STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INN AT QUAIL HAVEN VILLAGE	**155 BLAKE BOULEVARD PINEHURST, NC 28374**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 09/15/2020 through 10/05/2020. 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# 7YY311	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control survey and complaint investigation were conducted on 09/15/2020 through 09/16/2020. The survey was conducted onsite on 09/15/2020 and remotely on 09/16/2020. 4 of 10 complaint allegations were substantiated resulting in deficiencies. Immediate Jeopadry was identified at: CFR 483.80 at tag F 880 at a scope and severity K Immediate Jeopardy began on 09/15/2020 and was removed on 10/02/2020. The survey team returned to the facility on 10/05/2020 to validate removal of Immediate Jeopardy from tag F 880. The Immediate Jeopardy removal was validated on 10/05/2020 and the survey ' s exit date was changed to 10/05/2020.	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	F 695		10/6/20

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

Electronically Signed | 10/09/2020

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F 695	Continued From page 1 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 by: Based on record review, staff interview, and physician interview, the facility failed to initiate the physician ' s treatment plan for incentive spirometry (device utilized for breathing exercises) for Resident #1. This was for 1 of 3 residents reviewed for respiratory care. The findings included: Resident #1 was admitted to the facility on 2/28/20 with diagnoses that included pneumonia and Chronic Obstructive Pulmonary Disease (COPD). A physician ' s history and physical note dated 3/2/20 indicated Resident #1 was admitted to the facility for rehabilitation following hospitalization for pneumonia. The physician ' s treatment plan related to the diagnosis of pneumonia included incentive spirometry (device utilized for breathing exercises) for Resident #1. This note was scanned into the Electronic Medical Record (EMR) on 3/5/20 by the Health Information Manager (HIM). The admission Minimum Data Set (MDS) assessment dated 3/6/20 indicated Resident #1 ' s cognition was moderately impaired. Resident #1 ' s care plan indicated a focus area of COPD. The interventions included monitor/document/report to MD any signs or symptoms of respiratory infections, observe for	F 695	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1) Interventions for affected resident: The affected resident is discharged from the facility. 2) Interventions for residents identified as having the potential to be affected: An audit of the past 3 months of current resident□s physician orders/ history and physicals were audited for incentive spirometers orders to ensure orders were transcribed correctly, this audit was completed by the Director of Nursing on September 18, 2020 to ensure orders written and followed as prescribed by physician. Results were no other issues found in the orders for incentive spirometer. of current residents. 3. Systematic Change: Current licensed nursing staff as well as	

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F 695	Continued From page 2 difficulty breathing on exertion, and remind resident not to push beyond endurance. Resident #1 ' s care plan revealed no mention of incentive spirometry. Physician Assistant (PA) notes dated 3/5/20, 3/11/20, 3/18/20, 3/25/20, and 3/26/20 indicated Resident #1 had no signs or symptoms of shortness of breath or respiratory complications. These PA notes revealed no mention of incentive spirometry. Resident #1 had a planned discharge to the community on 3/26/20. Review of Resident #1 ' s physician ' s orders, Medication Administration Record (MAR), Treatment Administration Record (TAR), and nursing notes from 3/2/20 through discharge on 3/26/20 revealed no mention of incentive spirometry. A family interview for Resident #1 was conducted by phone on 9/16/20 at 8:39 AM. The family member stated that about a week after Resident #1 ' s admission (2/28/20) the physician indicated she was to have incentive spirometry treatment to exercise her lungs. She revealed that facility staff never implemented this treatment during Resident #1 ' s stay at the facility. The family member reported that she asked staff about Resident #1 ' s incentive spirometry treatment but was given no clear response as to why the treatment had not been implemented. She was unable to recall any specific staff members that she spoke with. During an interview with the Administrator on 9/15/20 at 12:30 PM she reported that the Director of Nursing (DON) was no longer working	F 695	the Health Information Manager were re-educated the proper review of physician orders to be transcribed to physician orders on September 20,2020. Newly hired licensed staff will be in-serviced within their initial orientation period on the review of physician orders for respiratory treatments to ensure proper transcription and implementation of orders. The Director of Nursing, Health Information Manager and Unit Manager will audit the insensitive spirometer quality assurance weekly for four weeks then monthly for three months. After review any staff identified as not transcribing or providing proper respiratory treatments will be identified and re-educated on proper policy and procedure. 4. Monitoring of the change to sustain ongoing system compliance: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for proper transcription of the incentive spirometer and implementation of those orders to the Quality Assurance and Performance improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 695	Continued From page 3	F 695		

at the facility as of this week. She indicated that she was familiar with the facility ' s nursing processes as she was previously the DON at the facility. The 3/2/20 physician ' s note that indicated his plan for treatment of Resident #1 ' s diagnosis of pneumonia included incentive spirometry was reviewed with the Administrator. The medical record that showed no mention of incentive spirometry for Resident #1 was reviewed with the Administrator. The Administrator stated that the normal process for implementing a new order for a treatment was for the physician to write a hard copy order that was then entered into the EMR by nursing staff working at the time of the order. She indicated it was possible that the physician gave a verbal ordered that was not entered into the EMR and/or wrote a hard copy order that mistakenly was not entered into EMR. She reported that the physician ' s notes were sent directly to the HIM and she scanned them into the computer. She indicated that the HIM was not responsible for reviewing the notes for any new treatments. The Administrator stated that she was not working at the facility in March 2020 and was unable to say for certain what happened, but she acknowledged that the physician ' s treatment plan for incentive spirometry should have been initiated for Resident #1.

An interview was conducted with the HIM on 9/15/20 at 12:40 PM. She stated that she received the physician ' s notes and scanned them into the EMR. She reported that she reviewed the notes for any new diagnoses, but was not responsible for reviewing the notes for treatment changes. The HIM indicated that the physician normally wrote his own hard copy orders if there was something new and the

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F 695	Continued From page 4 nursing staff then entered the orders into the EMR. Phone interviews were attempted with the former DON on 9/16/20 at 8:36 AM and 12:48 PM. She was unable to be reached. A phone interview was conducted with the physician on 9/16/20 at 8:40 AM. His note dated 3/2/20 that indicated his plan for treatment of Resident #1 ' s diagnosis of pneumonia included incentive spirometry was reviewed with the physician. The medical record that showed no mention of incentive spirometry for Resident #1 was reviewed with the physician. The physician stated that he was unable to recall this specific resident and also was unable to recall this 3/2/20 note related to incentive spirometry. He was asked what the normal process was when he indicated a plan for a new treatment in his note. The physician stated that normally he wrote the hard copy order himself. He indicated that it was possible that he told the nurse verbally of the order, but he was unable to know for sure. He added that his Physician ' s Assistant (PA) normally reviewed his notes and would identify and implement any new treatments. He revealed that this treatment plan for incentive spirometry for Resident #1 was somehow missed. He reported he was thankful no harm was caused to Resident #1 and stated that he and the facility needed to ensure this type of mistake did not happen in the future.	F 695		
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	F 880		10/6/20

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F 880	Continued From page 5	F 880		

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 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

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F 880	Continued From page 6 (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 and staff interviews, the facility failed to implement the Centers for Disease Control (CDC) guidelines and the facility's COVID-19 Preparation and Response policy in the facility's COVID positive unit in 4 of 4 residents (Resident #6, #7, #8 and #9) reviewed for enhanced droplet/contact precautions when staff, who were assigned to care for both COVID positive residents and residents in the general population, did not wear the required Personal Protective Equipment (PPE), failed to perform hand hygiene when entering/exiting resident rooms, and failed to store used isolation gowns in a manner that would reduce the chance of	F 880	The statements made on this Plan of Correction are not an admission to nor do they constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F880 For the residents involved, corrective	

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F 880	Continued From page 7 spreading COVID-19. These failures occurred during a COVID19 pandemic. Immediate Jeopardy began on 09/15/2020 when observations revealed the same staff were assigned to work with residents who resided on the COVID positive unit and the general population, and staff were observed not wearing required personal protective equipment (PPE) and not performing hand hygiene before or after entering the rooms of residents on enhanced droplet/contact isolation. The staff were observed removing PPE in the hall after leaving residents ' rooms on the COVID positive isolation unit and the quarantine unit and observed hanging used isolation gowns on the outside of the resident's doors. The Immediate Jeopardy was removed on 10/2/2020 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included: 1a. Centers for Disease Control (CDC) guidelines stated health care providers (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should use an approved N95 or facemask, gown, gloves, and eye protection. CDC guidelines retrieved on 9/15/2020. A review of the facility's in-service education titled Conserving PPE (pg. 2) provided to staff in July of 2020, stated; All staff and vendors when entering	F 880	action has been accomplished by: All active previously undiagnosed residents have received Covid-19 test on September 11, 14, 18, 22, 24 28, October 1, 5 and 8, 2020. No positive Covid-19 test results were received on any of those testing days. The Director of Nursing (Infection Preventionist) provided immediate education by guidance from the CDC on 9/15/2020 for the staff who were in violation of the current Personal Protective Equipment (PPE) policy to ensure the proper PPE was donned and doffed correctly. As well as the importance of wearing the proper PPE and hand washing to deter the spread of Covid-19 and any other contagious disease. The staff also performed return demonstration of the proper entrance and exit of a resident room with PPE and use of hand sanitizer. Gowns will not be reused. Corrective action has been accomplished on all residents with the potential to be affected by the alleged deficient practice by: On 10/2/2020, the clinical consultant (Infection Preventionist) educated the Director of Nursing and Administrator on the importance of having designated staff (including a nurse and housekeeper as well as a nursing assistant depending on the number of Covid-19 patients and care needs) that are assigned only to patients on the COVID-19 unit and do not provide care to patients in the general care areas. All previous undiagnosed residents were tested for Covid.	

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F 880	Continued From page 8 room where isolation is required should look at door sign for isolation PPE requirements. On 9/15/2020 10:45am a Minimum Data Set (MDS) nurse and Nurse Assistant (NA) #1 were observed entering a COVID positive resident's room (Resident #7) with only a mask and no other PPE. NA #1 came back and retrieved PPE from the isolation caddy on the door but the MDS nurse did not. The MDS nurse was observed leaving the resident's room, then left the COVID positive area without performing any hand hygiene. A hand hygiene station was located outside the resident's door. Signage on the resident's door indicated the resident was on enhanced droplet/contact precautions and mask, eye protection, gowns, and gloves were required when entering room . On 9/15/2020 at 12:00pm the MDS nurse was interviewed. She stated she went in to assist NA#1 with resident and forgot to apply PPE. She further stated she did not wash her hands before or after exiting the resident's room or before exiting the COVID positive unit despite having a hygiene station available outside the resident's room. She did wash her hands when she returned to her work area which was located in an office right outside the COVID positive unit. On 9/15/2020 at 11:33am an interview was conducted with NA#1. She stated she does wear PPE when entering the room of residents who are known to be COVID positive and those that are on the quarantine hall. She stated she was distracted by the resident and forgot to put on PPE prior to entering the room. She stated she did come back and retrieve PPE from the caddy. NA # 1 stated she was assigned to the COVID	F 880	Measures put into place or systematic changes made to ensure the alleged deficient practice does not occur: On October 2, 2020 the DON in-serviced all nurses, aides, med techs and housekeeping part-time and fulltime, on the expectation of following proper use of PPE and hand sanitizing by guidance from the CDC. The Director of Nursing, the Administrator and the MDS Nurse performed Infection control focused audits which included PPE and handwashing observations and continue to educate that personal protective equipment is very important to minimize the spread and transmission of infectious diseases including COVID-19. The consultant (Infection Preventionist) will over additional training and education. Failure to follow these instructions could cause harm to the residents and staff. Following the signs and instructions that are on enhanced precaution doors is a requirement for all staff. If staff do not comply with these policies and procedures disciplinary actions will be implemented. When the facility has an occupied COVID-19 unit the administrator or the Director of Nursing will review staffing for seventy- two hours during the stand- up meetings. This review will include ensuring that staff are designated for the COVID-19 unit only. The facility self -assessment was reviewed and approved by the Medical Director and Infection Preventionist on 10/12/2020. The facility has obtained an outside consultant to continue education and have input into the process of continuous improvement with	

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F 880	Continued From page 9 positive unit, which consisted of residents who were known to be positive for the virus, and residents who were on the quarantine hall. She stated the quarantine hall was for new admissions or readmissions. 1b. The Facility's policy titled COVID-19 Preparation and Response last updated on 9/5/2020 read (pg8); Minimize staff working across units/floors and assign staff to care for symptomatic only when possible. When it is not possible for staff to care for symptomatic only, then implement strategies to minimize contact. On 9/15/2020 at 11:00am Nurse #1 was observed in Resident #6's room. Resident #6 resided on the COVID positive unit. Nurse #1 was observed wearing a mask but was not wearing any other PPE while in the resident's room. A sign posted on the resident's door specified the resident was on enhanced droplet/contact precautions and mask, eye protection, gowns, and gloves were required when entering the room. On 9/15/2020 at 12:20pm Nurse #1 was interviewed and stated he was not required to wear PPE unless he was going to be less than six feet from the resident or if he was going to provide care that required direct contact. When asked where he got this information, he stated it was in accordance with the facility's policy and provided as part of an in-service education provided by the facility in July of 2020. When asked if he was dedicated to the COVID positive unit only, he stated he was not. He was assigned to residents on the COVID positive unit as well as residents in the general population. On 9/15/2020 at 11:45 am while interviewing the	F 880	the infection control process. The Infection Control Consultant will provide on site education two times per month in the areas of correctly donning and doffing of PPE and proper hand hygiene in the community based upon CDC Guidelines and recommendations. The facility has implemented a quality assurance monitor: The Director of Nursing, the Administrator and the MDS Nurse performed Infection control focused audits which included PPE and handwashing observations. The audits are being completed three times per week on each shift for a period of six weeks, then two times per week on each shift for a period of four weeks and once per week on each shift for two weeks. The audits will continue weekly per facility policy. The Infection Control Consultant (Preventionist) will also conduct audits for compliance with PPE use on isolation units, audits on hand hygiene compliance and review of any new or needed Performance Improvement Plans. The results of the audits will be reported monthly to the Quality of Life Team at the Monthly Quality of Life Meeting, team members include the Administrator, Director of Nursing, MDS Nurse, Nursing Supervisor, Infection Control Consultant (Preventionist) , Environmental Director. For each month with less than 100% compliance, the monitor will be extended for two months. Any corrective action required will be made by the Quality of Life Team at that time.	

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nursing supervisor, NA#1 was observed entering a resident's room (Resident #8) on the quarantine hall without any PPE other than a face mask. The resident's door signage specified the resident was on enhanced droplet/contact precautions indicating mask, eye protection, gowns, and gloves should be worn. The nursing supervisor immediately corrected the NA and she came out and donned PPE. The Nursing supervisor then stated the employee knew better than to enter the room without PPE.

On 9/16/2020 at 12:28pm an interview was conducted with the facility administrator in which she stated it was her expectation and the facility policy that all nurses wear full PPE when caring for residents on enhanced droplet/contact precautions.

2.A review of the facility's policy, titled COVID-19 Preparation and Response, last updated on 9/5/2020, stated (pg. 12); Single use gowns should be used and discarded for all contact and enhanced precaution rooms.

A review of the facility's in-service education titled Conserving PPE provided by the facility in July of 2020 stated; when you remove the gown, hang the gown on the back of the door and perform hand hygiene. At the end of your shift, discard the disposable gown.

On 9/15/2020 at 10:30 am, while on quarantine hall, used isolation gowns were observed hung outside of the doors of Resident #8 and Resident #9. The gowns hung over caddies containing unused isolation gowns and gloves. Direct contact between used and unused gowns was observed since unused gowns were not in

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INN AT QUAIL HAVEN VILLAGE	155 BLAKE BOULEVARD PINEHURST, NC 28374

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individual packaging. The same observation was made on the COVID positive unit. Used isolation gowns were hung on Resident #6 and Resident #7's door. The gowns hung over caddies containing unused isolation gowns and gloves. Direct contact between used and unused gowns was observed.

On 9/15/2020 at 10:30am NA #1 was observed exiting Resident #9's room, who resided on the quarantine hall. Signage on the resident's door indicated the resident was on enhanced droplet/contact precautions. NA #1 was observed to remove the isolation gown in the hall and hung it on a hook outside the resident's room on the outside of the door before performing hand hygiene.

On 9/15/2020 at 10:37am in an interview with the NA#1, she stated she worked in the COVID positive unit and on the quarantine hall. She further stated the staff was provided in-service education on reuse of PPE and in that in-service training they were told by the previous infection control nurse to hang the gown on the outside of the door. She stated they use the gown for the entire shift unless it became soiled. NA#1 stated this was the practice for both the COVID positive unit and the quarantine hall.

At 11:35am on 9/15/2020 and interview was conduct with the Nursing Supervisor who revealed the facility's infection control nurse had resigned the week prior and she was going to be assuming the responsibility of infection control nurse for the facility. She stated staff were told by previous infection control nurse to hang PPE gowns on the hook outside of the doors on COVID positive unit as well as the quarantine

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hall. When asked if she was familiar with the in-service training provided to employees by the facility, she stated she was not. When asked to demonstrate which side of the door was the back side of the door, the nurse demonstrated side facing the resident's room was the back of the door. When asked about designated staff for COVID positive unit and quarantine hall, she stated the facility had low census and only 4 residents in those areas. She further stated the NA, who provided most of the hands-on care for the residents and was at a greater risk of carrying the virus from resident to resident, was designated to the COVID positive and quarantine areas only. She was not providing care in the general population.

On 9/16/2020 at 12:28pm an interview was conducted with the facility administrator in which she stated it was her expectation and the facility policy that all nurses wear full PPE when caring for residents on enhanced droplet/contact precautions and that all staff adhere to the policy and in-service training provided by the facility when storing PPE intended for reuse, such as isolation gowns.
The facility Administrator was made aware of Immediate Jeopardy on 10/1/2020 at 4:40pm.

Allegation of Compliance F880

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 9/15/2020 the facility had the same staff assigned to resident # 6 and #7 who were on the Coivd-19 unit as well as the quarantine residents and residents in the general population. This staff

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was observed not wearing the required PPE for enhanced droplet/contact precautions. The staff was also observed not performing hand hygiene after exiting rooms of resident on the covid-19 unit. The staff increased the risk of spreading Covid-19 to the other residents in the community as well as other employees. The facility also did not have dedicated staff assigned to the Covid-19 unit as well as not performing proper hand hygiene when exiting resident rooms. As of 10/2/2020, there are no residents that have active COVID-19 in the facility. All residents have the potential to be affected by the noncompliance. All active residents have received COVID-19 test on September 11, 14, 18, 22, 24, 28, and October 1, 2020. No positive COVID-19 test results were received on any of those testing days. Used gowns were observed hanging on the front of doors over clean gowns.
The Administrator and Director of Nursing provided immediate education on 9/15/2020 for the staff who were in violation of the current PPE policy to ensure the proper PPE was donned and doffed correctly. As well as the importance of wearing the proper PPE and hand washing to deter the spread of Covid-19 and any other contagious disease. The staff also performed return demonstration of the proper entrance and exit of a resident room with PPE and use of hand sanitizer. When the MDS Nurse and nursing assistant were interviewed as to not donning the proper PPE the response was it was an emergency situation with the possibility of a fall of a resident. The Nurse replied he misunderstood the instructions as it was his impression if he was not within six feet of the resident the mask was the only required PPE. Gowns will not be reused.

Specify the action the entity will take to alter the

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process or system failure to prevent a serious adverse outcome from occurring or recurring.

On 10/2/2020, the clinical consultant educated the Director of Nursing and Administrator on the importance of having designated staff (including a nurse and housekeeper as well as a nursing assistant depending on the number of Covid-19 patients and care needs) that are assigned only to patients on the COVID-19 unit and do not provide care to patients in the general care areas. When the facility has an occupied COVID-19 unit the administrator or the Director of Nursing will review staffing for seventy- two hours during the stand- up meetings. This review will include ensuring that staff are designated for the COVID-19 unit only. This will include a licensed nurse and housekeeper at a minimum. Depending on the number of residents on the COVID unit and cares needs a nursing assistant may also be required. Additional staff may be required in order to adequately care for the residents on the unit. When designated staff is not available or when there are call outs, strategies to ensure staffing such as bonus and agency utilization can be used. If they are unable to provide designated staff the Administer or Director of Nursing should contact the clinical consultant for additional suggestions. This may include moving residents to COVID facilities if staffing cannot be secured. The local health department should also be contacted. This was completed on 10/2/2020.

All staff to include nurses, nursing assistants, housekeeping, social services, activities, therapy, and physicians were in-serviced on 10/2/2020 by Director of Nursing and clinical consultant. This in-service training included the need for

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designated nursing and housekeeping staff for COVID-19 positive patients. Nursing staff and other team members (therapy, social services, activities, others) assigned to the COVID -19 unit may not provide care for other residents in the facility. If you arrive at work and designated staff are not available contact the Administrator or Director of Nursing. When entering and exiting a resident's room, all staff must use alcohol- based hand sanitizers or wash their hands. Alcohol based hand sanitizers are located in the hallways. Residents on enhanced precautions will have a sign on their door that alerts staff as to what personal protective equipment (PPE) should be utilized. This includes a mask, eye protection, gowns and gloves. PPE must be donned prior to entering a resident room who is on enhanced precautions. The gown and gloves should be removed and discarded prior to exiting the room. Do not reuse gowns. Hand hygiene should be performed after the removal of the PPE and anytime you enter or leave a resident's room. Personal Protective Equipment is located near the resident's door. If hand sanitizer dispensers are low or if you do not have adequate supply of personal protective equipment notify the supervisor immediately. Extra stock of PPE is located in the office of the Director of Nursing. Hand sanitizer was placed on the isolation cart at each isolation resident door.

The Director of Nursing, the Administrator and the MDS Nurse performed Infection control focused audits which included PPE and handwashing observations. The audits are being completed three times per week on each shift for a period of six weeks, then two times per week on each shift for a period of four weeks and once per week on each shift for two weeks. The audits will continue

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weekly per facility policy and will be reviewed at clinical morning meeting. Personal protective equipment is very important to minimize the spread and transmission of infectious diseases including COVID-19. Failure to follow these instructions could cause harm to the residents and staff. Following the signs and instructions that are on enhanced precaution doors is a requirement for all staff. If you do not comply with these policies and procedures disciplinary actions will be implemented.

This training was started on 10/2/2020. Any staff that did not receive the education as of 5 PM on 10/2/2020 will not be allowed to work until the education is completed. Any staff who are not trained as of 10/2/2020 by 5pm will be completed by the Director of Nursing and the MDS nurse; who are the main trainers for the facility at this time. The two are aware of the responsibility and will schedule blocks of time for staff who have not been trained. The Director of Nursing and MDS Nurse were notified of this responsibility by the facility consultant on 10/2/2020. The Administrator and the Director of Nursing will review the schedule for 72 hours in advance to ensure that all staff have received the education until all staff have been in-serviced. If staff have not received the education and are not able to be educated, then they will be removed from the schedule.

The Facility alleges the removal of the immediate jeopardy on 10/2/2020.

On 10/5/2020 the facility's credible allegation for Immediate Jeopardy removal was validated by the following: Review of in-service training records of staff from all departments including

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F 880	Continued From page 17 Administrator and Nursing Supervisor/Infection control nurse. The training received included, COVID staffing; designated staff for COVID unit, application of PPE; donning and doffing with return demonstration, and hand hygiene. The facility ensured 100% participation by all staff in all departments. Results of the infection control monitoring were reviewed for the dates of 9/25/2020, 10/2/2020, and 10/5/2020. Staffing sheet for 10/5/2020 revealed designated staffing for the quarantine unit, the COVID unit was empty at that time. Interviews with facility staff revealed they received training and were able to describe the facility's policy on use of PPE and hand hygiene procedures as well as designated staffing for the COVID unit. Observations on the quarantine unit revealed staff wore the correct PPE for enhanced droplet/contact precautions and performed hand hygiene prior to and after entering the rooms of residents on enhanced droplet/contact precautions.	F 880		