

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/29/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345238	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/03/2021
NAME OF PROVIDER OR SUPPLIER WHITE OAK MANOR - CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 4009 CRAIG AVENUE CHARLOTTE, NC 28211		
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E 000	Initial Comments The survey team entered the facility on March 2, 2021 to conduct an unannounced COVID-19 Focused Survey and exited on March 2, 2021. Additional information was obtained on March 3, 2021. Therefore, the exit date was changed to March 3, 2021. 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 # RHFk11.	E 000			
F 000	INITIAL COMMENTS The survey team entered the facility on March 2, 2021 to conduct an unannounced COVID-19 Focused Survey and complaint investigation and exited on March 2, 2021. Additional information was obtained on March 3, 2021. Therefore, the exit date was changed to March 3, 2021. The facility was not found in compliance with 42 CFR 483.80 Infection Control Regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID# RHFk11.	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.	F 880		3/26/21	

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

TITLE

(X6) DATE

Electronically Signed

03/19/2021

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	<p>Continued From page 1</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> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct</p>	F 880			

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F 880	<p>Continued From page 2</p> <p>contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</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 1 of 2 staff members (Nurse Aide #1) on the quarantine hall entered and failed to wear a gown inside the room of 1 of 6 residents (Resident #4) reviewed for infection control who had an ongoing nebulizer treatment and failed to discard her mask and disinfect her goggles after leaving the room. 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, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus</p>	F 880	<p>F880</p> <p>White Oak Manor Charlotte ensures implementation and maintenance of an infection prevention and control program and policies designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable disease.</p> <p>Resident #4 was discharged home on 3/16/2021. When the observation of the aerosol generating procedure was reported to the facility on 3/2/2021, the facility immediately posted the aerosolizing procedure sign on Resident #4's room door. The facility also checked the other residents' rooms that had aerosolizing procedures ordered, to ensure the signs were posted. This was</p>		

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F 880	<p>Continued From page 3</p> <p>Disease 2019 (COVID-19) Pandemic," updated on 2/23/21 indicated the following statements under the section "Aerosol Generating Procedures":</p> <p>* Some procedures performed on patients with suspected or confirmed SARS-CoV-2 infection could generate infectious aerosols. Procedures that pose such risk should be performed cautiously and avoided if possible.</p> <p>* If performed, the following should occur: HCP (Healthcare Personnel) in the room should wear an N95 or equivalent or higher-level respirator, eye protection, gloves, and a gown.</p> <p>A review of the facility's infection control policy entitled, "COVID-19 Plan," revised on 2/25/21 indicated that aerosolizing procedures will be followed for all patients, regardless of COVID-19 status, per Aerosolizing policy and procedures.</p> <p>The facility's policy entitled, "Aerosolizing Procedure Precautions Guidance," dated 4/15/20 included the following statements: In the absence of a positive air pressure room, aerosolizing procedures required the following precautions for all residents at this time:</p> <ol style="list-style-type: none"> 1. Protection required: N95 respirator (or equivalent) covered with a cloth or surgical mask and eye protection (preferably a full face shield), other PPE as indicated by procedure. 2. Place a sign on resident's room door to: "Avoid entry during procedure for one (1) hour post procedure. Wear N95 respirator or equivalent if entry required before ALL CLEAR TIME." 3. After procedure: <ol style="list-style-type: none"> a. Clean goggles or face shield and store per facility protocol. b. If disposable face shield used, dispose of 	F 880	<p>completed by the SDC.</p> <p>Nurse Aide #1 was re-educated immediately on 3/2/21 by the Staff Development Coordinator (SDC) on the aerosolizing procedure including not entering a resident's room until one hour after treatment.</p> <p>The education also included that if she had to go into the resident's room she was required to wear a gown, discard the PPE (mask and gown) and then disinfecting her goggles after leaving the resident's room and prior to going into another resident's room. This was all completed on 3/2/2021 by the SDC.</p> <p>An audit of current resident's orders for aerosolizing procedures was completed on 3/2/2021 by the SDC and the resident's doors were checked for the aerosolizing procedure postings.</p> <p>The licensed Nurses were re-educated on displaying the aerosolizing procedure posting on the resident's door when it is ordered for the purpose of timing of the procedure, notifying the staff of the procedure, and for the staff not to enter unless needed. This education was done on 3/3, 3/4 and 3/5/21 by the SDC or Director of Nurses.</p> <p>Current nursing staff and other facility staff have been re-educated on the posting of the aerosolizing procedure. This education was completed by the SDC on 3/3, 3/20, 3/21 and 3/22/21 by the</p>		

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F 880	<p>Continued From page 4 per protocol.</p> <p>c. PPE worn during aerosolizing procedure must be changed or discarded after aerosolizing procedure (with exception of N-95 or equivalent if covered with a cloth or surgical mask and a full face shield).</p> <p>d. Full PPE required during aerosolizing procedure during prolonged close proximity to resident.</p> <p>During the entrance conference on 3/2/21 at 9:46 AM, the Director of Nursing (DON) indicated that the newly admitted and re-admitted residents were located on the East hall and occupied rooms E17 to E24. This hall was designated as the quarantine hall where newly admitted and re-admitted residents were placed on observation for 14 days prior to being moved to another part of the facility.</p> <p>A continuous observation on 3/2/21 from 10:30 AM to 10:45 AM of the quarantine hall revealed Resident #4 receiving a nebulizer treatment with his door open. He was observed wearing a nebulizer mask over his nose and mouth with the tie secured behind his head. The nebulizer machine was running, and mist was observed coming out from both sides of the nebulizer mask. Resident #4 was in the room by himself. There was no sign noted at the door regarding an aerosolizing procedure in process. At 10:35 AM, Nurse Aide (NA) #1 was observed going into Resident #4's room while wearing a KN95 mask and a surgical mask over it and goggles. She did not put on a gown prior to entering Resident #4's room. She walked towards Resident #4 while talking to him and was observed within six feet of the resident in the room. After five minutes, she washed her hands at the sink and then exited</p>	F 880	<p>SDC. Anyone unable to attend one of the above dates will be educated by the SDC prior to 3/26/21.</p> <p>Newly hired staff will receive this education during job specific orientation by the SDC.</p> <p>Residents on aerosolizing procedure will be monitored 3 times a week for 4 weeks then 1 time a week for 4 weeks. This monitoring will include newly admitted residents with aerosolizing procedure orders. The monitoring will be completed by the DON, ADON, SDC, or designated Nurse supervisor.</p> <p>Results from the monitoring along with identified trends will be discussed Monday through Friday during the Quality Improvement (QI) morning meetings with the team making recommendations as indicated.</p> <p>The Director of Nurses is responsible for ongoing compliance of F880.</p> <p>The Completion Date is: 3/26/21.</p>		

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F 880	<p>Continued From page 5</p> <p>Resident #4's room. At 10:40 AM, NA #1 proceeded to Resident #6's room while wearing a KN95 mask, a surgical mask, and goggles. She did not put on a gown prior to entering Resident #6's room. Resident #6 was lying in bed when NA #1 started to talk to her and adjust her pillows. After two minutes, NA #1 Resident #6's room while rubbing hand sanitizer to both hands.</p> <p>An interview was conducted on 3/2/21 at 10:42 AM with NA #1. NA #1 stated she only wore gowns in resident rooms when doing care that required close contact with the resident such as incontinence care, dressing, assisting with personal hygiene or transferring them in and out of bed. NA #1 did not know that she wasn't supposed to enter Resident #4's room while he was receiving his nebulizer treatment. She also stated that she discarded her masks and disinfected her goggles at the end of the day. She added that she did not think she needed to change her mask and disinfect her goggles after exiting Resident #4's room and before going to another room.</p> <p>An interview was conducted on 3/2/21 at 1:10 PM with Nurse #1 who stated that the facility has just started resuming nebulizer treatments after the COVID-19 outbreak. Resident #4 used to receive an inhaler, but his medication order was recently changed to a nebulizer treatment. Nurse #1 stated she usually wore gloves, goggles, an N95 mask and a gown prior to starting nebulizer treatments but forgot to put up the sign warning other staff members that an aerosolizing procedure was in process.</p> <p>An interview conducted on 3/2/21 at 3:49 PM with the facility's Infection Preventionist (IP) revealed</p>	F 880			

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F 880	<p>Continued From page 6</p> <p>NA #1 should not have entered Resident #4's room while the nebulizer treatment was ongoing and should have waited at least an hour after the treatment was over before entering the room. If she really had to go in the room, NA #1 should have worn a gown prior to entering the room and she should have discarded her masks and disinfected her goggles after leaving Resident #4's room and prior to going into another room. The IP also stated they utilized a laminated sign that read: STOP - Do Not Enter, Aerosolizing Procedure in Process, N95 Required - Avoid entry during procedure and for one hour post procedure. The IP stated Nurse #1 should have posted this sign and communicated it to NA #1.</p> <p>An interview with the DON on 3/2/21 at 6:14 PM revealed NA #1 should have waited an hour after the nebulizer treatment before she entered Resident #4's room. The DON stated NA #1 was probably not sure what to do but should have stopped and asked Nurse #1. The DON explained Resident #4 previously had orders for a handheld inhaler which was recently switched to aerosolized treatments. She added that NA #1 should have changed out all PPE especially her mask due to the possibility that her mask might have become saturated with particles from the nebulizer treatment. NA #1 should have also disinfected her goggles prior to going into another resident room.</p>	F 880			