STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING _____ B. WING _____	C 11/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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 Emergency Preparedness Survey was conducted on October 27-November 5, 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#WCBW11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 10/27/2020 through 11/5/20. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Immediate Jeopardy (IJ) was identified at CFR 483.12 at tag F880 at a scope and severity of K. Immediate Jeopardy (IJ) began on 10/25/2020 and was removed on 11/3/2020. 13 of 47 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and	F 583		11/30/20

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

Electronically Signed | 11/27/2020

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F 583	Continued From page 1 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to protect the private health information by leaving confidential medical information unattended and exposed on a medication cart and a medication cart computer in an area accessible to others for 3 of 3 medication carts observed. The findings included: An observation on 10/27/20 at 9:45 AM of the	F 583	F-583 In service education provided to 100% of all licensed nursing staff on either closing computer screens or minimizing the screen when not at med cart. This in services was conducted by the Director of Nursing and completed on 11/30/2020. This education will be included in new hire orientation. Facility found that all residents had the potential to be affected by this practice.	

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F 583	Continued From page 2 A-400 hall revealed Medication cart #1 was left unattended with the medication cart computer open exposing resident names. There was also a resident report sheet exposing 6 resident names with confidential information exposed including diagnosis, activity of daily living assistance needs, feeding status and antibiotic use. Nurse #1 was observed as she exited a resident's room and approached the medication cart. During an interview with Nurse #1 on 10/27/20 at 9:48 AM, she stated she should not have left the medication cart unattended with the resident report exposed and the medication cart computer open exposing resident names. An observation on 10/28/20 at 1:38 PM revealed Medication Cart #2, located on the C-100 hall was unattended with a resident roster exposing 6 resident names with information on diagnosis, medications and care needs. C-100 hall is used by multiple staff members to enter all other halls on C wing. An interview conducted on 10/28/20 at 1:52 PM with the Director of Nursing revealed resident information is not to be left in sight. An observation on 10/29/20 at 6:08 AM revealed Medication cart #3, located on the C-200 hall, revealed an unattended medication cart with a resident report sheet exposing resident names. Medication Aide #1 was observed exiting a resident room at the end of the hallway. An interview conducted on 10/29/20 at 6:10 AM with Medication Aide #1 revealed she was aware resident information should be kept out of sight.	F 583	Facility instituted QAPI Audits to randomly check 4 med carts per day at a minimum of 5 days per week spread across all shifts to determine that staff are maintaining confidentiality of medical records when they leave their med carts. These audits will be conducted by our Director of Nursing, Assistant DON, Assistant Administrator, Nurse supervisor or department managers and will continue for 3 months. Additional in service and training will be provided. QAPI Audits will be used to identify staff needing further training which will be provided at the time that failure to comply with requirements and corrections secured at that time. QAPI Audits will be submitted to monthly QAPI meetings by the Director of Nursing to review for additional actions if needed or to determine when substantial compliance has been obtained. Audits will continue at a minimum for 3 months and at that time if the QAPI Team has determined that substantial compliance has been secured and maintained the audits will be discontinued. The first review by the QAPI Team will be performed no later than 12/4/2020.	

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F 583	Continued From page 3 A follow up interview with the Director of Nursing on 10/29/20 revealed her expectation was that protected health information should be kept out of sight.	F 583		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		11/30/20

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F 676	Continued From page 4 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility staff failed to provide a bed bath and scheduled showers to a resident (Resident #14) per the resident's care plan and failed to provide incontinent care for another resident (Resident #16) per this resident's care plan. This was evident for two of four residents reviewed that were care planned to receive staff assistance with activities of daily living in the categories of bed baths and showers and incontinent care (Residents #14 and #16). The findings included: 1. Resident #14 was admitted to the facility on 04/16/2008 with cumulative diagnosis which included acquired absence of the right leg above the knee, acquired absence of the left leg above the knee, muscle weakness and shortness of breath on exertion. Review of the most recent comprehensive annual Minimum Data Set assessment, dated 9/13/2020, assessed the resident was cognitively intact and required one-person assistance with activities of daily living (ADL) that included personal hygiene, dressing and bathing. Review of the revised care plan, dated 09/29/2020, revealed Resident #14 had a focus of ADLs Functional/Rehabilitation potential or demonstrated need. The interventions included,	F 676	Tag 676 In-service education provided to 100% of all licensed nursing staff, medication aides and Certified Nursing Assistants on the bathing schedules and providing timely incontinence care. This in-service was conducted by the Director of Nursing to be completed by 11/30/2020. This education will be included in new hire orientation. 100% Audit of all residents to determine bathing preferences, to include shift and days of the week, and an evaluation of residents who require incontinence care by 11/30/2020. This audit was completed by our Director of Nursing, Assistant DON. 100% Audit of all residents were offered and provided with a shower by 11/30/2020. This audit was completed by our Director of Nursing and Assistant DON. Facility found that all staff and residents had to potential to be affected by this practice. Facility instituted new shower schedule completed by 11/30/2020, and all care guides were updated on 11/24/2020 by our ADON. All care guides were updated on 11/24/2020 by our ADON for residents who require incontinence care. The Director of Nursing, Assistant Director of Nursing, Nurse Supervisors and	

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F 676	Continued From page 5 in part, showers 2x's weekly with bathing assistance on non-shower days to be conducted by the nursing assistant staff. Review of the Point of Care ADL report for Resident #14 for the dates of 10/22/2020-10/28/2020 revealed documentation that no bed bath or shower was given. Review of the electronic medical record from 10/22/2020-10/27/2020 revealed no refusal of bed baths or showers during this 7 day look back period was documented. An Interview was conducted on 10/28/2020 at 11:32 a.m. with Resident #14. The resident reported the following: The date of 10/27/20 was the third consecutive day she had not been assisted with a bath or shower. On 10/27/2020, she had wanted to wash up and she had let her nurse aide know. The nurse aide had stated she was running behind because they did not have enough staff and did not come to help when the resident had requested a bath. By the time the nurse aide had come to help it was breakfast, and the nurse aide could not help with the bath. Following breakfast on 10/27/20, the nurse aide did not return until lunch time. The resident stated she likes to wash "good" and she is slow because she tires easily. There had not been enough time for a bed bath before the lunch meal was served on 10/27/20 and she was never given or offered one afterwards. According to the resident, the current day of the interview (10/28/20) was the fourth date on which she had not received a bed bath. She reported that she prefers a bath on first shift and would not have been offered a bath or shower on second shift to honor her preference. She said the problem of not getting a bath had	F 676	scheduler will review the daily schedule to review shower requirements and assignment of residents who require incontinence care to support sufficient staffing. Shower compliance will be monitored 5 days a week x 4 weeks then weekly x 4 weeks then monthly x 1 month. This audit will be conducted and monitored by our Director of Nursing or designee. Timely incontinence care will be monitored by the Director of Nursing, Assistant Director of Nursing and Nurse Supervisors by random audits of 3 residents per shift, using interviews of residents or observation of incontinence. These audits will be conducted no less than 5 days per week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. QAPI audits will be submitted to monthly QAPI Meetings by the Director of Nursing to review for additional actions if needed or to determine when substantial compliance has been obtained. Audits will continue at a minimum for 3 months and at that time if the QAPI Team has determine that substantial compliance has been secured and maintained the audits will be discontinued. The first review by the QAPI Team will be performed no later than 12/04/2020.	

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F 676	Continued From page 6	F 676		

been occurring for the past several weeks. The resident attributed the problem to a lack of staff.

An Interview was conducted on 10/28/2020 at 1:42 p.m. with Nurse Aide (NA) #2, who was assigned to Resident #14 on the day shift. NA # 2 stated during the last seven days she had worked four days on the same day shift assignment, which had included Resident # 14. The date of 10/28/20 made the fifth day shift she had worked with Resident #14 within a week's time period. The NA stated she did not document a bed bath or shower for Resident #14 during any of her shifts she had worked with Resident # 14 within the last seven days because she did not give the resident a bed bath or shower. The NA stated the resident was scheduled to receive two bed baths and two showers during the shifts she had worked with the resident within the past week. The NA stated she did not have time to give these scheduled bath/showers. She said that after she finished her morning rounds it was time to begin serving breakfast and then she had started her rounds again. She then stated she had not completed all daily assignments because there was not enough staff. She stated this had been occurring for almost a month.

An Interview was conducted on 10/28/2020 at 11:10 a.m. with Nurse Aide (NA) #3. NA # 3 was assisting NA #2 on Resident #14's unit. The NA reported over the past two months the amount of staffing had become low and it had become difficult to complete her assignments. She said she had provided personal hygiene care in place of a bed bath when necessary and did not document a bed bath in a resident's chart if she was not able to provide one. The NA stated she reported that she was unable to complete bed

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F 676	Continued From page 7	F 676		

baths to the interim administrator a little over a month ago.

An Interview was conducted on 10/28/2020 at 2:46 p.m. with the administrator. The administrator stated that it was his expectation that residents be offered a bed bath daily, and that a shower would be offered as per the resident's care plan. He stated he was new to his role at the facility, but he believed most residents would receive a shower twice a week.

2. Resident #16 was admitted to the facility on 02/19/2020.

Resident #16 was assessed on her 09/10/20 Minimum Data Set assessment as being cognitively intact, occasionally incontinent of bowel and required supervision with one-person physical assistance with personal hygiene and toilet use.

Review of the revised care plan, dated 9/26/2020, revealed Resident #16 had a focus of ADL Functional/Rehabilitation potential and needs assistance with bathing, toileting and personal hygiene. The goal stated the resident will receive assistance with daily care needs while in the facility over the next 90 days. The interventions included, in part, provide incontinence care as indicated during routine care to be completed by the nursing assistant (NA) and nursing staff.

Observations on 10/28/2020 at 1:02 pm revealed Resident #16's call light was activated. A strong odor was noted coming from the resident's room. Observations from 1:02 pm to 1:30 pm revealed no staff respond to Resident #16's call light. At 1:31 pm NA #2 entered Resident #16's room,

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F 676	Continued From page 8 answered the resident's call light and provided the resident with incontinent care. At 1:38 pm NA #2 exited the resident's room. An Interview was conducted with Resident #16 on 10/28/2020 at 1:38 pm. Resident #16 stated she had a bowel movement, turned her call light on to request staff assistance and waited for over 30 minutes for staff to respond. She said she believed the issue was the facility had been short staffed a few weeks. An Interview was conducted on 10/28/2020 at 1:42 p.m. with Nurse Aide (NA) #2, who was assigned to Resident #16 on the day shift. NA #2 stated that after she finished her morning rounds it was time to begin serving breakfast and then she had started her rounds again. She then stated she had not completed all daily assignments because there was not enough staff. She stated this had been occurring for almost a month.	F 676		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725		11/30/20

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F 725	Continued From page 9 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews the facility failed to allocate sufficient nursing staff to provide residents with bed baths and scheduled showers and incontinent care as care planned for 2 of 4 residents reviewed for the provision of activities of daily living (ADL) care (Residents #14 and #16). The findings included: This tag is cross referenced to tag F676: F-676: Based on observations, record review, staff and resident interviews the facility staff failed to provide a bed bath and scheduled showers to a resident (Resident #14) per the resident's care plan and failed to provide incontinent care for another resident (Resident #16) per this resident's care plan. This was evident for two of four residents reviewed that were care planned to receive staff assistance with activities of daily living in the categories of bed baths and showers and incontinent care (Residents #14 and #16).	F 725	F-725 The facility failed to ensure that sufficient staff was available to assist residents with showers, baths and timely response of incontinence care. All residents have the potential to be affected by this practice. 100% of all licensed staff, medication aides, and certified nursing assistants will be in-serviced by the Director of Nursing in assisting with bathing and incontinence care as deemed necessary per resident care plans. All licensed staff, medication aides, and certified nursing assistants will be in-serviced on notifying the Director of Nursing if the need is unable to be met with the current daily staffing. These in-services are to be completed by 11/30/2020. The facility will take corrective action to enhance staffing and to ensure the deficient practice does not recur with increasing coverage with use of facility	

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F 725	Continued From page 10 An Interview was conducted on 10/29/2020 at 9:15 a.m. with Unit Manager (UM) #1. The UM revealed it had been difficult to retain staff during the COVID-19 pandemic. UM #1 stated a review of ways to prevent staff burnout with the COVID-19 quarantine unit and the general population units had been discussed in morning meetings over the past two months. UM #1 specified the facility's daily resident census numbers were divided by the number of nursing assistants (NAs) working, to get each NAs assignment for the day. She stated an attempt was made to evenly distribute the acuity level of the facility's resident population on each facility hallway. But, the facility's COVID-19 hall and the ventilator hall had a higher acuity level and NAs would be assigned a lower resident to staff ratio if they worked on one of these hallways. UM #1 explained the company was interviewing for staff and staff were currently in orientation. She stated she was aware that NAs reported they felt they were unable to complete their assignments or needed to work overtime to complete tasks such as providing resident showers or baths. An Interview was conducted on 10/28/2020 at 2:46 p.m. with the administrator. The administrator stated the facility was advertising to hire new Nursing assistant staff when he was hired and there were new staff currently in the screening process and in orientation.	F 725	staff, agency staff and utilizing the facility emergency staffing policy. The staffing coordinator will utilize nurses and certified nursing assistants for all shifts from nursing agencies, offering overtime, clinical management assistance and continuation of hiring practices until the facility has completed their interview, orientation and training process to ensure sufficient nursing staff to provide residents with bed baths and scheduled showers and incontinent care as care planned. Monitoring will consist of daily Audits for 4 weeks, then weekly for 4 weeks and then monthly for one month to ensure resident needs are able to meet according to the care plan. These audits will be conducted by the Director of Nursing, Assistant Director of Nursing or a nursing supervisor. The Administrator will bring the results of these audits to the Quality Assurance Committee monthly x 3 months.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		11/30/20

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F 761	Continued From page 11 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep medications secured in a locked medication cart for 2 of 2 medication carts observed (Medication carts #1 and #2). The findings included: 1. An observation was made on 10/27/20 at 9:45 AM of Medication cart #1 on the A-400 hall. The lock mechanism was extended which indicated the cart was unlocked. Medication cart #1 was also unattended located outside a resident's room. At 9:46 AM, Nurse #1 was observed coming out of a resident's room and approached the cart.	F 761	F761 In service education provided to 100% of all licensed nursing staff and medication aides on locking medication carts when not in immediate use. This in-service was conducted by the Director of Nursing and completed by 11/30/2020. This education will be included in new hire orientation. Facility found that all staff and residents had to potential to be affected by this practice. Facility instituted QAPI audits to randomly check medication charts, 3 carts per shift at a minimum of 5 days a week to determine that staff are locking the	

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F 761	Continued From page 12 During an interview on 10/27/20 at 9:48 AM, Nurse #1 stated she was aware medication carts needed to be locked when unattended and immediately pushed in the locking mechanism to lock the cart. She added she was new to long term care and learning. An interview was conducted with the Director of Nursing on 10/29/20. She stated she all nurses and medication aides knew medication carts were to be locked when unattended. She added she expected all medication carts to be locked when unattended. 2. An observation was made on 10/29/20 at 6:02 AM of Medication cart #1 at the front of the A-400 hall. The lock mechanism was extended which indicated the cart was unlocked. Medication cart #1 was also unattended by a staff member. Nurse #2 was observed approaching the cart from the A-100 hallway. During an interview on 10/29/20 at 6:04 AM, Nurse #2 stated she was aware the medication cart should be locked when unattended. She apologized and was observed locking the cart. She added sometimes nurses and medication aides share carts. An interview was conducted with the Director of Nursing on 10/29/20. She stated she all nurses and medication aides knew medication carts were to be locked when unattended. She added she expected all medication carts to be locked when unattended. 3. An observation was made on 10/29/20 at 6:08 AM of Medication #2 on the C-200 hall. The lock	F 761	medication cart when not attended and in immediate use. These audits will be conducted by our Director of Nursing, Assistant DON, Nurse supervisors or department managers and will continue for 3 months. QAPI Audits will be used to identify staff needing further training which will be provided at the time that failure to comply with requirements and corrections secured at that time. QAPI audits will be submitted to monthly QAPI Meetings by the Director of Nursing to review for additional actions if needed or to determine when substantial compliance has been obtained. Audits will continue at a minimum for 3 months and at that time if the QAPI Team has determined that substantial compliance has been secured and maintained, the audits will be discontinued. The first review by the QAPI Team will be performed no later than 12/04/2020.	

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F 761	Continued From page 13 mechanism was extended which indicated the cart was unlocked. Medication cart #2 was also unattended at the station in the middle of the hall. A nursing assistant was observed sitting at the nurse's station. Medication Aide #1 was observed exiting a resident's room at the end of the hallway. During an interview on 10/29/20 at 6:10 AM with Medication Aide #1, she stated she was unaware she had to keep the medication cart locked at all times when it was unattended. An interview was conducted with the Director of Nursing on 10/29/20. She stated she all nurses and medication aides knew medication carts were to be locked when unattended. She added she expected all medication carts to be locked when unattended.	F 761		
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	F 880		11/30/20

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and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 15 §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, nurse practitioner (NP) interview, and review of the facility's COVID19 policies and Centers for Disease Control and Prevention (CDC) COVID 19 guidelines the facility failed to develop a policy to address aerosolized treatments and failed to implement their COVID policies and CDC guidelines when staff did not ensure a resident on enhanced droplet precautions was quarantined and remained on enhanced droplet precautions for 14 days after being readmitted to the facility following a hospitalization, staff failed to post precaution signage on the resident's door, failed to wear required personal protective equipment (PPE) when providing care or while in the resident's room, and failed to disinfect a face shield after providing suctioning for 1 of 1 resident (Resident #3) reviewed for enhanced droplet precautions. These failures occurred during the COVID-19 pandemic. A total of 16 residents tested positive for the COVID-19 virus on October 27, 2020. Additionally, five more residents tested positive for the COVID virus on 10/28/2020. Immediate Jeopardy began on 10/25/20 when the facility moved Resident #3, who was on enhanced droplet precautions, to a general	F 880	F880 Root Cause Analysis Oak Forest Health and Rehabilitation The facility failed to follow Infection Control practices related to wearing PPE appropriately and completing isolation of a re admit resident. The practice was related to the communication between departments and units. The facility needed a vent unit bed, and with the resident no longer requiring a ventilator, the resident was moved to the trach unit. Upon moving resident, the facility failed to move the enhanced isolation sign to the newly assigned room. Staff in the facility failed to wear appropriate PPE while providing care due to no isolation signage. The Regional Clinical and Operations Manager re educated the Administrator and Director of Nursing on proper protocols, to include initiation of audits of new admissions and re admissions, as well as audits of proper PPE usage through out the facility. All facility staff was re educated on new and re admission protocols, and PPE usage by the Director of Nursing. The RCA began the date of	

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F 880	Continued From page 16 population unit which was not a quarantine unit and failed to continue the resident's enhanced droplet precautions after he completed only 8 of the 14 days that were ordered by the physician. Additionally, the facility did not have a policy that addressed aerosolized treatments and a Respiratory Therapist suctioned Resident #3 without wearing a gown and failed to disinfect her face shield after she suctioned Resident #3 and a medication aide failed to cover her nose while in the resident's room. Immediate jeopardy was removed on 11/3/20 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of E (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. Findings included: The facility's COVID 19 guidelines titled "American Healthcare Association guidance for new admissions, personal protective equipment, and Dedicated Areas" were dated effective April 2, 2020. These guidelines stated that all residents being admitted or being re-admitted from an emergency room visit, should be placed on quarantined and on enhanced contact precautions for 14 days. The PPE requirements for the health care professionals included disposable gowns, N95 or KN95 mask, goggles or face shields. Centers for Disease Control and Prevention (CDC) "Preparing for COVID-19 in Nursing Homes" dated June 25, 2020 revealed that CDC guidance stated for managing new admissions and readmissions whose COVID-19 status is	F 880	notification of the IJ, 10-31-20. Resident # 3 was readmitted to Oak Forest Health and Rehabilitation on 10/16/20 after an admission to the Hospital. Upon return, resident # 3 was placed in isolation, to include Enhanced Droplet Precautions, based on Centers for Disease Control and Prevention (CDC) recommendations. On 10/25/20, 5 days prior to his scheduled date of isolation discontinuation, resident # 3 was moved to a non-isolated room, with another roommate. This decision was made without the acknowledgement or approval of the Administrator or Director of Nursing. On 10/29/20, this action was brought to the attention of the Administrator. Immediately upon acknowledgement, the appropriate Enhanced Droplet Precautions Infection Control signage was placed on the resident door and appropriate personal protective equipment (PPE) was placed for access to staff for resident care by the LPN Unit Coordinator. The Resident #3 and roommate were both tested for COVID-19 utilizing the BD Veritor Plus Point of Care testing device by the ADON on 10/29/2020, and results were negative. Staff that had any entrance to the room of the resident and roommate were identified and were tested for COVID-19 on 10/29/2020 using the BD Veritor Plus Point of Care testing device by the ADON and the DON. Of the 10 staff identified and at risk, 0 were found to be positive for	

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F 880	Continued From page 17 unknown, healthcare personnel should wear an KN95 or higher-level respirator, eye protection (googles or face shield that covers the front and sides of the face), gloves and gown when caring for these residents. In the CDC guidelines for Isolation dated 6/25/2020: "During procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation. During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols wear a fit-tested N95 or higher respirator in addition to gloves, gown and face/eye protection." In addition, the guidelines state that "While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe. Then, carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution". In the CDC guidance 3/27/2020 "Recommended Guidance for Extended Use and Limited Reuse of N95s" they state to: Discard N95 respirators following use during aerosol generating procedures. Resident #3 was admitted to the facility on 5/21/20 with the following pertinent diagnoses: Chronic respiratory failure with hypoxia, Tracheostomy, Pneumonia due to Pseudomonas, Resident #3 was hospitalized 10/5/20-10/16/20. Resident #3 was readmitted to the facility on 10/17/20 following a hospitalization for	F 880	COVID-19. Both resident #3 and roommate were placed on enhanced droplet precautions through 11/8/2020. On 10/29/20, all admissions and readmissions to Oak Forest Health and Rehabilitation during the previous two weeks, were identified and audited for appropriate isolation procedures to include appropriate Enhanced Droplet Precautions, to include masks, gloves, gowns and googles or face shields by the DON. Of the 12 admissions and readmissions, 0 residents were found to have been moved out of isolation procedures prior to the 14-day monitoring requirements. Respiratory therapist #1 provided tracheostomy care to resident # 3 on 10-28-20 at approximately 0940 per surveyor observation. Respiratory therapist #1, wore mask, gloves and face shield during tracheostomy care. Per surveyor reported observation, Respiratory therapist #1 did not wear a gown, and did not disinfect face shield after use. The facility does have a policy for tracheostomy care and suctioning related to PPE requirements with an addendum attached to follow CDC guidelines dated 4/2020, in regard to PPE conservation due to COVID-19. A clarification of cleaning or disinfecting the face shield was added to the policy related to aerosol generating procedures on 11-3-20. The residents with the same care team (nurse and respiratory therapist) as resident #3 and the roommate continue to be monitored for signs or symptoms of	

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F 880	Continued From page 18 pneumonia. He was admitted to the ventilator unit (C300 hall) into a private room upon arrival. Review of physician order dated for 10/17/2020 read: Enhanced droplet-contact precautions on admission x 14 days. Nursing note revealed that on 10/25/20, Resident #3 no longer required mechanical ventilation and was moved to a semiprivate room on the tracheostomy unit (C200 hall) which was not a quarantine hall. On 10/27/20 from 10:00 a.m. to 10:30 a.m., tour of the building it was noted to have a ventilator hall (C300), a tracheostomy hall (C200), a quarantine hall (C100), and a Covid-19 hall (C400). On 10/28/20 at 9:40 a.m. an observation was made of a Respiratory Therapist (RT) who performed tracheostomy care and suctioning on Resident #3 in the resident's semiprivate room on the C200 hall. There was no enhanced droplet precaution signage observed posted on resident's door. While providing the care the RT wore a KN95 mask, gloves, and a face shield. The RT did not wear a gown or an N95 mask when providing Resident #3's tracheostomy care and suctioning. She performed hand hygiene upon exiting the room but did not disinfect her face shield when she exited the resident's room and left the unit. Interview with RT on 10/30/20 at 12:05 p.m. revealed that Resident #3 was on enhanced precautions while on the ventilator unit. She stated that she did not recall seeing an enhanced droplet precaution sign on Resident #3's door since he was moved from the ventilator unit to his	F 880	COVID-19. Residents have temperature, heart rate and oxygen saturation monitored twice a day and are assessed for new cough or change in cough, sore throat, or shortness of breath. In-Service was provided to the Administrator and the Director of Nursing on the correct procedures of isolation and 14-day monitoring by the Regional Clinical Manager on 10/29/2020. Also, on 10/29/2020 all departments, including contract therapy and respiratory therapist were in-serviced on the appropriate readmission and admission isolation procedures and the Enhanced Droplet Precautions signage and use of PPE. This in-service was provided by the DON and was completed in person and via telephone. Staff was in-serviced that no room changes can be made without the approval of the Administrator or the DON. No staff members will be able to work beyond 10/29/20 unless appropriate in-servicing occurs. All new admissions and re admissions beginning 10/29/2020 will be tracked daily by the Administrator, and Director of Nursing to ensure the appropriate 14 days of isolation is followed and that all Enhanced Droplet Precaution signage has been placed with the availability of PPE. Prior to discontinuing isolation and moving a resident out of Enhanced Droplet Precautions, the Administrator and/ or Director of Nursing will validate date of admission, and date of discontinuation of isolation. The Administrator will maintain a daily tracking log of admissions and readmissions to include start date of	

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current room. She stated that while he was on enhanced precautions while on the ventilator unit, she had worn a KN95 mask, gloves, gown, and face shield which was disinfected after care. RT stated that on 10/28/20 she left the unit after providing tracheostomy care to Resident #3. RT did not wear a gown and a N95 mask when she suctioned/trach care Resident #3 who was on enhanced droplet precautions because she did not know he was still on enhanced droplet precautions.

An observation on 10/29/20 at 6:08 AM of the C-200 hall, revealed Medication Aide #1 was exiting Resident #3's room with her mask under her nose.

On 10/29/20 at 6:10 AM, an interview was conducted with Medication Aide #1. She stated she knew the mask was supposed to cover her nose, but it kept sliding down. She added she had received training on PPE.

On 10/29/20 at 10:05 a.m. Resident #3's room, which was a semi-private room, located on C200 hall, was observed. The resident's room did not have an enhanced droplet precaution sign posted on the door and there was no personal protective equipment outside or just inside of the resident's room.

10/29/20 at 10:10 am, Nurse #5 was observed entering Resident #3's room wearing only a mask and face shield. Nurse #5 did not don gloves or a gown prior to entering Resident #3's room. While in the room Nurse #5 was observed to administer medications and adjusted the resident's bed covers. At 10:15 a.m. Nurse #5 exited Resident #3's room, performed hand hygiene and entered

isolation and discontinuation of isolation based on CDC recommendations.
Face shields will continue to be cleaned and disinfected when visibly soiled between residents throughout the facility including the tracheostomy unit. All staff were in-serviced on use of PPE including proper disinfecting of soiled face shields on 10/29/2020 by the DON. Additional in service was provided to all licensed nurses and respiratory therapists on CDC guidelines to disinfect face shields after aerosolized treatment prior to re-use on 11-3-20 by the Director of Nursing.
A policy was put in place in April 2020 regarding quarantining new admits and readmissions. Policy follows CDC and CMS recommendations.
The facility put the extended use of eye protection in to place in April 2020 per the CDC recommendation for conservation of PPE. Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through. All facility staff were educated in April 2020 with on-going education taken place including 10/29/20 with the education on new admits, readmits and PPE. This in service was provided by the Director of Nursing.
We continue to monitor PPE and have a standard delivery of masks and face shields delivered monthly to the facility. In addition, the supply clerk continues to order and received additional PPE from outside suppliers. PPE supplies and availability are monitored weekly using a burn rate calculator. Random daily surveillance of staff , to include respiratory

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F 880	Continued From page 20 another resident room on the C200 hallway which was not a quarantine room. Prior to entering this room, Nurse #5 did not change her mask or face shield. She was not wearing gloves or a gown. While in this room Nurse #5 administered medications to both residents who resided in this room. Interview with Nurse #5 10/29/20 at 10:20 a.m. stated that she had been off for several days and was unsure if Resident #3 should be on enhanced precautions or not. She did state that it was facility policy that residents returning to the facility be placed on enhanced droplet precautions for 14 days. She also stated DON and ADON were responsible for assessing new admits and readmits and making sure staff were aware they were on 14-day quarantine. Interview with ADON/Infection Preventionist and DON 10/29/20 at 10:45 am --she stated that Resident #3 had physician's orders to remain on enhanced droplet precautions for 14 days from the date of his readmission of 10/17/20. But, staff mistakenly discontinued Resident #3's enhanced droplet precautions from 10/25/20 to 10/30/20 and staff failed to post enhanced droplet precaution signage on the door of his current room during this time period. The ADON explained enhanced droplet precaution signage was displayed while the resident was on the ventilator unit, but that it was not posted on the resident's room door when he was moved to his current room on 10/25/20. The ADON stated the staff did not know who had moved Resident #3 or why he was not moved to the quarantine hallway on 10/25/20. Both the ADON and DON stated that the facility liked to keep all the trach residents together on the same hall, but they can put a	F 880	therapist, by assigned team members, to include Administrator, Director of Nursing and nurse managers for proper enhanced droplet isolation protocols and cleaning of protective eyewear was put into place on 10-29-20.	

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resident on enhanced precautions regardless of what hall they are on. The DON stated they are following the CDC guidelines laid out in their Covid-19 book. When asked if the facility's previous Administrator, who left in late May/early June, put the Covid-19 book together, she stated yes.

Interview with Nurse Practitioner 10/29/20 at 11:55 a.m. stated when asked about the risk involved with not displaying enhanced droplet precaution signage and not wearing PPE, she replied she felt like everyone was at risk whether the sign was displayed or not. She did acknowledge that everyone should be wearing a mask and eyewear throughout the building except the Covid-19 unit which should be wearing full PPE and they should be following CDC guidelines for 14-day quarantine residents even as they are moved from room to room in the facility.

Interview with Administrator on 10/29/20 at 1:10 p.m. revealed that he relied on his director and assistant director of nursing to identify residents who should be on quarantine and to provide the staff with any updates to CDC guidelines and the training necessary. He stated that the DON and ADON have gone through every resident to ensure they had identified all residents who should still be on enhanced droplet precautions.

A phone interview was conducted on 10/31/20 at 10:45 a.m. with the Administrator informing him that Immediate Jeopardy was identified at tag F-880.

The facility's credible allegation of immediate jeopardy removal for F-880 INFECTION PREVENTION AND CONTROL included the

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	345443	A. BUILDING _____ B. WING _____	C 11/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

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following:
1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
Resident # 3 was readmitted to Oak Forest Health and Rehabilitation on 10/16/20 after an admission to the Hospital. Upon return, resident # 3 was placed in isolation, to include "Enhanced Droplet Precautions", based on Centers for Disease Control and Prevention (CDC) recommendations. On 10/25/20, 5 days prior to his scheduled date of isolation discontinuation, resident # 3 was moved to a non-isolated room, with another roommate. This decision was made without the acknowledgement or approval of the Administrator or Director of Nursing. On 10/29/20, this action was brought to the attention of the Administrator.
Immediately upon acknowledgement, the appropriate "Enhanced Droplet Precautions" Infection Control signage was placed on the resident door and appropriate personal protective equipment (PPE) was placed for access to staff for resident care by the LPN Unit Coordinator.
The Resident #3 and roommate were both tested for COVID-19 utilizing the BD Veritor Plus Point of Care testing device by the ADON on 10/29/2020, and results were negative. Staff that had any entrance to the room of the resident and roommate were identified and were tested for COVID-19 on 10/29/2020 using the BD Veritor Plus Point of Care testing device by the ADON and the DON. Of the 10 staff identified and at risk, 0 were found to be positive for COVID-19.
Both resident #3 and roommate were placed on enhanced droplet precautions through 11/8/2020.
On 10/29/20, all admissions and readmissions to Oak Forest Health and Rehabilitation during the previous two weeks, were identified and audited

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for appropriate isolation procedures to include appropriate "Enhanced Droplet Precautions", to include masks, gloves, gowns and googles or face shields by the DON. Of the 12 admissions and readmissions, 0 residents were found to have been moved out of isolation procedures prior to the 14-day monitoring requirements.
Respiratory therapist #1 provided tracheostomy care to resident # 3 on 10-28-20 at approximately 0940 per surveyor observation. Respiratory therapist #1, wore mask, gloves and face shield during tracheostomy care. Per surveyor reported observation, Respiratory therapist #1 did not wear a gown, and did not disinfect face shield after use. The facility does have a policy for tracheostomy care and suctioning related to PPE requirements with an addendum attached to follow CDC guidelines dated 4/2020, in regards to PPE conservation due to COVID-19. A clarification of cleaning or disinfecting the face shield was added to the policy related to aerosol generating procedures on 11-3-20.
The residents with the same care team (nurse and respiratory therapist) as resident #3 and the roommate continue to be monitored for signs or symptoms of COVID-19. Residents have temperature, heart rate and oxygen saturation monitored twice a day and are assessed for new cough or change in cough, sore throat, or shortness of breath.
2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete
In-Service was provided to the Administrator and the Director of Nursing on the correct procedures of isolation and 14-day monitoring by the Regional Clinical Manager on 10/29/2020. Also, on 10/29/2020 all departments, including contract

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therapy and respiratory therapist were in-serviced on the appropriate readmission and admission isolation procedures and the "Enhanced Droplet Precautions" signage and use of PPE. This in-service was provided by the DON and was completed in person and via telephone. Staff was in-serviced that no room changes can be made without the approval of the Administrator or the DON. No staff members will be able to work beyond 10/29/20 unless appropriate in-servicing occurs.

All new admissions and re admissions beginning 10/29/2020 will be tracked daily by the Administrator, and Director of Nursing to ensure the appropriate 14 days of isolation is followed and that all "Enhanced Droplet Precaution" signage has been placed with the availability of PPE. Prior to discontinuing isolation and moving a resident out of "Enhanced Droplet Precautions", the Administrator and/ or Director of Nursing will validate date of admission, and date of discontinuation of isolation. The Administrator will maintain a daily tracking log of admissions and readmissions to include start date of isolation and discontinuation of isolation based on CDC recommendations.

Face shields will continue to be cleaned and disinfected when visibly soiled between residents throughout the facility including the tracheostomy unit. All staff were in-serviced on use of PPE including proper disinfecting of soiled face shields on 10/29/2020 by the DON. Additional in service was provided to all licensed nurses and respiratory therapists on CDC guidelines to disinfect face shields after aerosolized treatment prior to re-use on 11-3-20 by the Director of Nursing.

A policy was put in place in April 2020 regarding quarantining new admits and readmissions.

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Policy follows CDC and CMS recommendations.
The facility put the extended use of eye protection in to place in April 2020 per the CDC recommendation for conservation of PPE. Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through. All facility staff were educated in April 2020 with on-going education taken place including 10/29/20 with the education on new admits, readmits and PPE. This in service was provided by the Director of Nursing.
We continue to monitor PPE and have a standard delivery of masks and face shields delivered monthly to the facility. In addition, the supply clerk continues to order and received additional PPE from outside suppliers. PPE supplies and availability are monitored weekly using a burn rate calculator. Random daily surveillance of staff, to include respiratory therapist, by assigned team members, to include Administrator, Director of Nursing and nurse managers for proper "enhanced droplet" isolation protocols and cleaning of protective eyewear was put into place on 10-29-20
IJ removal date: 11/3/20

On 11/5/2020 the facility's Immediate Jeopardy removal plan and date of Immediate Jeopardy removal of 11/3/2020 was validated by the following:

Resident #3 and roommate had an enhanced droplet precaution sign on door and a large yellow cart with PPE in drawers. Nurse, housekeeping and nurse assistant interviewed on the hall verbalized the reason for the quarantine and stated they had an in-service regarding proper mask, gloves, gowns and face shield/google use.
Record review showed Resident #3 and

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roommate continue to test negative for Covid-19, as well as, immediate staff who cared for him.

All residents who were currently on enhanced droplet precautions were reviewed. All resident rooms had appropriate signage on doors, door was closed to each room and PPE located outside of room door. Verified credible allegation of compliance through observations of signage and PPE carts, observation of staff entering and exiting resident rooms with appropriate PPE and performing hand hygiene. Review of in-service training records revealed staff from all shifts and disciplines had been in-serviced. Interviews with multiple staff, review of facility policies, review of staff surveillance and review of in-service records. Reviewed in-service titled, "Infection Control/PPE ", and "14-day Isolation for Admissions/Readmissions," dated 10/29/20 and 11/3/20. Inservice information included proper disinfecting of soiled face shields. All staff were educated on policies/procedures. A review of the facility tracking log of all new admission/readmissions and noted dates of admission and dates of isolation discontinued date revealed no concerns. Reviewed facility policy of use of eye protection, dated 3/18/20. Updated information added 11/3/20 regarding disinfecting goggles/face shields during aerosolized procedures.