STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345014	A. BUILDING _____ B. WING _____	12/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT GREENSBORO, LLC	1201 CAROLINA STREET GREENSBORO, NC 27401

(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 12-30-20 . 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: YMZK11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 12-31-20. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID # YMZK11	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	F 880		1/12/21

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

Electronically Signed | 01/14/2021

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		

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.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 2 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, resident interview, staff interview and physician interview, the facility failed to implement their "Coronavirus Testing" policy for donning personal protective equipment (PPE) and Center for Disease Control and Prevention (CDC) COVID19 guidelines, when 1 of 1 staff members (Nurse #1) failed to wear a gown while performing COVID19 testing on the residents. This failure occurred during the COVID19 pandemic. Findings included: Review of the facility's "Coronavirus Testing" policy and procedure dated 9-29-20 revealed in part; the facility will maintain proper infection control and use recommended personal protective equipment, which includes N95 or higher, eye protection, gloves and gown when collecting specimens. Review of the Centers for Disease Control and Prevention (CDC) guidance "Performing Broad-Based testing for SARS-CoV-2 in Congregate Settings" dated June 2020 revealed in part; personal protective equipment requirements: gown, N95 equivalent or higher, gloves and eye protection are needed for staff collecting specimens or working within 6 feet of the person being tested.	F 880	Nurse #1 was immediately re-educated regarding wearing proper PPE when performing Covid 19 testing by the Director of Nursing. Resident #3 was last tested on 12/8/2021 at which time he was positive and asymptomatic. He has not been tested since. The licensed Nurse will perform testing for all residents wearing the proper PPE which includes: N95, eye protection, gloves and a gown. Training was completed on 1/12/2021 by the Director of Nursing/Infection control Preventionist with current licensed Nurses on the proper PPE to be worn when testing; N95, eye protection, gloves, gown and proper handwashing. The Root Cause determined education was ineffective during a change in Infection Preventionists and lack of surveillance of licensed Nurse during resident testing. Ad Hoc QAPI Committee (Loie Leopardi, Administrator, Robin Niles, Regional Director of Operations, Theresa Alston, Director of Nursing, Dr. Joel Blass, Medical Director and other	

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F 880	Continued From page 3 During an interview with Nurse #1 on 12-29-20 at 12:43pm, the nurse confirmed she performed the COVID19 test for the residents in the facility. She described how she performed the test and what personal protective equipment (PPE) she wore. The nurse stated she wore her mask, face shield and gloves when she performed the COVID19 test on the residents. Nurse #1 explained that she did not wear a gown when performing the test because the facility did not have any COVID positive residents. Resident #3 was interviewed on 12-29-20 at 1:02pm. The resident discussed staff wearing a mask and face shield or goggles when they entered his room, but he stated when he was tested for COVID19 he did not recall the nurse wearing a gown. The Administrator was interviewed on 12-29-20 at 2:25pm. The Administrator stated she had not observed Nurse #1 perform the COVID19 test on the residents, so she was not aware the nurse was not wearing a gown. She confirmed the nurse should be wearing the required PPE to include a gown when she was performing COVID19 testing. During an interview by telephone with the facility's Medical Director on 12-30-20 at 3:09pm, the Medical Director discussed not being concerned that Nurse #1 was not wearing a gown when performing the COVID19 test on the residents because there were no COVID positive residents in the building.	F 880	Administrative Staff) met on 1/12/2021 to review the current Directed Plan of Correction and Root Cause determination. The Director of Nursing will complete random observations audits on resident testing by licensed Nurses during Covid 19 testing. Audits will include observation rounds, based on Directed Plan of Correction to ensure staff use proper hand hygiene and proper PPE usage. Audits will be completed weekly for 4 weeks or until compliance is achieved. The Director of Nursing will complete a summary of audit results that will be presented to the QAPI Committee montly to ensure compliance.	