STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345138	A. BUILDING ______ B. WING ______	R-C **09/08/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR HEALTHCARE CENTER	**322 NUWAY CIRCLE** **LENOIR, NC 28645**

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 09/07/21. Additional information was obtained on 09/08/21; therefore, the exit date was extended to 09/08/21. Tags F550, F561, F580, F641, F689 and F925 were corrected as of 09/08/21. Repeat tags were cited. The facility is still out of compliance.	{F 000}		
{F 677} SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to provide showers or bed baths for 1 of 3 dependent residents (Resident #3) reviewed for assistance with activities of daily living (ADL). The findings included: Resident #3 was admitted to the facility on 6/24/21 with diagnosis which included muscle weakness, anxiety, and depression. A review of the admission Minimum Data Set (MDS) dated 6/30/21 indicated Resident #3 was cognitively intact and required extensive assistance with one person staff for bathing and two person staff for transfers. Review of the shower schedule revealed Resident #3 was originally scheduled for showers on Wednesday and Thursday's but was switched to Wednesday and Saturdays on 9/1/21 when the	{F 677}	1. The facility failed to provide showers as schedule for residents #3. Resident #3 was discharged home on 9/15/2021. 2. All residents have the potential to be affected by the deficient practice. The nurse manager or designee will interview each resident for their preference in their personal shower schedules. This will be completed by 9/23/2021. The nurse managers and or DON will develop the new master shower schedule accordingly 3. All nursing staff will be educated regarding expectations that the residents shower/bed bath is completed on the designated day and the process if a resident refuses a shower/bed bath. Education was also provided on the importance of completing documentation both on paper and in the computer.	9/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 09/25/2021

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.

{F 677} Continued From page 1

resident was moved to a different room.

Resident #3's shower schedule for September 2021 revealed a shower or bath was not documented as given on 8/26/21, 9/1/21 or 9/4/21. The shower schedule further indicated the last shower documented as given was on 8/25/21.

An observation was conducted on 9/7/21 at 3:11 PM revealed Resident #3 hair appeared to be oily and unbrushed.

An interview with Resident #3 on 9/7/21 at 3:15 PM revealed Resident #3 changed rooms six days ago on 9/1/21 and had not receive a shower or bath since the end of August. Resident #3 further revealed staff explained to the resident that Residents #3's showers were missed due to not having enough staff to assist with showers. Resident #3 pointed towards her head and stated, "look at my hair you can tell I haven't had a shower in several days". Resident #3 indicated she had cleaned herself with a cloth and water but had not received a partial bath or bath since the last shower scheduled.

An interview conducted with Nurse Aide (NA) #2 on 9/7/21 at 4:32 PM revealed she had been scheduled to give Resident #3 a shower on 8/30/21 but did not because she was the only nurse aide on that hall during her shift. NA #2 further revealed several residents' showers had been missed due to short staffing, and not having time to get them completed. NA #2 stated Resident #3 had never refused care and preferred showers.

An interview conducted with NA #1 on 9/7/21 at

{F 677}

Education completed by DON and/or ADON and will be complete by 9/24/2021.

Nurse Managers or the DON will ensure that shower schedules are updated timely when residents have room changes, are discharged or upon new admissions.

Nurse managers will audit a sample of showers daily Monday through Friday for 2 weeks, then weekly for four weeks, then monthly for 2 additional months shower/bed bath schedules to ensure that residents are receiving a shower and/or bed bath as scheduled per their preference

In addition, the Director of Nursing will review weekly audits to ensure shower/bed bath schedules to ensure that residents are receiving a shower and/or bed bath as scheduled and per their preference.

4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

5. Person responsible: Director of Nursing

6. Completion Date of 9/24/2021

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{F 677}	Continued From page 2 3:30 PM revealed she was assigned to Resident #3 on 9/1/21, but Resident #3 did not receive a shower. NA #2 further revealed Resident #3 preferred showers and never refused showers. An interview conducted with Director of Nursing (DON) on 9/7/21 at 5:13 PM revealed she would expect for residents' showers to be completed by preference and on their scheduled days. An interview conducted with the Administrator on 9/7//21 at 6:02 PM revealed she was aware scheduled showers had not been getting done due to short staffing. The Administrator further revealed she did not know why Resident #3 had missed multiple showers, but stated it was an issue throughout the facility with several residents. The Administrator indicated she expected residents to be able to get their preferred shower or bath on their schedule once staffing had improved.	{F 677}		
{F 725} SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services	{F 725}		9/24/21

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{F 725}	Continued From page 3 by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide sufficient nursing staff, resulting in missed showers for 1 of 3 dependent resident (Resident #3) reviewed for staffing. The findings included: This tag is cross referred to: 1. F677: Based on observation, record review, resident and staff interviews, the facility failed to provide showers for 1 of 3 residents (Resident #3) reviewed for activities of daily living (ADL). An interview was conducted on 09/07/21 at 11:49 AM with Nurse Aide (NA) #3 who revealed staffing was adequate with 2 NAs on the hall but when there was only one on the hall it was not possible to get showers done and were not able to get everyone up that wanted to be up out of bed daily. An interview was conducted on 09/07/21 at 12:03	{F 725}	1. Facility failed to provide sufficient nursing staffing, resulting in missed showers for resident #3. Resident #3 was discharged home on 9/15/2021. Agreements with additional staffing agencies have been signed to supplement the facility□s staffing. 2. An audit was conducted of the last 14 days to ensure staffing was adequate for resident census. This audit was completed by 9/23/2021. 3. Administrator educated Director of Nursing on the requirement to properly staff the facility based up on facility census. This education was completed by 9/23/21. All nursing staff will be educated regarding expectations that the residents shower/bed bath is completed on the	

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{F 725}	Continued From page 4 PM with NA #4 who revealed staffing could be a lot better. The NA stated sometimes she was the only NA on the hall and just had to do the best she could and get just bare basics of incontinence care and feeding residents done. NA #4 stated on days there was only one NA on the hall it was impossible to get showers done. An interview was conducted on 09/07/21 at 12:08 PM with NA #7 who revealed staffing was not much better. NA #7 stated she had worked doubles to cover the schedule and had worked several shifts as the only NA on the unit. She further stated when she was the only one on the unit, she was not able to complete showers, answer lights or get residents up out of bed. NA #7 indicated it was all she could do to complete incontinence rounds and feed residents that required feeding assistance. An interview was conducted on 09/07/21 at 3:30 PM with NA #5 and NA #6. NA #5 and NA #6 stated they were having to work over on a consistent basis to cover the next shift and had worked 12 to 16 hours per day on scheduled days. They both further stated the facility had tried to bring agency NAs in the building but said they left mid shift, didn ' t show up or call in and then staff were left to carry the load. NA #5 and NA #6 indicated there were still a lot of showers that were not being completed on residents but had tried to at least give residents one shower per week. An interview was conducted on 09/07/21 at 4:12 PM with NA #8 who stated staffing was slim to none. NA #8 further stated there were times she was the only NA on the hall after 7:00 PM and it was impossible to get all the showers assigned	{F 725}	designed day and the process if a resident refuses a shower/bed bath. Education also provided regarding proper documentation both on paper and in the computer. Education completed by DON and/or ADON and will be complete by 9/24/2021. Administrator and/or Director of Nursing will audit daily staffing schedules 5 x per week x 12 weeks to ensure staffing is adequate for resident census. On weekends, a supervisor will continue to notify the DON and/or the Administrator of changes in staffing levels. Administrator and DON will conduct a daily labor meeting (Mon-Fri) as part of the morning meeting to ensure facility has adequate staffing for current census. Administrator will enlist the assistance from outside staffing agencies to supplement facility staff if needed. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Administrator and Director of Nursing 6. Completion Date 9/24/2021	

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{F 725}	Continued From page 5 done. NA #8 indicated it was difficult to provide incontinence care, answer lights, get residents to bed and do showers, so showers were often not done. An interview was conducted on 09/07/21 at 5:30 PM with the Administrator who revealed staffing was still a struggle for the facility. The Administrator stated she was not sure what the answer was for their staffing crisis. She further stated she was working with the Regional Director of Operations on recruiting candidates and getting agency in the building to relieve some of the vacancies. The Administrator indicated they had contracts with 4 staffing agencies and were working with another one to obtain a contract. She further indicated she was providing bonuses to staff to work extra shifts or parts of shifts and was providing referral bonuses for any new hires and was offering sign on bonuses. The Administrator explained it was difficult in their area to hire employees and to keep them, but they were strategizing with corporate on ways to increase their staffing.	{F 725}		
{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	{F 880}		9/24/21

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{F 880}	Continued From page 6	{F 880}		

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 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

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{F 880}

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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 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 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 1 staff member (Nurse #1) failed to wear eye protection prior to entering the room of 1 of 3 residents (Resident #4) on enhanced droplet isolation. This failure occurred during a COVID-19 global pandemic.

The findings included:

The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 02/23/21 indicated the following information regarding Personal Protective Equipment (PPE) use under the section, "Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed

{F 880}

1. 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 Nurse #1 failed wear an eye protection in a room on enhanced droplet precautions.

2. Nurse #1 was re-educated by the Director of Nursing and Executive Director on Transmission Based Precautions and the recommended Personal Protective Equipment of gown, gloves, eye protection, and N95 mask utilizing the facility policy on COVID-19 Response Guidelines to include recommendations of PPE for a resident on Enhanced Droplet Precautions in addition to signage. This education was provided on 9/23/2021

3. All residents have the potential to be affected by this deficient practice.

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SARS-CoV-2 infection:
" Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area. Remove eye protection after leaving the patient room or care area, unless implementing extended use.

A review of the facility's COVID-19 policy entitled, "Personal Protective Equipment (PPE)," updated on 05/28/21 indicated the following information:
" Residents with known or suspected COVID-19 (PUI, COVID+)
1. Healthcare Personnel (HCP) should use all recommended COVID-19 PPE for the care of all residents in the PUI and COVID are (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents
a. If HCP PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated. Broader testing could be utilized to prioritize PPE supplies (See Guidance on Testing).
2. HCP should wear an N95 or higher-level respirator (or facemask if respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.

Resident #4 was admitted to the facility on 03/17/21 and readmitted on 05/06/21 with diagnoses which included right fractured hip and lower leg with surgical repair, and contracture of

{F 880}

4. A root cause analysis was completed by Director of Nursing, Infection Preventionist, Regional Nurse Consultant and QAPI (Quality Assurance Performance Improvement) Committee and Governing Body on 9/23/21. This root cause analysis was incorporated into the facility intervention plan.

Beginning on 9/16/2021 with completion date of 9/24/2021, all staff including any contract or agency staff were educated on recommended Personal Protective Equipment (PPE) for residents on Enhanced Droplet Precautions by the Director of Nursing and Executive Director. Education was provided to staff through multiple avenues including but not limited to verbal, written and telephonically dependent on the staff members availability. Upon hire all staff will be educated by the Director of Nursing or her designee about Transmission Based Precautions and the recommended PPE for residents on Enhanced Droplet precautions beginning 9/27/21. An attestation statement was completed by the Director of Nursing to attest education was completed on 9/24/21.

After 9/24/2021, no staff will be allowed to work until education is completed.

Administrative staff (Executive Director, Director of Nursing, and Infection Preventionist) will conduct Personal Protective Equipment Audits to ensure Transmission Based Precautions are

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{F 880}	Continued From page 9 the muscle in the right lower leg. The resident received her COVID-19 vaccines on 12/28/20 and 02/18/21. Resident #4 tested positive for COVID-19 on 09/01/21 and was moved from the 300 unit to the 100 unit and placed on enhanced droplet contact isolation. An observation was made of Nurse #1 on 09/07/21 at 4:38PM entering Resident #4's room while wearing a gown, gloves and N95 mask. A sign for enhanced droplet isolation was posted on Resident #4's door. The sign indicated the following instructions to follow before entering the room: N95 must fully cover the nose, mouth, and chin; eye protection when entering the room and gown and gloves when entering the room. There was a storage bin for PPE right outside Resident #4's room. Nurse #1 carried a cup filled with medications into Resident #4's room without putting on eye protection. She administered the medications to Resident #4 and watched her swallow each of the medications. After 5 minutes, Nurse #1 doffed her gloves, exited Resident #4's room and sanitized her hands. Nurse #1 then doffed her gown, changed her mask, and proceeded to the medication cart to prepare the next resident's medications for administration. An interview with Nurse #1 on 09/07/21 at 4:48PM revealed she had left her goggles in her car and stated she could go get the goggles if necessary. She stated she had glasses on and could not see without them and the goggles caused her glasses to fog making it difficult for her to see out of her glasses. Nurse #1 further stated she could get her goggles out of her car if she needed to wear them on the unit.	{F 880}	maintained by performing random observations of donning and doffing PPE consisting of various shifts each day to include all three shifts daily for two weeks then 3 times weekly x 6 weeks then weekly x 6 weeks. If no resident is on Transmission Based Precautions, then interviews will be completed to assess the employees knowledge base regarding PPE required for Transmission Based Precautions. 5. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 6. Person Responsible: Administrator and Director of Nursing 7. Completion date 9/24/2021	

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{F 880}	Continued From page 10 An interview with the Director of Nursing (DON) on 09/07/21 at 5:12PM revealed she had been at the facility since 08/04/21. The DON stated on the COVID (+) unit the staff did not have to change their mask and gown between residents but needed to change gloves and perform hand hygiene. The DON indicated staff should have been wearing goggles or a face shield. She further indicated there were supplies of all PPE on the unit and if they ran low or out of supplies, they could call, and supplies were delivered to them on the unit. According to the DON, all staff had been trained on appropriate use of PPE and donning and doffing procedures for PPE. She stated they had had several meetings regarding PPE and procedures for COVID-19 isolation. An interview with the Administrator on 09/07/21 at 5:30PM revealed Nurse #1 had been educated about proper procedures with PPE during a town hall meeting held on 08/05/21. The Administrator stated the education included donning and doffing procedures for all PPE. She indicated Nurse #1 knew better and should have always worn eye protection on the COVID (+) unit when entering resident rooms.	{F 880}		