STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345109	A. BUILDING ______ B. WING ______	12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY PLACE	**24724 SOUTH BUSINESS 52** **ALBEMARLE, NC 28001**

(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 Surveyws conducted on 12/15/2020 to 12/17/2020. The facility ws found in compliance with 42 CFR 483.73 reltaed to E-0024(b)(6) subpart B Requirements for Long Term Care Facilities. Event ID # 5MVT11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID 19 Focused Infection Control Survey was conducted on 12/15/2020 to 12/17/2020. The faciity was found out of compliance with CFR 483.30 Infection Control Regulations and was cited at F880. Event ID # 5MVT11.	F 000		
F 880 SS=D	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	F 880		12/29/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/28/2020

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		

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.

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

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F 880	Continued From page 2 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 record review and staff interviews the facility failed to ensure a staff member was medically cleared when exhibiting symptoms of COVID-19 (Corona Virus of 2019) while working in the facility for 1 of 3 COVID-19 positive staff members reviewed. Findings included: The facility's policy, Coronavirus Disease 2019 (COVID-19) Plan and Protocol, dated 12/2/2020 stated, "Anyone who enters the facility for any reason (with the exception of EMS personnel) will be screened for an increased temperature, symptoms of respiratory disease, recent travel to locations with high levels of COVID-19 infections, and potential exposure to someone who has or is being isolated for the virus. Any person who is questionable for any reason will be denied entrance to the facility". A review of the Team Member/Visitor Log for 11/30/2020 at 8:34 am revealed the Activity Director had responded "no" she did not have a cough when screened when entering the building. The Team Member/Visitor Log for 12/1/2020 at 7:56 am was reviewed and the Activity Director had responded "no" she did not have a cough when screened when entering the building. A review of the Team Member/Visitor Log for	F 880	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law. 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(s) indicated. Trinity Place will continue to maintain high standards with infection control measures by taking precautions to prevent and mitigate the transmission of communicable disease and infections by providing a safe, sanitary and comfortable environment. For all residents that have the potential to be affected: The facility began re-educating teammates when the administrator was made aware by the surveyor on 12/15/2020 that the interview with the Activity Director indicated that the Activity	

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F 880	Continued From page 3 12/2/2020 at 8:36 am the Activity Director had responded "no" she did not have a cough when screened when entering the building. During a phone interview with the Activity Director (AD) on 12/15/2020 at 11:18 am she stated she was tested on 11/30/2020 for COVID-19 and when her results came back on 12/3/2020 she tested positive for COVID-19. The AD stated she told the Director of Nursing (DON) on 11/30/2020 she had a cough and she thought the cough was from seasonal allergies. The AD stated she had an intermittent cough when she worked on 11/30/2020, 12/1/2020, and 12/2/2020. The AD stated she had worked outside the facility putting up Christmas lights on 11/30/2020, 12/1/2020 and 12/2/2020 but she had come into the facility and went into her office. She stated she did not remember being in proximity (less than 6 feet) to any residents on 11/30/2020, 12/1/2020, or 12/2/2020 but she had been near two staff members, Activity Aide #1 and Activity Aide #2. An interview was conducted with the Director of Nursing (DON) on 12/15/2020 at 11:52 am she stated the staff were all tested on 11/30/2020 and they received the positive results of the AD on 12/2/2020 in the evening and the AD was notified of the results by the Infection Control Nurse on 12/3/2020 before reporting to work in the facility. The DON stated the AD did tell her on 11/30/2020 she had a cough, but she thought the cough was from seasonal allergies. She stated she did not send the AD home because she had a history of seasonal allergies and had a cough at the same time each year. The DON stated the AD had worked outside the facility on 11/30/2020 putting up Christmas lights and decorations but came into the facility to go into her office. The Director	F 880	Director had worked while having a cough on 11/30/20, 12/01/20 and 12/2/20. The administrator immediately had the Staff Development Coordinator/ Infection Control RN began re-educating staff on covid symptoms, staying at home when sick and properly completing daily covid Team Member/visitor screening. Additional education was sent on 12/23/2020 by facility text messaging to all teammates. The educational weblink sent was the CDC "Keep Covid 19 Out!". This was a mandatory educational viewing for all staff. The Activity Director was re-educated on covid symptoms, the importance of appropriately responding to the daily covid Team Member/Visitor screening tool, and most importantly staying home if sick. The Activity Director had communicated on 11/30/20, to the Director of Nursing that she had a on going chronic cough but associated this cough to allergies. The Activity Director did not recognize this as a new onset symptom and the Director of Nursing accepted her reasoning for the cough of chronic allergies. The Just Culture Process was utilized and the investigation found human error to be the issue. Coaching and consoling was the appropriate course of action and provided by the administrator to the activity director. Measures Put in Place to ensure deficient practice will not reoccur: A Systematic approach was taken when investigating the event of a teammate	

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of Nursing stated they did have rapid tests, but the AD was not tested because she had seasonal allergies.

Activity Assistant #1 was interviewed on 12/15/2020 at 2:14 pm and stated she worked on 11/30/2020 with the AD and had been outside most of the day putting up Christmas lights and decorations. Activity Assistant #1 stated they had come into the building and went into the activity office. The Activity Assistant #1 stated she had not seen the AD near any of the residents on 11/30/2020, 12/1/2020, or 12/2/2020. Activity Assistant #1 stated she had been in the office with the Activity Director, and she was tested on 11/30/2020 and her test was negative when they received the results on 12/3/2020.

During an interview with Activity Assistant #2 on 12/16/2020 at 2:50 pm and he stated he had been outside on 11/30/2020, 12/1/2020 and 12/2/2020 putting up Christmas lights and decorations for a drive by light show the facility was doing for the Christmas holiday. He stated he had not been around the Activity Director on 11/30/2020, 12/1/2020 or 12/2/2020, and had not witnessed her being around any of the other staff or residents.

The Administrator was interviewed on 12/17/2020 at 9:30 am and stated she was aware the Activity Director worked on 11/30/2020, 12/1/2020 and 12/2/2020 after telling the Director of Nursing she had a cough. The Administrator stated the Director of Nursing had allowed the Activity Director to work because the cough was chronic, and the Activity Director had reported she had the cough since 2018. The Administrator stated since the Activity Director had a history of cough

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working while exhibiting covid symptoms. This approach was conducted by completing a root cause analysis, utilizing the 5 Whys worksheet, a fishbone diagram, and the just culture investigation tool was used. The root cause was identified as a human error. The teammate did not notice a change in her typical allergy cough that would have indicated that she may be symptomatic for covid. Re-education to all staff by the Staff Development Coordinator/ Infection Control RN, on covid symptoms, accurately responding to daily covid Team Member/Visitor screening tool, and staying home when sick. Additional education was provided to all teammates by the weblink "Keep Out Covid 19" by the CDC. This educational link was mandatory for all staff to view. A biweekly review was put in place to monitor the Team Member/Visitor Screening Tool compared to the facility illness log. This review is to ensure that any teammates experiencing covid like symptoms does not work. The second process put in place is the Director of Nursing or Charge RN will also antigen and/or PCR test any teammate arriving at the facility exhibiting any symptoms of covid. After testing, the teammate will immediately be sent home until negative results of the covid test have been received and the teammate no longer has symptoms for at least 24 hours. If the covid test is positive the teammate will remain out the duration of 10 days from test date and fever free with symptoms improving for at least 24 hours prior to returning to work without taking

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F 880	Continued From page 5 before it did not rise to a level of urgency. The Administrator stated the facility does have rapid COVID-19 tests but they had not felt the Activity Director's chronic cough rose to that level of need and had not done a rapid test on 11/30/2020 when the Activity Director reported her cough to the Director of Nursing..	F 880	any fever reducing medication. Monitoring plan to ensure solutions are sustained: Director of Nursing along with the Infection Control/Staff Development RN will compare the teammate reported teammate illness log to the daily covid teammate member visitor screening to ensure teammates were properly screened and if concerns were noted they were immediately communicated to that teammates supervisor. This review will occur 2 time a week for four weeks and then weekly until 3 months of compliance is sustained. The reviews of the illness log and screening tool will be reported to Quality Assurance Performance Improvement Committee by the Director of Nursing.	