or goggles, repeat hand hygiene.

On 8/11/2020 the Medical records directory and the RN Supervisor completed an audit to assure Enhanced Droplet-Contact Precautions PPE signage is on all rooms that are in COVID Isolation and Quarantine units. The Enhanced Droplet-Contact Precaution Isolation signage includes instructions to perform hand hygiene, wear mask, wear eye protection, wear gown, and wear gloves when entering. It instructs the required PPE to enter is mask, eye protection, gown, and gloves. No negative findings noted.

All residents will continue to receive a respiratory assessment every shift to assess for signs and symptoms of COVID-19 and/or other changes in condition. This will continue until there are no positive cases in the facility for at the minimum of

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28 days.
Continuing 8/11/2020 residents and staff are tested weekly for COVID at this time.

Actions taken to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring

On 7/28/2020 the nurse supervisor started an in-service with facility staff of all departments including nursing, dietary, housekeeping, therapy, maintenance, and administrative on personal protective equipment use. This in-service will be complete on 8/11/2020 for all staff including agency by in-person in-servicing or by mail on 8/11/2020. If the in-service was mailed, the staff member must complete the included quiz to prove competence and return prior to next scheduled shift. On 8/11/2020 the in-service was added to the orientation for staff of all departments by the director of nursing. This in-service included glove use, changing of gloves, and hand hygiene. No staff will be allowed to work after 8/11/2020 without in-service completion by phone, in-person, or satisfactory completion of mailed quiz. The quizzes are monitored and graded by the director of nursing, assistant director of nursing and/or the staff facilitator. This in-service was added to the orientation of new staff by the director of nursing on 8/11/2020.

On 8/11/2020 the Director of Nursing and Assistant Director of Nursing began additional in-servicing zhalls, the importance to change PPE between Droplet Precaution isolation and Contact Precaution isolation (following infection control procedures), wearing gloves when going into the quarantine and isolation halls, removing the

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gloves and washing their hands prior to exiting the room, and donning and doffing PPE to prevent transmission of infection. This in-service will be complete on 8/11/2020 for all staff including agency by in-person in-servicing or by mail on 8/11/2020. If the in-service was mailed, the staff member must complete the included quiz to prove competence and return prior to next scheduled shift. On 8/11/2020 the in-service was added to the orientation for staff of all departments by the director of nursing. This in-service included glove use, changing of gloves, and hand hygiene. No staff will be allowed to work after 8/11/2020 without in-service completion by phone, in-person, or satisfactory completion of mailed quiz. The quizzes are monitored and graded by the director of nursing, assistant director of nursing and/or the staff facilitator. This in-service was added to the orientation by the director of nursing on 8/11/2020.

On 8/10/2020 the CDC "Use Personal Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19" signage was posted on all rooms in the quarantine and COVID unit. This signage was posted as an additional visual reminder to staff on proper PPE use, which includes gloves.

On 8/11/2020 the facility posted an additional hand hygiene posting reminder at the entrance and exit to the quarantine and COVID unit. This signage was posted as an additional visual reminder to staff on correct hand hygiene.

On 8/11/2020 the facility audited their on hand stock of gloves and hand sanitizer to ensure proper infection control could be maintained. This

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F 880	Continued From page 38 audit revealed sufficient supplies on hand for all PPE required to ensure infection control procedures are maintained. On 08/17/20 at 8:45 AM the facility's plan for immediate jeopardy removal was validated by the following: review of in-service training records revealed staff from all shifts and disciplines had been in-serviced on 08/11/20 regarding glove usage, infection control, hand hygiene, enhanced droplet contact isolation precautions, and medication administration. Beginning at 9:20 AM on 08/17/20 multiple interviews were conducted with staff in different departments/shifts. These interviews validated staff had undergone training the previous week regarding glove usage, infection control, hand hygiene, enhanced droplet contact isolation precautions, and medication administration. The facility's date of immediate jeopardy removal of 08/11/20 was validated.	F 880		