

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345246</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/26/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>HICKORY FALLS HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 SUNSET STREET GRANITE FALLS, NC 28630</b>	
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E 000	Initial Comments	E 000		
F 000	INITIAL COMMENTS	F 000		
F 880 SS=D	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</p> <p>§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.</p> <p>§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:</p>	F 880		3/5/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/11/2021

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  §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.	F 880			

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F 880	<p>Continued From page 2</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 reviews, observations and staff interviews, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 2 of 3 staff members (Nurse Aide #1 and Nurse Aide #2) on the COVID-19 unit failed to wear eye protection while providing resident care to 5 of 8 residents (Resident #6, Resident #7, Resident #8, Resident #9 and Resident #10) reviewed for infection control. This failure occurred during a COVID-19 pandemic.</p> <p>The findings included:</p> <p>The Centers for Disease Control and Prevention (CDC) guidance entitled, "Preparing for COVID-19 in Nursing Homes," updated on 11/20/20 indicated the following statement: *Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face),</p>	F 880	<p>All staff will wear proper PPE (gloves, gowns, goggles, and masks) while in a resident's room and/or providing care according to CDC guidance.</p> <p>The Infection Control Specialist re-educated all staff on the proper PPE (gloves, gowns, goggles, and masks) guidelines on February 23rd and February 24th, 2021. The Director of Nursing or designee from the Nursing Administration team will monitor staff daily on all shifts for one month and weekly for three months therefore to ensure compliance.</p> <p>All staff will receive continued education regarding proper PPE according to CMS guidelines monthly by the Infection Control Specialist or designee for three months. All new hires will be educated during orientation on the proper PPE guidelines by the Infection Control Specialist or designee immediately and ongoing.</p>		

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F 880	<p>Continued From page 3 gloves, and gown.</p> <p>A review of the facility's policy entitled, "Personal Protective Equipment for COVID-19 or Suspected COVID-19 Residents," dated April 2020 read, in part: Personal Protection Equipment (PPE) will consist of gowns, gloves, goggles or face shields, and appropriate masks.</p> <p>The facility's policy entitled, "Admission/Readmission/Isolation/COVID-19 Positive Units," dated July 2020 included the following statement: Staff providing care for residents who are COVID-19 positive and in isolation for recent diagnosis, will wear full PPE in the resident's rooms.</p> <p>During the entrance conference on 2/23/21 at 11:45 AM, the Director of Nursing (DON) indicated that the current residents who tested positive for COVID-19 were located on the C hall.</p> <p>A review of the facility census revealed the current COVID-19 positive residents occupied rooms 308 to 316 on the C hall.</p> <p>During a continuous observation on 2/23/21 from 4:45 PM to 5:55 PM of the COVID-19 unit, all resident doors had posted signage for enhanced droplet isolation precautions requiring mask, gown, gloves and face shield or goggles. Two plastic hanging organizers were placed on either side of the entrance to the COVID-19 unit and contained masks and goggles. Plastic bins containing gowns and gloves were in the hallway outside the doors in the COVID-19 unit.</p> <p>a. On 2/23/21 at 5:15 PM, Nurse Aide (NA) #1 was observed entering room Resident #7's room</p>	F 880	<p>Root Cause Analysis (RCA) was completed by the Administrator, Director of Nursing, and Infection Control Specialist on February 25th, 2021. Findings from the RCA were 1. Staff failed to wear proper eyewear while in resident's room providing care.</p> <p>Administrator or designee from the Nursing Administration team will ensure adherence to the practice of wearing proper PPE by daily audits on all shifts. The Administrator will report all findings to the QA Committee monthly for three months.</p> <p>Corrective action will be completed by March 5th, 2021.</p>		

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F 880	<p>Continued From page 4</p> <p>after putting on a gown and gloves. She was wearing an N95 mask. She did not have a face shield or goggles on and was only wearing her prescription eyeglasses. After five minutes, NA #1 removed her gown and gloves, exited Resident #7's room and used hand sanitizer out in the hallway. At 5:25 PM, NA #1 was observed going into Resident #6's room after putting on a gown and gloves while still wearing an N95 mask and her regular eyeglasses. She proceeded to assist with feeding Resident #6.</p> <p>An interview with NA #1 on 2/23/21 at 5:45 PM revealed this was her first time working on the COVID-19 unit but she had been told to wear an N95 mask, gown and gloves when going into a resident's room and to use hand sanitizer before going into and after leaving a room at the COVID-19 unit. NA #1 confirmed that she had been wearing her prescription eyeglasses and stated she was supposed to wear shield goggles over them, but she admitted that she forgot to get some. She also stated she had not been having any issues with the shield goggles fogging up her prescription eyeglasses.</p> <p>b. On 2/23/21 at 5:20 PM, NA #2 was observed putting on a gown and gloves while wearing a KN95 mask. She was not wearing a face shield or goggles. She entered room Resident #8's room. After a minute, she removed her gown and gloves, discarded them in the trash bin by the door and exited Resident #8's room. She rubbed hand sanitizer to both hands while in the hallway. She proceeded to Resident #9's room after putting on a gown and gloves at the door before entering. She was not wearing a face shield or goggles. After five minutes, NA #2 exited room Resident #9's room after discarding her gown and</p>	F 880			

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F 880	<p>Continued From page 5</p> <p>gloves inside the room. She was further observed using hand sanitizer. At 5:55 PM, NA #2 was observed inside room Resident #10's room wearing a gown, gloves and a KN95 mask while feeding Resident #10. NA #2 did not have any eye protective gear on.</p> <p>An interview was conducted with NA #2 on 2/23/21 at 6:00 PM. NA #2 stated she was aware that she was supposed to wear an eye protective gear when working inside the rooms on the COVID-19 unit but her goggles broke while she was giving a resident a shower during the earlier part of the shift. She said she got busy and had not gotten around to getting a new pair.</p> <p>An interview conducted on 2/24/21 at 12:41 PM with the DON revealed NA #2 had come to her on the evening of 2/23/21 to ask for another pair of goggles. The DON stated NA #2 told her that her goggles had broken after she dropped it in the shower room. The DON had not been aware that NA #2 did not immediately replace her goggles and that she went back to the COVID-19 unit without any eye protective gear on. The DON said both NA #1 and NA #2 should have asked her or any nurse for eye protective gear because they had plenty of supplies and they should not have gone into any of the rooms in the COVID-19 unit without eye protection.</p> <p>An interview with the Administrator on 2/24/21 at 4:20 PM revealed she expected her staff to wear eye protection when working on the COVID-19 unit.</p>	F 880			