STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	102 LEONARD AVENUE NEWTON, NC 28658

(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 recertification and complaint investigation survey was conducted on 05/02/2022 through 05/05/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Prepardness. Event ID # HRPF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conduceted from 05/02/2022 through 05/05/2022. The following intakes were investigated: NC00185278, NC00181592, NC00180854 and NC00176295. 12 of 12 allegations were unsubstantiated. Event ID #HRPF11.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.	F 565		5/27/22

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

Electronically Signed | 05/27/2022

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F 565	Continued From page 1 (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident council meeting minutes, resident, and staff interview the facility failed to resolve dietary grievances that were reported in the resident council meeting for 8 out of 10 months (June 2021, July 2021, August 2021, September 2021, October 2021, December 2021, January 2022, and February 2022). a. Review of the 06/03/21 Resident Council (RC) minutes revealed the following dietary concern: the council commented on vegetables such as green beans and potatoes sometimes being undercooked. The response to the concern of vegetables such as green beans and potatoes being undercooked read in part: will address with staff in kitchen. The response was signed by the Administrator. b. Review of the 07/01/21 RC minutes revealed the following dietary concerns: the group had the following concerns about food such as beans, potatoes, carrots, rice, and noodles being	F 565	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Abernethy Laurels of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey dates, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or	

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F 565	Continued From page 2 undercooked and too hard to eat. They were often served something other than what was on the menu. The response to the concern of "food quality" read in part: will follow up with individual resident on food preferences. The response was signed by the Administrator. c. Review of the 08/19/21 RC minutes revealed the following dietary concerns: meals are cold and tough, and they were not being served what was on the menu. The response to the concern of "food/dining" read: being addressed by Dietary Manager (DM). The response was signed by the Executive Director (filling in for the Administrator). d. Review of the 09/02/21 RC minutes revealed the following dietary concerns: poor communication when menu changes occur, they would like to be notified when the menu changed, and vegetables were still undercooked. The response to the "dining and food service concerns" read: response from DM noted in green (no attachment was included that indicated the DM's response to the concerns). The response was signed by the Executive Director. e. Review of the 10/07/21 RC minutes revealed the following dietary concerns: still not getting items listed on the menu and baked and sweet potatoes are served undercooked. The response to the "food service concerns" were in an attached email that read in part: We are experiencing supply challenge from vendors.	F 565	action. This plan of correction serves as the allegation of substantial compliance. Prefix Tag: 0565 - 483.10 It is the intent of this facility to resolve dietary grievances that are reported during resident council meetings. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/23/22, Certified Dietary Manager, Registered Dietician, Activities Director, and Social Workers met with identified residents who had attended the last 10 (ten) Resident Council Meetings that voiced dietary concerns. The IDT worked with each resident to address their dietary wants and needs and special food preferences. Preferences shared were used to update the meal tickets. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/25/22, Director of Dining Services educated dining service staff on stocking all meal carts and dining rooms appropriately with condiments. New hires will be educated by Director of Dining Services or dietary supervisor during orientation process. On 5/23/22, Certified Dietary Manager, Registered Dietician, Activities Director,	

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F 565	Continued From page 3 Regarding the baked and sweet potatoes being served undercook the response read: we will look into that and correct it. The response was signed by the Administrator. f. Review of the 12/02/21 RC minutes revealed the following dietary concerns: potatoes and green beans were not cooked long enough, and food was served cold in the rooms. The response to the "food concerns" read: addressed by staff who attended the meeting. The response was signed by the Administrator. g. Review of the 01/03/22 RC minutes revealed the follow dietary concerns: the council expressed concerns about not having condiments requested in the dining room like ketchup, honey mustard or ranch. The DM reminded them of the supply issues they were having. The response form was blank and was signed by the Administrator. h. Review of the 02/10/22 RC minutes revealed the following dietary concerns: the council expressed concerns about not having everything needed on their meal tray or when being served in the dining room such as water, salt, pepper, and other condiments. The response to the concerns of not having needed items such as water, salt and other condiments on meal trays read: staff educated to ask if anything else was needed before leaving room/dining table. Spoke with DM about stocking cabinets and assigned duties of staff. The response was signed by the Administrator.	F 565	and Social Workers met all residents to interview them about any dietary concerns and to address their dietary wants and needs and special food preferences. Preferences shared were used to update the meal tickets. Residents were educated and encouraged to report unsatisfactory meal service immediately. On 5/25/22, Director of Dining Services educated dietary supervisors to update weekly menu in each dining room based on changes in menu. Any changes in the menu will be communicated with residents as they come into dining room to order their meal. During the event that Director of Dining Services hires a new supervisor, education will be provided during orientation process. On 5/24/22, Director of Quality and Education educated nursing staff on reading meal tickets and placing appropriate condiments requested by residents on meal tray. Director of Quality and education will educate new hires during orientation process. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 5/25/22, comment cards were created. These cards will be utilized during meal service for residents to rate their meal and make suggestions on how to improve quality. These comment cards will be delivered to the Certified Dietary Manger to review and update food preferences	

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F 565	Continued From page 4 A RC meeting was held on 05/05/22 at 10:19 AM with 13 members of the RC. The council reported having "food concerns" with cold food and as well as the food "not being good". A follow up interview was conducted with Resident #117 on 05/05/22 at 2:15 PM. Resident #117 confirmed that she regularly attended resident council and she continued to have issues with not having condiments on her meal tray and the vegetables were hard and undercooked. Resident #117 stated that last week the baked potato was not done and was "so hard you couldn't put the spoon through it." The Activity Director (AD) was interviewed on 05/05/22 at 2:11 PM who confirmed that she took notes during each RC meeting and then sent an email to the department head that was affected and copied the Administrator on the email as well. The AD stated that food was always a major discussion in RC, but it was never a consistent issue. Sometimes the council would complaint that the food was undercooked and sometimes it was overcooked. She added that they seemed to resolve one topic and move on to something else and sometimes a resolved issue would come back up later. The AD stated she always received a response from the department head, and she would take that response to the RC meeting the following month. The DM was interviewed on 05/05/22 at 3:01 PM and stated that he or a member of his staff attended the RC meetings. He stated that after the RC meeting he would receive an email from AD with any concerns voiced during the meeting and he was responsible for responding to and determining how to address the concern. Once	F 565	based on individual requests. During quarterly QAPI meetings, Certified Dietary Manager will report on food quality concerns. During care plan meetings, Certified Dietary Manager and/or Registered Dietician will query the residents/family meal service, temperature of food, and food quality expectations are being met. During quarterly QAPI meeting, Activities Director will bring Resident Council Minutes and report on any residents complaints and grievances and their resolution. Director of Activities created a new template for Resident Council Minutes. Instead of narrative form, a bulleted list will be utilized. This will be beneficial to list specific resident concerns and suggestions. Monthly minutes will be distributed to relevant Department Heads for concerns/suggestions to be addressed. Final minutes with specific action plans will be turned into the Nursing Home Administrator. The NHA will review and ensure compliance and follow through on concerns. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Activities Director and Certified Dietary Manager with oversight	

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F 565	Continued From page 5 the concern had been investigated and resolved it was sent to the Administrator for approval. The DM stated that sometimes the council would complain of the vegetables being undercooked and hard and then it would be too soft and mushy. He stated he had switched to green beans because the residents seemed to like those. The DM stated that he did not believe the issues voiced in resident council represented a concern of the majority of the residents and he could not alter the menu as a whole so he tried to correct individual concerns. He added the vegetables were cooked to a point where they were palatable and further explained he had his staff interacting with the residents after meals to see if they enjoyed the meal and they always received positive feedback. The DM stated he had no additional documentation to the resolutions provided to the RC except what was documented in the RC meeting minutes. The Administrator was interviewed on 05/05/22 at 2:26 PM. The Administrator confirmed that the AD took notes during the RC meeting and would send an email to the department head and to her. The Administrator stated she generally gave the department head a couple of days to submit their response and follow up and if she agreed with the response then the response was signed off. The Administrator stated she would have expected the DM to identify who was complaining and see if it was a mastication (chewing) issue and to see why the vegetables were undercooked. The Administrator confirmed that she had no other documentation and if the follow up was provided via email the email was attached to the RC minutes. She added that the AD attended the Quality Assurance (QA) meeting quarterly but did not always bring the RC minutes which she stated	F 565	by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Activities Director and Certified Dietary Manager will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 565	Continued From page 6 might be helpful in resolving some of the dietary issues.	F 565		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to label, date, and seal stored food items in 2 of 2 kitchens (main kitchen and satellite kitchen located on the first floor at the front of the facility). The facility also failed to discard stored foods after the manufacturer's expiration date in 2 of 2 kitchens (main kitchen and satellite kitchen). These practices had the potential to affect all residents who receive oral food nutrition. The findings included:	F 812	Prefix Tag: F0812 - 483.60 It is the intent of this facility to label, date, seal, and store food items appropriately. It is the intent of this facility to discard stored foods after manufacturer's expiration date. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	5/27/22

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F 812	Continued From page 7 1. A brief tour of the satellite kitchen located on the first floor in the front of the facility on 05/02/22 at 10:59 AM with Cook #1 and Dietary Supervisor #1 revealed the following items which had all been removed from their original packaging: In the mini freezer located under the toaster: - A press and seal plastic bag with 3 frozen hamburger patties unlabeled or dated with visible ice crystals on the surface - A partially used and unsealed bag containing 8 frozen chicken tenders unlabeled or dated - A partially used and unsealed bag of potato wedges unlabeled or dated - A partially used and unsealed bag of French fries unlabeled or dated - A metal steam table container which held 4 frozen fish filets with a prepare by date of 4/26 - A clear plastic bag of frozen chicken tenders unlabeled or dated which showed visible ice crystals on the surface In the two-glass door reach-in cooler: - 5 cartons of chocolate milk with no manufacturer's expiration date - An open sleeve of pasteurized American cheese unlabeled with an open/expiration date In single-door solid front reach-in refrigerator: - 2 containers of probiotic yogurt with an expiration date of 5/1/22 - 1 container of strawberry yogurt with an expiration date of 5/1/22 An interview on 05/02/22 at 11:15 AM with Cook #1 and Dietary Supervisor #1 revealed they did not realize the food items located in the freezer and cooler were unlabeled and undated nor did	F 812	On 5/2/22 and 5/4/22, Director of Dining Services labeled all unlabeled food items with open date and appropriate expiration date. Any expired food items were thrown out. Food items that had ice crystals present and those identified as being spoiled were thrown out. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice: On 5/25/22, Director of Dining Services educated dining supervisors on Food Safety Walk through utilizing opening and closing checklists daily. Daily opening and closing checklists will be turned into Administrator to ensure compliance, the checklists will be reported during Quarterly QAPI meeting. On 5/25/22, Director of Dining Services educated all dining staff members on returning food items back to manufacturer if expiration date is not placed on food or drink products. These products will be placed in a separate location with a appropriate signage to identify and avoid co-mingling with usable products in the kitchen. New hires will be educated by Director of Dining Services or supervisor during orientation process. On 5/25/22, Director of Dining Services educated all dining staff members to utilize Ziploc bags to safely store food instead of utilizing plastic wrap. Proper food storage was reviewed with staff during staff meeting to remind them of	

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F 812	Continued From page 8 they realize the food items located in the refrigerator had expired. Both had been trained all items should be labeled and dated when removed from their original packaging and items should be discarded if they have reached their expiration dates. 2. A follow-up observation of the satellite kitchen located on the first floor at the front of the facility on 05/04/22 at 10:30 AM with the Food Service Director (FSD) revealed the following items which had all been removed from their original packaging: In the mini freezer located under the toaster: - A partially used and unsealed bag of French fries unlabeled or dated - A metal steam table container which held 3 frozen fish filets with a prepare by date of 4/26 Under the food preparation counter, a pan was on the lower shelf which contained multiple spices: - A smaller metal container which held an unidentifiable reddish-orange spice with clear plastic wrap partially covering the container and the other portion exposed to air unlabeled or dated 3. An observation of the main kitchen on 05/04/22 at 10:45 AM with the FSD revealed the following: In the milk cooler: - 5 cartons of chocolate milk with no manufacturer's expiration date In the side-by-side freezer: - A clear plastic bag of frozen chicken tenders unlabeled or dated which showed visible ice	F 812	safe handling, storage, labeling, and dating of food products. New hires will be educated by Director of Dining Services or supervisor during orientation process. On 5/25/22, Director of Dining Services educated all dining staff members on new labeling process that includes using the open date as well as the use by date. New hires will be educated by Director of Dining Services or supervisor during orientation process. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Dining QAPI checklist to be completed quarterly by Director of Dining Services/Administrator/Executive Director/Senior Director of Hospitality to ensure effectiveness of safety walk through. Daily opening and closing checklists will be turned into Administrator to ensure compliance, the checklists will be reported on quarterly by Director of Dining Services during Quarterly QAPI Committee Meeting. Semi-Annually, Director of Dining Services will complete dining services QAPI checklist to audit overall compliance for food safety and sanitation. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when	

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F 812	Continued From page 9 crystals on the surface - 4 hotdog wieners wrapped in a clear plastic wrap unlabeled or dated - A large partially used and unsealed plastic package of hotdog wieners which contained visible ice which had formed were unlabeled or dated - An opened white paper box with a clear plastic lining containing an unidentifiable breaded food item. The clear lining was not resealed, showed visible ice crystals on the surface, and the packaging did not contain a label or date 4. A follow-up observation to the main kitchen on 05/04/22 at 2:15 PM with the FSD revealed the following: In the side-by-side refrigerator: - A paper box of raisins with an opened lid was labeled 12/16/21 with no expiration date. - A large clear plastic bag which was unsealed containing a head of lettuce. The lettuce showed signs of spoilage with the leaves which had turned from its original color to a yellow-brown discoloration. - A cardboard egg tray which contained 15 whole eggs with no label or use by date on the crate In the walk-in fridge: - A plastic container of sliced cheddar cheese which was opened and contained no labels with an open or discard date. When the package was lifted, the bottom of the orange cheese showed 3 large areas of a white and green circular fuzzy substance attached. - 2 large plastic bags of spinach leaves which contained a visible reddish brown liquid substance seeping through the bag and onto the spinach leaves. When the bags were lifted, the bags of spinach leaves contained small pin holes	F 812	corrective action will be completed. These corrective measures will be monitored by the Director of Dining Services with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Dining Services will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 812	Continued From page 10 in the plastic from the manufacturer. An interview with the FSD on 05/04/22 at 2:45 PM revealed he was unable to explain why items were found in the kitchen and available for use/resident consumption were unlabeled or dated, expired, or with signs of spoilage. The FSD stated all dietary staff should label, store, rotate and discard items when they have reached their expiration date or show signs of spoilage. The FSD indicated the coolers, refrigerators, and freezers should be checked at least weekly and items discarded appropriately. An interview with the Administrator on 05/05/22 at 11:21 AM revealed she was made aware the satellite on the first floor and main kitchen had food items observed which were unlabeled or dated. She also indicated she had been made aware of item which were expired and that showed signs of spoilage that were available for staff usage and resident consumption. The Administrator stated the dietary staff should label all food items stored and all items should be discarded by their expiration dates, storage dates, or if they show signs of soilage.	F 812		
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	F 880		5/27/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	102 LEONARD AVENUE NEWTON, NC 28658

(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
F 880	Continued From page 11	F 880		

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 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

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F 880	Continued From page 12 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 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 observation, record review, and staff interview, the facility failed to ensure staff donned Personal Protective Equipment (PPE) according to the Center of Disease Control and Prevention (CDC) to include a gown, gloves, eyewear, and a N-95 mask when Nurse Aide #1 (NA #1) entered a resident's room who was under transmission-based precautions (TBP) labeled Quarantine Enhanced Barrier Precautions for 1 of 1 residents reviewed for infection control (Resident #331). Findings included: The Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 2/2/22 indicated the following statement under Section 2.	F 880	Prefix Tag:F-880 - 483.80 It is the intent of this facility to maintain an infection control program designed to provide safe, sanitary, and comfortable environment to prevent development and transmission of communicable diseases and infections. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 5/5/22, Director of Nursing provided education for the nurse aide identified about donning appropriate PPE according to the Transmission Based Precautions signage on the resident's door. 2) How the facility will identify other residents having the potential to be	

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F 880	Continued From page 13 Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection: HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Resident #331 was admitted to the facility on 04/28/22 for short term rehabilitation. An observation and interview on 05/02/22 at 12:18 PM revealed NA #1 knock on Resident #1's door and speak to the resident from the doorway. The signage on the door indicated Resident #1 was under the transmission-based precautions: "Quarantine Enhanced Barrier Precautions" which indicated a gown, gloves, eyewear, and a N-95 mask were to be worn when in entering the room. NA #1 entered the room wearing only a surgical mask and retrieved two clear plastic bags and exited the room carrying them in his ungloved hand. One bag was observed to contain facility linen and the other contained trash. The surveyor immediately stopped NA #1 when he exited Resident #1's room and asked him about the observation. NA #1 indicated he had been educated to don a gown, gloves, eyewear, and N-95 mask when he went in a resident's room who was on Quarantine Enhanced Barrier Precautions. NA #1 stated he had not intended to go in the room and completely forgot to don the PPE on when he entered. An interview on 05/05/22 at 1:40 PM with Medication Aide #1 (MA#1) revealed she was	F 880	affected by the same deficient practice: On 5/21/22, Infection Preventionist RN completed an audit on all other resident's placed on Transmission Based Precautions for appropriate signage. On 5/23/22, Director of Nursing and Infection Preventionist began education with all facility staff to read and follow the appropriate PPE based on Transmission Based Precautions signs on the resident's door. All new hires will be educated during orientation process by Director of Quality and Education using Employee Training and Certification Personal Protective Equipment (PPE) form. On 5/23/22 - 5/26/22, Director of Nursing and Infection Preventionist provided mandatory education with all facility staff on Contact Precautions and appropriate PPE that should be worn when entering and exiting a resident room on Transmission Based Precautions. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Ongoing: Infection Preventionist or facility appointed designee will audit staff donning PPE on identified residents on Quarantine Enhanced Barrier Precautions prior to entering resident's room. Audits will be conducted once weekly for four weeks and then monthly for eleven months. Audits will be turned into Nursing Home Administrator and reported during	

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F 880	Continued From page 14 assigned to the medication cart where Resident #1 resided on 05/02/22 during day shift. MA #1 indicated Resident #1 was a new admission and was on TBP: Quarantine Enhanced Barrier Precautions because he was unvaccinated upon admission. MA #1 stated she was not aware staff had entered Resident #1's room without PPE but had been educated to stop staff and remind them to don full PPE to include a gown, gloves, eyewear, and a N-95 mask before entering the room of all residents on Quarantine Enhanced Barrier Precautions and alert the nurse if she saw. An interview on 05/05/22 at 2:02 PM with the Director of Nursing (DON) revealed she was not aware NA #1 had been observed to not don his PPE when he entered Resident #1's room; however, confirmed Resident #1 was on TBP: Quarantine Enhanced Droplet Precautions due to his vaccination status upon admission. The DON stated all staff had been educated to don full PPE to include a gown, gloves, eyewear, and a N-95 mask before entering the room of a resident on Quarantine Enhanced Droplet Precautions and wondered what NA #1 was doing with the bags since Resident #1 is continent of bowel and bladder and performs his own personal Activities of Daily Living (ADL) care and asked that we speak with NA #1 together. A follow-up interview on 05/05/22 at 2:10 PM with NA #1 and the DON revealed NA #1 stated on 05/02/22 during day shift he had approached Resident #1's room to speak to Resident #1 and his family member to see if they needed anything which he did from the threshold of the door when he noticed a soiled towel near the sink in Resident #1's room. NA #1 stated without a	F 880	Quarterly QAPI Committee Meeting. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Infection Preventionist with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Infection Preventionist will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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second thought, he entered the room to retrieve it and noticed the trash also needed to be emptied, so he quickly grabbed both bags and exited Resident #1's room when the surveyor approached him. NA #1 explained he immediately realized he had not donned on the PPE according to the signage posted on both Resident #1's room and the isolation cart placed directly outside Resident #1's room. NA #1 elaborated to say, "Had I not saw the linen, I wouldn't have ever gone in the room. I've thought about it all week and feel terrible about it. It won't happen again."

An interview on 05/05/22 at 2:15 PM with the Administrator revealed she was familiar with Resident #1 and expects all staff to don the appropriate PPE posted on all TBP signage. She stated staff should don full PPE once they cross the doors threshold to include: a gown, gloves, eyewear, and a N-95 mask before entering rooms labeled Quarantine Enhanced Barrier Precautions.