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	345330	A. BUILDING _____ B. WING _____	12/16/2020

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THE GRAYBRIER NURS & RETIREMENT CT	116 LANE DRIVE TRINITY, NC 27370

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 12/16/20. 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#17CT11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control survey was conducted onsite on 12/1/20 and continued offsite through 12/4/20. Validation of credible allegation was conducted on 12/9/20. Additional information was obtained on 12/16/20, exit date was changed to 12/16/20. Immediate jeopardy (IJ) was identified at CFR 483.80 at tag F880 at a scope and severity of L. Immediate jeopardy began on 11/27/20 and was removed on 12/4/20. The immediate jeopardy start date was amended from 11/27/2020 to 11/28/2020.	F 000		
F 880 SS=L	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:	F 880		12/22/20

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

Electronically Signed | 12/28/2020

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F 880	Continued From page 1 §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 (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	F 880		

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F 880	Continued From page 2 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 record review, observation, review of facility's infection control policy and procedure, and interviews with the staff and Health Department Nurse, the facility failed to ensure that 3 of 3 COVID positive residents (Residents #1, #2 & #3) did not share rooms with COVID negative residents (Residents #13, #14 & #5) which resulted in 1 of the 3 COVID negative residents (Resident #14) tested positive for COVID. The facility also failed to separate COVID positive residents from COVID negative residents on the unit by placing 3 of 26 COVID negative residents (Residents #5, #6 & #7) on the COVID positive unit and 7 of 32 COVID positive residents (Residents #1, #2, #8, #9, #10, #11, #12) on the COVID negative unit which resulted in 2 of 3 COVID negative residents (Residents #6 & #7) tested positive for COVID. Additionally, the facility failed to implement the guidelines regarding the use of Personal Protective Equipment (PPE) when 1 of 1 maintenance staff failed to wear a gown, to remove gloves and to perform hand hygiene when entering and exiting the room of a resident on enhanced droplet/contact precautions. These failures occurred during the COVID 19 pandemic. As of	F 880	On 12/1/2020, facility staff members began room changes for residents with current COVID negative status and shared a room with residents that tested positive. Prior to moving resident #13, who resided with a positive roommate (resident #1), a rapid COVID test was completed, resident #13 was negative for COVID. Resident was relocated to a private room in an observation area, due to exposure. Prior to moving resident #14 on 12/1/2020, who resided with a positive roommate (resident #2), a rapid COVID test was completed and resident was positive for COVID; resident #14 was not relocated due to COVID result. On 12/2/2020, the facility Administrator contacted resident representative of resident #5, who resided with a positive resident. Representative of resident #5 did not want resident moved. Resident #5 previously tested positive for COVID and recovered prior to admission to the facility; family felt strongly that her risk of exposure was low, and she desired her to stay in the dementia unit where she	

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F 880	Continued From page 3 12/1/20, there were 61 residents and 63 staff members who tested positive for COVID 19 and on 12/9/20, 20 more residents, a total of 81 residents, and 5 more staff, a total of 68 staff, tested positive for COVID. Immediate jeopardy began on 11/28/20 when the facility failed to ensure that COVID positive residents did not share rooms and units with COVID negative residents. Resident #14 tested positive while sharing a room with Resident #2 and Residents #6 & #7 tested positive while placed on the COVID positive unit. Immediate jeopardy was removed on 12/4/20 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure the action plan put into place in cohorting COVID positive and COVID negative residents are effective. Findings included: The facility's policy and procedure (updated on 11/23/20) indicated identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit if possible. Roommates of residents with COVID-19 should be considered exposed and potentially infected and if all possible should not share rooms with other residents unless they remain asymptomatic	F 880	received excellent care. To ensure 100% compliance, on 12/4/2020, resident #5 was COVID tested, result remained negative. Resident #5 was relocated to a private room on the observation area. On 12/4/2020, the facility expanded previously created COVID units to allow for all COVID-positive residents to be in a defined unit. All remaining COVID-negative residents were moved to a separate COVID Observation unit. Room changes were complete as of 12/4/2020. Residents #1, #2, #3, #4, #6, #8, #9, #10, #11, #12, and #14 have tested positive for COVID and are appropriately placed on a COVID unit as of 12/4/2020. Residents #5, #7, and #13 remain negative for COVID and are appropriately placed on the non-COVID unit as of 12/4/2020. During room change for resident #13, on 12/1/2020, a state surveyor witnessed a Maintenance Assistant transferring the resident's belongings without wearing proper Personal Protective Equipment (PPE). On 12/2/2020 and 12/4/2020, the staff member was in-serviced on proper PPE necessary for residents on enhanced droplet isolation, proper procedures to apply and remove (DON/DOFF) PPE, and hand hygiene procedures for hand washing and alcohol-based hand sanitizer. Sources for in-service training include the Centers for Disease Control (CDC) and North Carolina Statewide Program for Infection Control and Epidemiology (NC SPICE). Through root cause analysis it was determined that the facility utilized guidance from the CDC	

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F 880	Continued From page 4 and or have tested negative for COVID 14 days after their last exposure (such as date the roommate was moved to the COVID unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. Residents with known or suspected COVID-19 should be cared for using all recommended PPE which includes use of N95 or higher level of respirator (or face mask if respirator is not available), eye protection, gloves and gown. The facility's door signage for suspected or known COVID positive was "enhanced droplet/contact precautions" which include gown, eye protection, surgical mask, gloves when entering room, hand hygiene, private room and to keep door closed. 1a. Resident #2 was admitted to the facility on 8/26/14 with multiple diagnoses including Dementia and Hypertension. Resident #14 was admitted to the facility on 9/15/17 with multiple diagnoses including Dementia and Hypertension. The alphabetical resident list provided on 12/1/20 revealed that Resident #2, who tested positive for COVID on 11/28/20 shared a room with Resident #14, who tested negative for COVID on 11/26/20. On 12/1/20 at 11:16 AM, Resident #2 and Resident #14 were observed sharing the same room on the COVID negative unit and their door has a signage "enhanced droplet/contact precaution". They were not wearing a mask and their privacy curtain was not pulled between their beds.	F 880	memo titled “Responding to COVID-19” which was updated April 30, 2020 and guidance from the Randolph County Health Department (RCHD) (per conversation on 11/27/20202) to limit room changes due to widespread COVID exposure. The CDC memo states, “Facilities that have already identified cases of COVID-19, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected).” The facility reached 60% infection rate on 11/28/2020. By following CDC guidance in the “Responding to COVID-19” memo and by utilizing guidance of the RCHD, this led to the practice identified as deficient, specifically regarding COVID-unit designation. In addition, staffing services were strained due to COVID prevalence among employees (both facility and contracted employees). Multiple staffing requests were made through ReadyOp, local Emergency Management, agency staffing contracts, housekeeping vendor, and RCHD. Facility vendors, specifically the housekeeping vendor and agency contracts, were able to provide staffing support. The housekeeping vendor was able to provide support via corporate team, including 2 representatives who assisted in day-to-day services. Staffing support that was confirmed by the state resources (specifically through ReadyOp), had numerous (at least 6 12-hour shifts), that were not in fact provided, nor was cancellation informed to facility.	

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F 880	Continued From page 5 Resident #14 was retested and became positive for COVID on 12/1/20. b. Resident #2 was admitted to the facility on 8/26/14 with multiple diagnoses including Dementia and Hypertension. The alphabetical resident list provided on 12/1/20 revealed that Resident #2 who tested positive for COVID on 11/28/20, resided on the COVID negative unit. The resident in the room next door was COVID negative. On 12/1/20 at 11:16 AM, Resident #2 was observed in bed on the COVID negative unit with her door wide open. Her door has a signage "enhanced droplet/contact precaution" with the instruction to keep the door closed. c. Resident #1 was admitted to the facility on 9/21/18 with multiple diagnosis including cerebrovascular accident. Resident #13 was admitted to the facility on 3/21/18 with multiple diagnoses including Alzheimer ' s Disease and Hypertension. The alphabetical resident list provided on 12/1/20 revealed that Resident #1, who tested positive for COVID on 11/28/20 and Resident #13, who tested negative for COVID on 11/26/20 shared a room on the COVID negative unit. Resident #1 was observed in bed on 12/1/20 at 11:15 AM. He was not wearing a mask. The staff was in the process of moving Resident #13 to a	F 880	On 12/2/2020, the Administrator completed a room audit compared to COVID status to ensure compliance. One room sharing arrangement was identified with a COVID-positive (resident #15) and COVID-negative resident (resident #16); resident #16 shared a room with his spouse (resident #15). The facility Administrator called the responsible party, the family member did not want the husband and wife to be separated. To ensure 100% compliance, on 12/4/2020, resident #16 was COVID tested, results remained negative. Resident #16 resident was relocated to a private room on the observation area. On 12/4/2020, the Administrator completed a facility-wide room audit compared to COVID status to ensure compliance; regarding placement of residents based on COVID status in rooms and by hall (COVID units); 100% compliance was achieved on 12/4/2020. Beginning 12/8/2020, the facility was able to remove some residents from isolation. On 12/8/2020, the facility created a third type of COVID unit, COVID-negative. Residents that recovered from COVID are permitted to be removed from isolation after 14 days, pending no further symptoms or fever for at least 24 hours without the use of fever reducing medication. As more residents are removed from COVID isolation, the units will be adjusted to ensure continued compliance. Through root cause analysis on 12/4/2020, the facility Administrator and Director of Nursing (DON) concluded that PPE training efforts were previously focused on direct-care staff members.	

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F 880	Continued From page 6 different room. Their room has a door signage "enhanced droplet/contact precautions". Nurse #1 was interviewed on 12/1/20 at 11:30 AM. She reported that Residents #1 who tested positive for COVID shared a room with Resident #13 who tested negative and Residents # 2 who tested positive for COVID shared a room with Resident #14 who tested negative. She indicated that she was assigned to rooms 35 through 60 and had 20 residents. The unit has COVID positive and COVID negative residents. d. Resident #1 was admitted to the facility on 9/21/18 with multiple diagnosis including cerebrovascular accident. Review of the facility's floor plan also revealed that rooms 35-60 were designated as COVID negative unit. Review of Resident #1's COVID test result revealed that he tested positive on 11/28/20 and he resided on the COVID negative unit. The resident in the room next door was COVID negative. Resident #1 was observed in bed on 12/1/20 at 11:15 AM on the COVID negative unit with his door wide open. His room has a door signage "enhanced droplet/contact precautions" with instruction to keep the door closed. e. Resident #3 was admitted to the facility on 7/30/20 with multiple diagnoses including Dementia, Congestive Heart Failure (CHF) and Myocardial Infarction (MI).	F 880	Following the citation, where a non-direct care staff member was required to provide support outside of the normal required duties (e.g., enter a resident's room to perform a room change), the facility implemented PPE training of all facility staff and all contracted staff members (Therapy and Environmental Services). On 12/7/2020, all facility staff and all contracted staff members (Therapy and Environmental Services) began training on the proper PPE necessary for residents on enhanced droplet isolation, proper procedures to apply and remove (DON/DOFF) PPE, and hand hygiene procedures for hand washing and alcohol-based hand sanitizer. PPE training was provided by the DON, who is also the facility Infection Preventionist. The DON coordinated PPE training efforts and sources with the facility Administrator and Medical Director. Sources for PPE training include the CDC and NC SPICE. All staff have been trained on proper use of PPE, except for staff eleven members that have not worked since 12/7/2020. The remaining eleven staff members will be in-serviced upon returning for his/her next shift, until 100% compliance is achieved. An official completion date cannot be provided at this time, some staff members are out due to varying medical conditions. To prevent future deficient practice, the Administrator and DON shall be responsible for on-going monitoring of room assignments related to COVID status. Residents will be on a	

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F 880	Continued From page 7 Resident #5 was admitted to the facility on 9/12/20 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Alzheimer ' s Disease and Hypertension. Review of the alphabetical resident list provided on 12/1/20 revealed that Resident #3, who tested positive for COVID on 11/30/20 shared a room with Resident #5, who tested negative for COVID on 11/30/20. On 12/1/20 at 11:20 AM, Resident #3 and Resident #5 were observed sharing the same room on the COVID positive unit. They were not wearing a mask and their privacy curtain was not pulled between their beds. f. Resident #6 was admitted to the facility on 11/16/19 with multiple diagnoses including dementia and Hypertension. Review of the facility's floor plan revealed that rooms 61-71 were designated as COVID positive unit. On 12/1/20 at 11:23 AM, Resident #6, who tested negative for COVID on 11/30/20, was observed residing on the COVID positive unit with her door wide open. Her room has a door signage "enhanced droplet/contact precautions" with the instruction to keep the door closed. On 12/3/20, Resident #6 was retested and became positive for COVID. g. Resident #7 was admitted to the facility on	F 880	COVID-positive unit, COVID-negative unit, or Observation unit based on current COVID status, exposure event, or admission time frame. Beginning 12/8/2020, through 12/18/2020, all residents on Ashley River and Lowcountry were able to be removed from isolation. The remaining COVID-positive unit, Cooper River was able to remove residents from isolation once the outbreak is complete; this occurred on 12/22/2020. The Administrator and DON will continue to maintain appropriate room cohorting based on COVID status, or exposure to COVID. The facility created a Quality Assurance (QA) Team, the “COVID Compliance QA Team,” to maintain compliance of CDC guidelines, facility policies, including revising policies. The QA Team consists of the Administrator, DON (who is Infection Preventionist), Quality Assurance Nurse, and Admissions Coordinator. Once the outbreak is complete, the QA team will re-evaluate the process to accept new admissions through a team approach. On-going monitoring will be completed by the Administrator and DON to ensure continued success with appropriate resident cohorting, related to COVID status. Facility leaders will also seek guidance from local and state health departments, as needed, for future COVID reporting and guidance. To prevent future deficient practice the COVID Compliance QA Team reviewed the current facility policy related to resident cohorting on 12/22/2020. This	

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F 880	Continued From page 8 5/29/19 with multiple diagnoses including Diabetes Mellitus and Hypertension. Review of the facility's floor plan revealed that rooms 61-71 were designated as COVID positive unit. Review of the alphabetical resident list provided on 12/1/20 revealed that Resident #7 resided on the COVID positive unit. Review of Resident #7's COVID test result revealed that she tested negative for COVID on 11/30/20. On 12/1/20 at 11:25 AM, Resident #7, who tested negative for COVID, was observed residing on the COVID positive unit with her door wide open. Her room has a door signage "enhanced droplet/contact precautions" with the instruction to keep the door closed. On 12/8/20, Resident #7 was retested and became positive for COVID. h. Resident #5 was admitted to the facility on 9/12/20 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Alzheimer ' s Disease and Hypertension. Review of the facility ' s floor plan revealed that rooms 61-71 were designated as COVID positive unit. Review of Resident #5's COVID test result revealed that she tested negative for COVID on 11/30/20.	F 880	policy was reviewed to current CDC guidelines regarding resident COVID cohorting. Adjustments were made, based on CDC guidelines and language. On 12/10/2020, the facility began discussions with Aliant Quality, the Quality Improvement Organization (QIO) assigned to the facility for a Quality Improvement Initiative (QII). On 12/21/2020, the facility began the QII with Alliant Quality, the QIO. On 12/21/2020, the facility completed an Infection Control Assessment and Response (ICAR Assessment) with coordination of the Aliant Quality QIO representative. The QII will systematically evaluate facility compliance with Hand Hygiene (HH) and Personal Protective Equipment (PPE). The QII is planned to be completed by March 31, 2021, per the deadline set during the meeting between the QIO and Administrator and DON. The goal of the QII is to improve PPE and HH compliance, knowledge, and effectiveness. The COVID Compliance QA Team will meet at the next scheduled Quality Assurance and Assessment (QAA) Team meeting, which is scheduled 1/19/2021. On 12/22/2020, the COVID Compliance QA Team, a corporate team member, and Medical Director conducted a Quality Assurance team meeting to formally document root cause analysis regarding resident cohorting and PPE training. This RCA has been incorporated into the intervention plan. The Administrator will report compliance with the intervention plan or report any required adjustments to the COVID	

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F 880	Continued From page 9 On 12/1/20 at 11:20 AM, Resident #5, who tested negative for COVID, was observed residing on the COVID positive unit with her door wide open. Her room has a door signage "enhanced droplet/contact precautions" with the instruction to keep the door closed. i. Resident #8 was originally admitted to the facility on 11/27/18 with multiple diagnoses including Diabetes Mellitus and Hypertension. Review of the facility's floor plan revealed that rooms 35-60 were designated as COVID negative unit. Review of the alphabetical resident list provided on 12/1/20 revealed that Resident #8 resided on COVID negative unit. Review of Resident #8's COVID test result revealed that she tested positive for COVID on 11/28/20. On 12/1/20 at 11:35 AM, Resident #8, who tested positive for COVID, was observed residing on the COVID negative unit with her door wide open. Her door has a signage "enhanced droplet/contact precautions" with the instruction to keep the door closed. j. Resident #9 was originally admitted to the facility on 10/19/18 with multiple diagnoses including Congestive Heart Failure (CHF) and Hypertension. Review of the facility's floor plan revealed that rooms 35-60 were designated as COVID negative	F 880	Compliance QA Team's efforts to maintain regulatory compliance at each QAA meeting during 2021, or unless no longer necessary (e.g., pandemic no longer exists). A member of the corporate team, the Chief Operating Officer, has been appointed to the facility QA team and will continue to participate to provide oversight and guidance as needed. This includes working to reduce the likelihood of any future deficient practice in COVID related areas. The facility alleges compliance with this plan of correction on 12/22/2020.	

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unit.

Review of Resident #9's COVID test result revealed that she tested positive for COVID on 11/28/20.

On 12/1/20 at 11:37 AM, Resident #9, who tested positive for COVID, was observed residing on the COVID negative unit. The resident in the room next door was COVID negative. Her door was observed wide open and she has a door signage "enhanced

droplet/contact precautions" with the instruction to keep the door closed.

k. Resident #10 was admitted to the facility on 11/25/19 with multiple diagnoses including Dementia and Hypertension.

Review of the facility's floor plan revealed that rooms 35-60 were designated as COVID negative unit.

Review of Resident #10's COVID test result revealed that she tested positive for COVID on 11/30/20.

On 12/1/20 at 11:38 AM, Resident #10, who tested positive for COVID, was observed residing on the COVID negative unit. The resident in the room next door was COVID negative. Her door was open and has a signage "enhanced droplet/contact precautions"

with the instruction to keep the door closed.

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l. Resident #11 was admitted to the facility on 8/3/20 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Hypertension.

Review of the facility's floor plan revealed that rooms 35-60 were designated as COVID negative unit.

Review of Resident #11's COVID test result revealed that she tested positive for COVID on 11/28/20.

On 12/1/20 at 11:39 AM, Resident #11, who tested positive for COVID, was observed residing on the COVID negative unit. The residents in the room across the hall were COVID negative. Her door was open and has a signage "enhanced droplet/contact

precautions" with the instruction to keep the door closed.

m. Resident #12 was admitted to the facility on 1/23/20 with multiple diagnoses including Cerebrovascular Accident (CVA) and Hypertension.

Review of the facility's floor plan revealed that rooms 35-60 were designated as COVID negative unit.

Review of Resident #12's COVID test result revealed that she tested positive for COVID on 11/30/20.

On 12/1/20 at 11:40 AM, Resident #12, who tested positive for COVID, was observed residing

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on the COVID negative unit with her door open. The residdnt in the room next door was COVID negative. She has a door signage "enhanced droplet/contact

precautions" with the instruction to keep the door closed.

In an interview with the Administrator on 12/2/20 at 1:15 PM, he confirmed that Residents #1, #2, #3, #8, #9, #10, #11, #12 & #14 tested positive for COVID and Residents # 5, #6, #7, & #13 remained negative for COVID. He indicated that he was aware that these residents were either sharing rooms or units. He reported that residents had already been exposed and moving the resident would cause an increase spread and would make the outbreak worse, so the facility decided to leave the exposed residents in place. The Administrator also stated that the facility had rooms available but had to be deep cleaned and due to staffing shortages in the housekeeping department, the rooms were not available. He further reported that he had been in contact with the Health Department (HD) who had given him direction to isolate residents in place. The Administrator reported that on 11/27/20, he started leaving COVID positive and COVID negative residents in place. On 12/16/20 at 4:20 PM, a follow up interview was conducted with the Administrator. He reported that he had informed the Health Department about their staffing shortages (didn't remember the date) and he had reached out to the local emergency healthcare coalition for staffing needs. His last contact with the local emergency healthcare coalition was on 11/27/20 and he was told that they did not have housekeeping staff, only nurses and nurse's

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aides. He indicated that the emergency coalition had provided him some nurses and a paramedic who worked as nurse's aide. The Administrator also reported that he had called their contracted housekeeping agency and they were unable to provide him with housekeeping staff.

In an interview with the HD Nurse on 12/2/20 at 1:52 PM, she stated that she was aware that the facility has COVID outbreak and she had advised the Administrator to lock down the facility and to separate COVID positive from COVID negative residents. On 12/16/20 at 4:30 PM, a follow up interview with the HD Nurse was conducted. She stated that the Administrator had informed her about their staffing needs for nurses and nurse's aides but not for housekeeping staff. He was advised to call the local emergency staffing management and she had sent a request for them.

In an interview with the Director of Nursing/Infection Control Preventionist on 12/2/20 at 2:29 PM, she stated that she was aware that COVID positive and COVID negative residents shared rooms and units. The DON reported that the Health Department had instructed the facility to stop moving the residents and to leave the residents in place since the residents had already been exposed. She confirmed that Residents #1, 2, 3, 8, 9, 10, 11. 12 & 14 tested positive for COVID and Residents # 5, 6, 7, & 13 remained negative for COVID. She indicated that Resident #14 who tested negative on 11/26/20, became positive on 12/1/20. On 12/9/20 at 1:20 PM, the DON reported that Resident #6 became positive on 12/3/20 and Resident #7 became positive on 12/8/20.

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2. Resident #1 was observed on 12/1/20 at 11:15 AM with a door signage "enhanced droplet/contact precautions". The instruction on the sign revealed to wear surgical mask, eye protection, gown, gloves when entering the room, perform hand hygiene, private room and to keep the door closed.

Review of Resident #1's COVID test result revealed that he tested positive on 11/28/20.

On 12/1/20 at 11:25 AM, the Maintenance staff member was observed entering Resident #1's room without wearing a gown and he was wearing a non- disposable pair of gloves. He was observed to enter and to exit the resident's room three times without wearing a gown, without removing/changing his gloves and not performing hand hygiene. At 11:55 AM, the Maintenance staff member was observed to leave the unit without removing his gloves and without performing hand hygiene.

On 12/1/20 at 11:57 AM, the Maintenance staff member was interviewed. He stated that he was moving the personal belongings of Resident #13. He stated that he was aware that Resident #13 was COVID negative, but he didn ' t know that Resident #1 was COVID positive. He also reported that he didn ' t notice the sign on the door to wear a gown, gloves and to perform hand hygiene. A follow up interview was conducted with the Maintenance staff member on 12/2/20 at 2:50 PM and he revealed that he was not responsible for room changes including transfer of resident's personal belongings, but he was just helping. He indicated that the housekeeping department was responsible for the room

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changes but most of their staff were out due to COVID. The Maintenance staff member verified that he did not wear a gown, nor changed his gloves and performed hand hygiene when entering and exiting the room and he did not remove his gloves and performed hand hygiene when leaving the unit. He reported that he had attended an in-service on the use PPE in the past but could not remember the date.

On 12/2/20 at 2:29 PM, the Director of Nursing/Infection Control Preventionist was interviewed. She stated that she expected the staff to implement the guidelines on the use of PPE and the door signage when entering the room of resident on enhanced droplet/contact precautions.

The Administrator was interviewed on 12/3/20 at 2:48 PM. He stated that he could not find documentation that the Maintenance staff member had attended training/in-service on the use of PPE and door signage.

The Administrator was notified of the immediate jeopardy on 12/4/20 at 12:27 PM. The facility provided the following credible allegation for immediate jeopardy removal:

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.
Previous and on-going communication had been made with the Health Department ("HD") nurse regarding the facility COVID-19 status. The facility had 2 positive staff and one positive resident as of 11/19/2020, which caused the facility to be in

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COVID outbreak status. By 11/27/2020, the facility had 37 residents and 46 staff testing positive for COVID. On 11/27/2020, the Nursing Home Administrator ("NHA") called the local HD contact, to inform the HD of new positive cases and to discuss steps of action for increasing positive cases.

On 11/28/2020, twelve new residents became positive. The facility did not have space to isolate new positive residents, due to limited rooms (seven were available on the COVID-hall at that time) and due to limited staff, both housekeeping and total staff. The facility was only able to safely conduct a portion of required room changes to the COVID-hall. All residents could not be relocated due to limited space, limited staff, and limited staff to disinfect rooms of previously identified positive residents. The remaining room changes were not conducted based on the limited staff and access to clean rooms to relocate residents. The housekeeping department had no COVID-negative housekeeping staff available to work on 11/28/2020. Additionally, due to numerous new nursing and administrative staff, there were no alternative staff available to complete room changes. Prior to 11/28/2020 numerous room changes were conducted by the remaining non-COVID Administrative staff, due to housekeeping staff shortages as housekeeping staff tested positive for COVID. On 11/26/2020, two Administrative staff members conducting room changes tested positive for COVID, they were required to leave and isolate. On 11/27/2020, the last remaining Administrative team leader available for room changes tested positive for COVID, he was required to leave and isolate. All other Administrative and support staff had previously tested positive and were not safe to conduct room changes for negative residents.

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· Resident #1 resided on a non-COVID unit with resident #13. On 11/28/2020 resident #1 tested positive for COVID. Resident #13 was tested negative for COVID on 12/1/2020 and was relocated to a private room on a non-COVID unit. Resident #1 was moved to the COVID unit on 12/4/2020.

· Resident #2 resided on a non-COVID unit with resident #14. On 11/28/2020 resident #2 tested positive for COVID. Resident #14 tested positive for COVID on 12/1/2020. Resident remained in current room. On 12/4/2020, residents were moved to the COVID unit.

· Resident #3 resided on a COVID unit with resident #5. Resident number #3 tested positive for COVID on 11/30/2020. Resident #5 tested negative for COVID and was moved to the non-COVID unit on 12/4/2020.

· Resident #4 became COVID positive on 11/30/2020. Resident is appropriately placed on COVID-positive unit as of 11/30/2020.

· Resident #6 resided on a COVID unit with resident #7. Resident #6 was tested positive for COVID on 12/3/2020. Resident is appropriately placed on COVID-unit. Resident #7 was tested for COVID on 12/4/2020 and remains negative, resident was moved to the non-COVID unit on 12/4/2020.

· Resident #8 was in a private room on the non-COVID unit. On 11/28/2020 resident became COVID positive. Resident was moved to the COVID-unit on 12/4/2020.

· Resident #9 was in a private room on the non-COVID unit. On 11/28/2020 resident became COVID positive. Resident was moved to the COVID-unit on 12/4/2020.

· Resident #10 was in a private room on the non-COVID unit. On 11/30/2020 resident became COVID positive. Resident was moved to

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F 880	Continued From page 18 the COVID-unit on 12/4/2020. · Resident #11 was in a private room on the non-COVID unit. On 11/28/2020 resident became COVID positive. Resident was moved to the COVID-unit on 12/4/2020. · Resident #12 was in a private room on the non-COVID unit. On 11/30/2020 resident became COVID positive. Resident was moved to the COVID-unit on 12/4/2020. Specify the Action the Facility will take to alter the process or system failure to Prevent a Serious Outcome from occurring or reoccurring and when the Action will be complete. On 12/1/2020, some negative staff were available to conduct room changes. An audit was conducted of residents that were negative and roomed with residents that were positive. Results of the audit concluded there were three room changes to occur. The facility focused on residents sharing rooms versus, specific negative and positive hallways. Based on an audit of all residents in the facility on 12/4/2020, all residents had been appropriately separated based on COVID status by room. On 12/4/2020, the facility implemented room changes and developed clearly defined units: COVID-positive, COVID-negative, and COVID-recovered (for those removed from quarantine), which aligns with the facility Infection Control Policy. As of 12/4/2020 all residents that remain COVID-negative have been relocated to a COVID-negative unit. All residents that are positive for COVID are relocated to a COVID unit. · Residents #1, #2, #3, #4, #6, #8, #9, #10, #11, #12, and #14 have tested positive for COVID and are appropriately placed on a COVID unit as of 12/4/2020. · Residents #5, #7, and #13 remain	F 880		

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negative for COVID and are appropriately placed on the non-COVID unit as of 12/4/2020.

To prevent future deficient practice, a corporate team representative met with the NHA and Director of Nursing ("DON") on 12/1/2020 and has re-enforced that the facility cannot rely on guidance that is not consistent with CDC, CMS, and NC DHHS guidelines. The facility is expected to follow all current guidelines from the above listed entities and no changes are allowed at the facility level, even during an outbreak, without approval from the corporate team. This clarification will reduce the potential for miscommunication, misunderstanding or other future deficient practice that occurred during the cited outbreak. To clarify, the facility will follow testing, monitoring, and surveillance guidance for residents and staff as defined by CMS, state, and local regulations. The facility will continue twice weekly testing of staff and residents for COVID, during the outbreak status and will follow the appropriate CMS guidelines following the outbreak based on county positivity rates. The facility will follow the Infection Control Policy, including appropriate cohorting of residents based on COVID status. The facility will explore additional options for staffing, in addition to staffing plans already included in the Staffing Contingency Plan.
The Facility alleges the removal of the immediate jeopardy on 12/4/2020.

On 12/9/20, the facility's credible allegation for immediate jeopardy removal was validated by the following:

-review of the alphabetical resident list and the list of residents tested positive for COVID

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F 880	Continued From page 20 - observation of residents on the COVID positive unit and COVID negative unit to verify proper placement of residents according to their COVID test results - observation of staff on the COVID unit to verify use of PPE according to the CDC guidelines and facility's policy - interview with staff on COVID positive and COVID negative units to verify proper placement of residents according to their COVID test results - review of in-service record and interview with the Maintenance staff member regarding the use pf PPE The facility's date of immediate jeopardy removal of 12/4/20 was validated.	F 880		