STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING ______ B. WING ______	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	**4412 SOUTH MAIN STREET** **SALISBURY, NC 28147**

(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 12/9/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 7J1V11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 10/7/2020 to 10/9/2020. The facility was found not in compliance with 42 CFR §483.80 infection control regulations. Please see event ID 7J1V11	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		12/23/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/18/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1	F 880		

§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.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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F 880	Continued From page 2 §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 observation, staff interviews and record review the facility failed to implement their policy on "Hand Hygiene" when staff failed to perform hand hygiene when picking up meal trays from resident rooms for 6 of 6 residents observed for infection control (Resident #1, #2, #3, #4, #5, #6). Additionally, the facility failed to implement their Covid 19 screening process when the facility's screener failed to ask 1 of 1 employee (NA #2) the required screening questions prior to his shift (NA #2). This failure occurred during a COVID-19 pandemic. Findings included: 1. A review of the facility's hand hygiene policy date 01/2010 reads in part, "it is the policy of this facility that hand hygiene be regarded as the single most important means of preventing the spread of infections". Specific indications of hand hygiene include; before resident contact, after touching equipment or furniture that is near a resident and after handling items potentially contaminated with any patient's/resident's blood, excretions, or secretions. A continuous observation was made on 12/7/2020 from 12:29 PM to 12:36 PM of the facility's 300 hallway which was a general population hallway. NA #1 entered Resident #2's room and picked up Resident #2's meal tray and put the tray on the meal cart positioned in the hallway, NA #1 did not perform hand hygiene after removal of the meal tray. NA #1 proceeded to enter Resident #6's room and picked up her meal tray and placed the tray on the meal cart.	F 880	1) On 12/7/2020, the infection control licensed practical nurse (LPN) rescreened the staff member that was improperly screened. Those results were that the staff member passed screening. On 12/7/2020, Infection control licensed practical nurse (LPN) under the direction of the Director of Nursing, completed education with NA #2 on how to appropriately screen staff, visitors, and venders prior to entrance which was validated with competency evaluation on 12/8/2020 by the Director of Nursing. On 12/7/2020 the Minimal Data Set Coordinator RN (registered nurse) assessed the 6 residents that were affected by the failure of the staff to perform hand hygiene for signs of injury or infection. Those findings were no signs of injury or infection. On 12/7/2020 the Infection Control licensed practical nurse (LPN) began education with all staff on hand hygiene and pre entrance screening processes for staff, vendors, and visitors. 2) All current residents and staff have potential to be affected by deficient infection control practices. On 12/7/2020 the Infection Control licensed practical nurse under the direction of the Director of Nursing began education with all staff on hand hygiene and screening processes. Upon receiving 2567, education was	

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F 880	Continued From page 3 NA #1 did not perform hand hygiene after removal of the meal tray. NA #1 proceeded to enter resident #3's room and spoke to her at her bedside and exited without a meal tray. NA #1 did not sanitize her hands when she entered or exited Resident #3's room. NA #1 proceeded to enter Resident #5's room and pick up the resident's meal tray and put the tray on the meal cart. NA #1 did not perform hand hygiene after removal of the meal tray. NA #1 proceeded to enter Resident #1's room and pick up the resident's meal tray and put the tray on the meal cart. NA #1 did not perform hand hygiene after removal of the meal tray. NA #1 proceeded to enter Resident #4's room and picked up the resident's meal tray and put the tray on the meal cart. NA #1 did not perform hand hygiene after removal of the meal tray. NA #1 then went back into Resident #3's room and was at her bedside table talking to resident and then exited the room. NA #1 did not perform hand hygiene after entering or exiting Resident #3's room. At 12: 36 PM NA #1 proceeded to Resident #4's room and did not perform hand hygiene when she entered the room. NA #1 partially shut Resident #4's door and reopened the door, NA #1 was observed to be wearing a pair of gloves and was assisting the resident with putting on her shoe. At 12: 42 PM NA #1 exited the room and walked down the hallway and entered the shower room. On 12/7/2020 at 12:45 PM an interview was completed with NA #1. She stated that she went into the shower room to throw away her gloves and wash her hands. NA #1 was asked what assistance the resident needed in room 303 and the NA stated Resident #3 wanted her bed lowered, so she completed that task. NA #1 stated this was only her second day, and she was	F 880	started using provided you tube videos on hand hygiene and preparing facilities for COVID 19 per CDC education series which included screening. On 12/8/2020, A root cause analysis was completed for failure to perform hand hygiene and screening process by the Director of Nursing. The root cause found for failure to provide hand hygiene between the passes of trays was limited accessibility to alcohol based hand rub between rooms and lack of knowledge by staff on importance of performing hand hygiene between trays. The root cause found for the lack of screening questions was lack of knowledge related to the importance of screening questions by staff. On 12/7/2020 the Infection Control license practical nurse, under the direction of the Director of Nursing began education with all staff on hand hygiene and screening processes. Upon receiving 2567, Minimal Data Set Coordinator started in person education using provided you tube videos, Preparing Nursing Homes and Assisted Living Facilities for Covid-19 and Clean Hands, on hand hygiene and preparing facilities per CDC which included screening. 3) On 12/7/2020 the Infection Control licensed practical nurse began education with all staff on appropriate hand hygiene and pre-entrance screen process for staff, vendors, and visitors, screening processes. On 12/8/2020 the Director of Nursing began skills observation validations of both hand hygiene and the	

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F 880	Continued From page 4 mostly observing, but was told to pick up the meal trays. NA #1 stated that she knew staff were supposed to use hand sanitizer when we touch the patients and change them, but stated she was still in training. NA #1 said I think we are to hand sanitize when we enter and when we leave a resident's room. On 12/9/2020 at 10:13 AM and interview was completed with the Director of Nursing (DON) who stated that staff should apply hand sanitizer before going into each room and when leaving each room. 2. A review of the facility's policy titled COVID -19 Preparation and Response updated 9/5/20 reads in part; iii) (3) All employees are screened as they arrive at the beginning of the shift and upon returning after leaving the facility. Employee screens are conducted by a nurse an consist of a temperature, sign and symptom review and screening questions. A review of the employee log sheet revealed the employee was to be asked a series of questions related to COVID-19. An observation on 12/7/2020 at 2:55 PM revealed NA #2 entered the facility to come to work. NA #2 stopped at the COVID19 screening station and the screener at the station took NA #2's temperature and asked the employee the following questions: "Any temperature? Coughing? Sniffles? Been around anybody"? NA #2 answered no to each of these questions. NA #2 sanitized his hands, obtained a new mask and left the screening station. On 12/7/2020 at 2: 57 PM an interview was completed with the screener. The screener was asked what questions she asked employees	F 880	screening process of all staff. On 12/15/2020, the Minimal Data Set coordinator began using provided you tube videos on hand hygiene and preparing facilities per CDC which included screening to education 100% of staff. This education will be incorporated into new hire training for all staff. Education for all facility Registered nurses, Licensed practical nurse, medication aides, nursing assistances, staff, department heads, therapy department, environmental services, maintenance and dietary staff will be completed by 12/22/2020 On 12/17/2020 the corporate Quality Assurance (QA) nurse consultant completed COVID policy education for the administrator and director of nursing which included hand hygiene and screening policy based on Centers for disease control (CDC) guidelines. 4)Beginning 12/24/2020, the Administrator, Director of Nursing or designee will observe and monitor hand hygiene during tray pass for 2 day shift and 2 evening shift 3 x a week with at least one observation being on Saturday or Sunday to ensure that proper hand hygiene is occurring. This audit will be completed weekly x4 and then monthly x3. Beginning 12/24/2020, the Administrator, Director of Nursing or designee will observe and monitor screening using QA screening form 5 day shift and 5 evening	

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F 880	Continued From page 5 when they arrived for their shift. The screener began to read the list of questions on the employee log. The screener was asked why she did not ask NA #2 all of the questions listed on the employee log and she replied, "I don't have a very good reason, I am sorry, I work with him and I know him." The screener stated that this was a job that she normally did not do. On 12/9/2020 at 10:13 AM, an interview was completed with the Director of Nursing (DON), who stated that all employees need to go through the screening process which is to enter through the front door, get their temperature taken and the screener is to ask the employee a series of questions on the screening log before allowing the staff member to go into the building.	F 880	shift 3 x a week with at least one observation being on Saturday or Sunday to ensure that proper hand hygiene is occurring. This audit will be completed weekly x4 and then monthly x3. QA Reports will be presented in the weekly QA meeting by the Director of Nursing/designee to ensure that the corrective action for trends or ongoing concerns is initiated as appropriate for compliance with regulatory requirements. The weekly QA meeting is attended by Administrator, Director of Nursing, Medical Director, infection control licensed practical nurse , Minimum Data Set Registered nurse , Environmental services director , Social services director, Dietary Manager, Health information Manager, and Activities Director.	