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	345228	A. BUILDING ______ B. WING ______	C 09/17/2020

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 9/15/20 through 9/17/20. 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# LIPO11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 9/15/20 through 9/17/20. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations resulting in Federal Citation F880. Two of the six complaint allegations were substantiated resulting in deficiencies. Event ID #LIPO11.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure a resident who was at risk for falls was wearing shoes according to the care plan for the resident (Resident #1) who fell during an independent transfer for 1 of 3 residents reviewed for accidents.	F 689	1.Resident #1 was d/c from the facility on 10-2-20. Prior to the discharge, she was provided skid free socks if shoes were not available. Primary nurse was educated on how to review CP interventions in PCC on 10-2-20. NA# 2 Will be educated on CP interventions and location on Kardex	10/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/05/2020

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 689

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The findings included:

Resident #1 was admitted to the facility 02/09/11 with diagnoses which included cerebral palsy and rheumatoid arthritis.

The quarterly Minimum Data Set (MDS) dated 07/03/20 revealed Resident #1 was severely cognitively impaired. She was sometimes understood and sometimes understands. She had no behaviors or rejection of care. She required extensive assistance for transfers and dressing. She needed limited assistance to walk in the room. She was not steady and required staff assistance to stabilize with all areas of balance during transfers.

The care plan dated 4/5/19, which was in effect on 8/31/20 revealed Resident #1 was at risk for falls related to psychotropic drug use, impaired mobility and incontinence. One of the interventions dated 8/5/19 read ensure Resident #1 had proper fitting shoes on.

Resident #1's medical record revealed on 08/31/20 at 3:52 PM Nurse #2 was called to Resident #1's room due to the resident fell on the floor. The note specified Resident #1 was sitting in her chair when the nurse arrived.

On 09/17/20 at 3:45 PM Nurse #2 stated Resident #1 was already sitting in the chair when she arrived in the room on 8/31/20. Nurse #2 reported Resident #1 had a blanket around her lower body, was wearing white socks and was not wearing shoes. Nurse #2 stated the socks were not slip resistant socks. Nurse #2 stated Nurse #3 was the nurse who assessed Resident #1 and

F 689

on 10-6-20.
2.All current facility residents that are at risk for falls could be affected by the deficient practice. UC /ADON completed a review all Fall Care plans to ensure all interventions are in place on 10-5-20. Concerns identified were corrected at the time of the audit.
3.All nursing staff will be educated on Fall prevention program, including completion of incident report, fall prevention measures, care-plan interventions, and resident Kardex. DON/Staff Development coordinator will begin education on 10-6-20. Employees will be in serviced as they return to work. New hires will be educated during orientation.
4.ADON /DON/Unit coordinator will audit 10 residents a week to ensure care-plan interventions are in place x 4 weeks, then 5 residents a week x 4 weeks.
5.DON/ADON will review audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. DON/ADON will review the plan during the monthly QAPI meeting and the audits will continue at the desecration of the QAPI

The Director of Nursing and the Staff Development Coordinator/Infection Control Preventionist plan to complete in-service education for facility staff on October 6, 2020, regarding the essential time points for hand hygiene and hand hygiene protocol for staff and visitors signing in at kiosk. The Quality Assessment and Performance

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Continued From page 2
assisted her back into the chair.

On 09/17/20 at 2:30 PM Nurse #3 stated she responded to Resident #1's fall on 8/31/20. Nurse #3 said she assessed Resident #1 then assisted her back into the chair. She stated the resident had no apparent injuries. Nurse #3 reported it looked like Resident #1 tried to get from her chair into the wheelchair and she fell. Nurse #3 stated when she assessed Resident #1 after the fall on 8/31/20, the resident was not wearing shoes and was wearing regular socks.

The care plan updated 09/02/20 indicated Resident #1 had an actual fall and was at risk for falls due to impaired mobility, use of psychotropic drugs and incontinence. The intervention of ensure Resident #1 had proper fitting shoes remained on the care plan.

On 09/16/20 at 12:15 PM Resident #1 was observed in her room sitting in her chair. She was dressed in pants, shirt, sweater and regular white socks. She was not wearing shoes. A pair of shoes was observed inside a plastic bag tied to the outside of the resident's clothing hamper.

On 09/16/20 at 12:15 PM Nursing Assistant (NA) #2 was observed in Resident #1's room assisting her with the setup of her lunch. NA #2 stated Resident #1 was not wearing shoes because the shoes were soiled. She reported Resident #1 had another pair of shoes but those did not fit. NA #2 said Resident #1 did not have any slip resident socks because her family provided the clothes and the white socks were the only socks she had. She stated the supply clerk would have slip resident socks. She was unable to say why she had not obtained slip resistant socks for

F 689

Improvement Committee created a Performance Improvement Group to complete a Root Cause Analysis for the problems identified by the DHSR Surveyors of 09-15-2020. Root causes identified included low staff to resident ratio; high number of residents assigned to staff; staff not recognizing importance of hand hygiene protocol; signage removed when COVID Units expanded; and an insufficient number of signs. The facility will: monitor the staffing ratios; monitor the number of residents assigned to staff; and educate regarding the importance to hand hygiene protocol. On the day of survey 09-15-2020 signage was re-posted on entrances to both COVID Units and handwashing signage in the reception area was improved.

Team Facilitator: Mike Kelly, CEO & Lisa Hartley, DON

Date RCA Started: Wednesday September 30, 2020

Date RCA Ended: Plan to meet at least every other week until sustained improvement demonstrated

Team Members:

Name Position Name Position
Mike Kelly CEO Eboni McCabe Housekeeping
Lisa Hartley DON Sheila Cox CNA II, Transporter
Gloria Mitchell ADON Yulonda

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F 689	Continued From page 3 Resident #1 since she had no shoes. The Director of Nursing (DON) was interviewed on 09/17/20 at 3:15 PM and reported fall investigations were reviewed in the morning meetings. The team discussed what happened and to decide on interventions. She stated she was not aware Resident #1 was wearing regular socks and not wearing shoes when she fell on 8/31/20. She stated Resident #1 should have slip resistant socks if she was not wearing shoes and slip resistant socks were available in the supply room.	F 689	Hayes-Moore CNA Betty Sawyer SDC/IP Brief Narrative Description of Event (Including Timeline): 1. A facility policy titled Infection Control Guidelines for all Nursing Procedures dated 1-24-2019 read in part, employees must wash their hands before and after all patient contact. CNA left resident□s room (a quarantine room) after providing care. CNA did not perform hand hygiene after providing care. CNA placed used gloves in a receptacle placed in the doorway of the room and proceeded to another resident□s room without performing hand hygiene prior to providing care to next resident. 2. CDC Guidelines titled Responding to COVID-19 in Nursing Homes updated 4-30-2020 read in part. place signage at the entrance to the COVID-19 care unit that instructs Health Care Personnel they must wear eye protection and an N-95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. During an observation by DHSR Surveyor on 9-15-2020 at 10:00am no signage was observed on the doors to COVID-19 Unit A	

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F 689	Continued From page 4	F 689	During an observation by DHSR Surveyor on 9-15-2020 at 10:03am no signage was observed on the doors to COVID-19 Unit B During an observation by DHSR Surveyor on 9-15-2020 at 2:15pm no signage was observed on the entrance to COVID-19 Unit B 3. A facility policy titled COVID-19 dated 5-11-2020 read in part, if visitation is granted, visitor(s) must perform hand hygiene. During the screening process to enter the facility on 9-15-2020 at 9:00am two of two DHSR Surveyors were not required to perform hand hygiene. Observation on 9-15-2020 at 9:10am revealed a DHSR Surveyor was not required to perform hand hygiene upon reentry into the building. 1. Problem: Staff member forgot to perform hand hygiene after and before providing care. Root Cause Corrective Action Responsible Individual/Group Completion Deadline Low staff to resident ratio due to number of staff out related to active COVID infection created a feeling in staff of being overwhelmed 1. Increase nurse to resident ratio	

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F 689	Continued From page 5	F 689	2. Increase CNA to resident ratio DON ADON 10-31-2020 High number of residents assigned to staff caused staff to feel pressured/hurried 1. Decrease number of residents assigned to nurses 2. Decrease number of residents assigned to CNAs DON ADON 10-31-2020 Staff do not recognize importance of handwashing protocol Education: 1. Review essential time points for hand hygiene 2. View CDC hand washing video titled, Clean Hands 3. Randomly observe all staff during at least one time point requiring hand hygiene to ensure hand hygiene performed before and/or after appropriate event 4. Handwashing review quiz 1. DON & SDC/IP 2. DON & SDC/IP 3. All Managers 4. DON & SDC/IP 1. 10-06-2020 2. 10-06-2020 3. 10-31-2020 4. 10-06-2020 2. Problem: No signage on COVID Unit A or B zipper walls. Root Cause Corrective Action Responsible Individual/Group Completion Deadline Signs removed when COVID Units expanded and not replaced Educate maintenance department staff about required signage SDC/IP 10-05-2020	

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F 689	Continued From page 6	F 689	Ran out of Enhanced Barrier Precautions signs Print additional signs and post on both COVID Unit entrances SDC/IP 09-15-2020 3. Problem: DHSR Surveyors were not required to perform hand hygiene at required time point, i.e. when signing in at screening kiosk. Root Cause Corrective Action Responsible Individual/Group Completion Deadline Staff do not recognize importance of handwashing protocol Education: 1. Review essential time points for hand hygiene 2. View CDC hand washing video titled, Clean Hands. 3. Randomly observe all staff during at least one time point requiring hand hygiene to ensure hand hygiene performed before and/or after appropriate event. 4. Handwashing review quiz. 1. DON & SDC/IP 2. DON & SDC/IP 3. All Managers 4. DON & SDC/IP 1. 10-06-2020 2. 10-06-2020 3. 10-31-2020 4. 10-06-2020 Improve signage at reception desk and entrance to prompt all staff and visitors to complete hand hygiene before and after checking in on kiosk 1. Additional signs posted in reception area	

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F 689	Continued From page 7	F 689	2. Educate reception staff in hand hygiene protocol for staff and visitors signing in at kiosk 1. CEO 2. DON & SDC/IP 1. 09-15-2020 2. 10-06-2020 MEASURES OF SUCCESS Corrective Action Measures of Success Reporting Schedule Individual Responsible Increase nurse to resident ratio Ns to resident ratio 9/15 for each shift compared to weekly average for each shift Weekly until sustained improvement demonstrated HR Manager & SDC/IP Increase CNA to resident ratio CNA to resident ratio 9/15 for each shift compared to weekly average for each shift Weekly until sustained improvement demonstrated HR Manager & SDC/IP Corrective Action Measures of Success Reporting Schedule Individual Responsible Decrease number of residents assigned to nurses Number of residents assigned to each nurse each shift on 9/15 compared to weekly average for each shift Weekly until sustained improvement demonstrated Medical Records Manager & SDC/IP Decrease number of residents assigned to CNAs Number of residents assigned to each CNA each shift on 9/15 compared to weekly average for each shift Weekly	

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F 689	Continued From page 8	F 689	until sustained improvement demonstrated Medical Records Manager & SDC/IP Review essential time points for hand hygiene All staff sign attendance roster 10-06-2020 or prior to next scheduled work day DON & SDC/IP View CDC hand washing video titled, Clean Hands All staff sign attendance roster 10-06-2020 or prior to next scheduled work day DON & SDC/IP[Randomly observe all staff during at least one time point requiring hand hygiene to ensure hand hygiene performed before and/or after appropriate event All managers observe assigned staff performing hand hygiene correctly at least once By 10-31-2020 All Managers Handwashing review quiz All staff complete quiz 10-06-2020 or prior to next scheduled work day DON & SDC/IP Educate maintenance department staff about required signage Maintenance Manager & Assistant sign attendance sheet 10-06-2020 SDC/IP Print additional signs and post on both COVID Unit entrances Signs posted Completed 09-15-2020 SDC/IP Additional signs posted in reception area Signs posted Completed 09-15-2020 CEO Educate reception staff in hand hygiene protocol for staff and visitors signing in at kiosk All staff that work reception area sign attendance sheet By 10-15-2020 DON & SDC/IP Signature of RCA Team Leaders:	

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F 689	Continued From page 9	F 689	Mike Kelly, CEO Date	
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: §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	F 880		10/9/20

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F 880	Continued From page 10 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, resident and staff interviews, the facility failed to ensure hand hygiene was performed between residents (Resident #2, Resident #3, and Resident #4), failed to post signage related to Coronavirus disease 2019 (COVID-19) on 2 of 2 isolation	F 880	1. NA #1 was interviewed and educated DON on the incident of failing to wash her hands after providing resident care on 9-16-20. Front desk clerks were educated by Administrator on asking visitors to wash	

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F 880	Continued From page 11 units, and failed to ensure hand hygiene was performed by 2 of 2 visitors during the entrance screening process. This failure occurred during a COVID-19 pandemic. 1. A facility policy titled "Infection Control Guidelines for all Nursing Procedures" dated 1/24/19, read in part, "employees must wash their hands before and after all patient contact". During an observation on 9/15/20 at 9:30 AM Nursing Assistant (NA) #1 was observed leaving Resident #2's room, a quarantine room, after providing care. She was observed not performing hand hygiene after care. NA #1 placed her used gloves in a receptable placed in the doorway of the room. During an interview with NA #1 on 9/15/20 at 9:32 AM she stated she was preparing to give Resident #3 and Resident #4 a bath. She indicated she forgot to perform hand hygiene after leaving Resident #2's room. An interview was conducted with the Infection Control Nurse on 9/15/20 at 9:51 AM who stated NA #1 should have performed hand hygiene prior to leaving Resident #2's room. An interview was conducted with the Director of Nursing on 9/15/20 at 4:40 PM who indicated NA #1 should have performed hand hygiene prior to leaving Resident #2's room. 2. Centers for Disease Control (CDC) guidelines titled Responding to the Coronavirus (COVID-19) in Nursing Homes updated 4/30/20 read in part, "place signage at the entrance to the COVID-19 care unit that instructs Health Care Personnel	F 880	their hands and a sign asking staff/visitors to perform hand hygiene was placed on the kiosk as a reminder on 9-16-20. Enhanced precaution Signs were placed on the outside of the Covid unit on 9-15-20. 2. All residents are at risk for this deficient practice of staff not performing hand hygiene. Root cause analysis was completed on 9-30-20 and included analysis of hand washing, Visitor sign in process and signage on the units. 3. The Director of Nursing and the Staff Development Coordinator/Infection Control Preventionist will complete in-service education for facility staff on October 6, 2020, regarding the essential time points for hand hygiene and hand hygiene protocol for staff and visitors signing in at kiosk. The Quality Assessment and Performance Improvement Committee created a Performance Improvement Group to complete a Root Cause Analysis for the problems identified by the DHSR Surveyors of 09-15-2020. Root causes identified included low staff to resident ratio; high number of residents assigned to staff; staff not recognizing importance of hand hygiene protocol; signage removed when COVID Units expanded; and an insufficient number of signs. The facility will: monitor the staffing ratios; monitor the number of residents assigned to staff; and educate regarding the importance to hand hygiene protocol. On the day of survey 09-15-2020 signage was re-posted on entrances to both COVID Units and handwashing signage in	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 they must wear eye protection and an N-95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. During an observation on 9/15/20 at 10:00 AM no signage was observed on the doors to COVID-19 unit A. During an observation on 9/15/20 at 10:03 AM no signage was observed on the doors to COVID-19 unit B. An observation was conducted on 9/15/20 at 2:15 PM no signage was observed on the entrance to COVID-19 unit B. An interview was conducted with the Infection Control Nurse on 9/15/20 at 2:35 PM who stated there should be signs on the entrances to both COVID-19 units. She reported signs were not placed on the COVID-19 units because she ran out of signs. Rooms on COVID-19 unit B were observed to have signs at each doorway. 3. A facility policy titled "COVID-19", dated 5/11/20 read in part, "if visitation is granted, visitor(s) must perform hand hygiene". During the screening process to enter the facility on 9/15/20 at 9:00 AM, two of two state surveyors were not required to perform hygiene. The Medical Records Clerk, Administrator, and Receptionist were present during screening process. Observation on 9/15/20 at 9:10 AM revealed a state surveyor was not required to perform hand	F 880	the reception area was improved. 4. All staff will be educated on the visitor sign in process, isolation signs and hand washing, via the sparkling hands video. In servicing, will begin on 10-6-20. Staff will be in serviced on their return to work. Education will be included in new hire orientation. 5. DON/ ICP will audit 10 staff members a week on hand washing/hand hygiene x 4 weeks, 5 employees a week x 4 weeks and then 10 employees a month x 3 months. Administrator /DON will audit visitor /staff check in 3 days a week minimum of 10 staff/visitor each day x 4 weeks, then 2 days week x 4 weeks then 4 days a month x 1 month. 6. DON/ ICP will monitor isolation rooms for appropriate signs 3 x week x 4 weeks, then 2 x week x 4 weeks then 1 x week x 1 month. DON/ADON will review audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. DON/ADON will review the plan during the monthly QAPI meeting and the audits will continue at the desecration of the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345228	A. BUILDING ______ B. WING ______	C 09/17/2020

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F 880	Continued From page 13 hygiene upon reentry into the building. An interview was conducted with the Medical Records Clerk on 9/15/20 at 3:25 PM who stated all individuals completing the screening procedure on the agency kiosk should use hand sanitizer prior to using the kiosk and afterwards. She indicated the state surveyors were not asked to perform hand hygiene during the screening process on 9/15/20 at 9:00 AM. During an interview with the Director of Nursing on 9/15/20 at 4:40 PM she stated the state surveyors should have been asked to use hand sanitizer during the screening process on 9/15/20. An interview was conducted with the Administrator on 9/15/20 at 4:49 PM who stated the state surveyors should have been asked to use hand sanitizer during the screening process on 9/15/20. He indicated that when he entered the lobby during the screening process he believed the state surveyors had completed hand hygiene.	F 880		