STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	C 09/22/2020

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CAROLINA CARE HEALTH AND REHABILITATION	111 HARRILSON STREET CHERRYVILLE, NC 28021

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 09/21/20 through 09/22/20. 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# WHXT11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Infection Control Survey was conducted in conjunction with a complaint survey on 09/21/2020 through 09/22/20. Four of the five allegations were unsubstantiated. One allegation was substantiated. Event ID #WHXT11.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services	F 582		11/5/20

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

Electronically Signed | 10/15/2020

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F 582	Continued From page 1 available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interviews with staff , resident's responsible party and record reviews the facility failed to provide a Notice of Medicare non-coverage (NOMNC) letter for a resident discharged from Medicare Part A when the resident stopped participating in therapy and remained in the facility for 1 of 1 residents	F 582	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all	

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F 582	Continued From page 2 reviewed for notification. (Resident #4). Findings Included: Resident #4 was admitted on 05/18/20 with diagnosis which included hypertension and Parkinson's. Resident #4's quarterly minimum data set (MDS) assessment dated 08/24/20 revealed she was assessed as moderately cognitively impaired. She required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. She required supervision with eating. Review of a Physical Therapy discharge summary dated 06/29/20 revealed Resident #4 was discharged from therapy services on this date due to reaching her highest practical level achieved. A review of Resident #4's chart revealed there was not a completed Notice of Medicare non-coverage (NOMNC) letter for Resident #4. Review of a resident note dated 08/25/20 at 2:14 PM written by the Business Office Manager revealed the following information. Resident #4's family member had requested a copy of the NOMNC however the Business Office Manager did not have a copy and told the family member she would ask for it. The family member stated the previous social worker had told him Resident #4 was still being covered by Medicare on 07/06/20 and no one from the facility had contacted him letting him know she was no longer covered. The note revealed the family member was frustrated they owed such a large amount of	F 582	federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F 582 SS = D 1. Corrective action has been accomplished for the alleged deficient practice for Resident #4 - Medicaid/Medicare Notice of Medicare non-coverage (NOMNC) was issued on 10/12/2020 by the Social Worker. 2. All residents with Medicare insurance have the potential to be affected by the same alleged deficient practice; therefore, the Regional Reimbursement Manager has conducted an audit of all residents with Medicare Insurance coverage in the last 6 months. Corrective action taken for any other residents identified as being affected by the same deficient practice. 3. Measures put into place to ensure alleged deficient practice does not recur include: • Experienced Social Worker hired and trained on 9/06/2020 to issue NOMNCs timely and to the appropriate parties. • Increased Medicare meeting to 3 times weekly to facilitate increased communication with IDT team - Business Office Manager, Social Worker, Therapy Director and Nursing Home Administrator. • Administrator will review the NOMNC's weekly for 1 month.	

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F 582	Continued From page 3 money when they thought Medicare was still paying. During an interview on 9/21/20 at 10:52 AM the facility's Regional Ombudsman stated she had received concerns from the family of Resident #4 regarding not receiving a NOMNC letter in July 2020 notifying them Resident #4's Medicare coverage was ending. She stated the family had received a bill from the facility for twenty thousand dollars at the first of August and they had concerns of how they were going to pay. The interview revealed the Ombudsman had attempted to contact the facility regarding the situation but hadn't heard back from them yet. During an interview on 9/22/20 at 10:30 AM an interview was conducted with the Business Office Manager, who stated the Social Worker had left the facility around July 2020 and she was filling in as the interim. The interview revealed the Business Office Manager was handing the NOMNC letters sent to families and had spoken with Resident #4's family member. She stated the family was concerned on July 21,2020 because they had not received a NOMNC letter and received a bill for twenty thousand dollars. She stated the family expressed they didn't have the money to pay the bill and would have appealed the decision if they had received a notification letter that coverage was ending. She stated she investigated the situation and notified the Administrator because she could not find where the previous Social Worker had sent a NOMNC form to the family. She stated she decided to let the Administrator handle the situation. On 9/22/20 at 11:35 AM an interview was conducted with the Director of Nursing (DON).	F 582	• The Regional Accounts Receivable Manager will review the NOMNCs issued during the month as part of the Triple Check process monthly for 3 months. 4. The Administrator and Quality Assurance/Performance Improvement (QAPI) committee analyze the data and report any patterns/trends to the Regional Operations Manager for immediate correction. Findings of the QAPI committee will be reviewed monthly for 3 months to ensure continued compliance. The QAPI committee will evaluate the effectiveness of the above plan and will make additional interventions based on the audits to ensure continued compliance.	

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F 582	Continued From page 4	F 582		

She stated the Social Worker had left the facility around July 2020. The interview revealed the DON and Administrator were trying to ensure the NOMNC letters were being sent to the families however they could not find where a letter was sent to Resident #4's family. The DON stated it may have just been missed due to staff turnover in the facility.

On 9/22/20 at 12:30 PM an interview was conducted with the Administrator. The interview revealed she was notified by the Business Office Manager Resident #4's family had not received a NOMNC letter. She stated she looked for it however could not find where one was sent by the previous Social Worker. She stated the facility had hired a new Social Worker who had been in the facility for two weeks and he would be taking over the NOMNC letters moving forward.

During an interview on 09/22/20 at 3:30 PM with Resident #4's Responsible Party (RP), he stated he had called the facility's Regional Ombudsman after he received a bill for twenty thousand dollars when Resident #4 was switched to private pay without being notified. The interview revealed Resident #4 was originally admitted into the facility for rehab services with the goal of returning to home. The RP stated when Resident # 4 was admitted she had other insurance in addition to Medicare. The facility had advised Resident # 4 be under Medicare insurance since she was receiving therapy services. He stated after receiving the bill from the facility he called and was told Resident #4's insurance had run out and she was listed as private pay since July 7, 2020. He stated he had spoken with the previous Social Worker who had told him Resident #4 would not be private pay due to her having other

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F 582	Continued From page 5 insurance in addition to her Medicare. He stated he never received a NOMNC form from the facility to let him know what date Resident #4's Medicare had run out due to not receiving therapy services. The interview revealed if he had received the form he would have appealed and was upset he didn't get the chance to appeal. He stated he shouldn't have been surprised with a bill and should have had notification ahead of time. The responsible party stated he had sent two email requests to the Administrator and Business Office Manager wanting a NOMNC form to know exactly the date Resident #4's insurance services were terminated.	F 582		
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 arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		11/5/20

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F 880	Continued From page 6 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 transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 7 §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 observations, record reviews, staff interviews and review of the facility's Infection Control Policies and Procedures, the facility failed to implement the facility's policy on enhanced droplet-contact precautions and the Centers for Disease Control and Prevention (CDC) recommended practices when staff working on the isolation hall 1. failed to perform hand hygiene before and after entering a resident's room, failed to dispose of used gloves appropriately, 2. failed to wear a face mask on the isolation unit, failed to wear required personal protective equipment (PPE) correctly when staff used the same reusable gown and lab coats for more than one resident on enhanced droplet precautions due to being newly admitted, 3. and staff failed to follow CDC guidelines and their own policy for cleaning and disinfecting of resident care equipment when equipment was cleaned in a resident's room and taken directly into another resident's room. These failures occurred during a COVID-19 pandemic. The findings included: The CDC guidelines entitled "Infection Control for Nursing Homes" last updated July 15, 2020 indicated the following statements: *Healthcare Personnel (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing	F 880	The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Corrective action has been accomplished for the alleged deficient practice □ not adhering to proper infection control prevention procedure □ specifically for residents on the intake/isolation hall related to enhanced droplet -contact precautions for Residents# 3, 4 and 6 on 09/22/2020. a. 1:1 Staff education provided immediately by the Director of Nursing Services (DON)/Infection Preventionist (IP) and Regional Clinical Manager with the staff identified as violating policy/procedure for infection control. Education included when to perform hand hygiene □ before and after entering a resident room, proper disposal of used gloves, wearing a face mask properly and	

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F 880	Continued From page 8 PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. *HCP should perform hand hygiene by using Alcohol Based Hand Sanitizer (ABHS) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. *Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. *HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. *Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. *Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. *Dedicated medical equipment should be used when caring for patients with suspected or confirmed SARS-CoV-2 infection. *All non-dedicated, non-disposable medical	F 880	continuously wearing of PPE while on the isolation unit, proper use of gowns and cleaning and disinfecting of equipment between uses. b. All equipment identified as unclean, was removed from patient care areas and cleaned in soiled linen per the company policy for disinfecting equipment. c. Facility discontinued use of re-usable PPE in the form of lab coats on the isolation/intake hall on 9/22/2020. 2. Other residents who are on isolation have the potential to be affected by the same alleged deficient practice; therefore, the Regional Clinical Manager in conjunction with the Infection Preventionist has conducted an audit of current residents and no other residents were found to be affected by the deficient practice. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: " DON/IP and facility Treatment Nurse attended and completed additional SPICE training for infection control on 9/28 □ 9/30/2020. " Facility hired permanent Staff Development Coordinator (SDC) on 9/23/20 to assist the DON/IP in conducting all training and surveillance for Infection Control. " SDC began observation/surveillance rounds of staff on 10/2/20 to ensure proper donning and doffing of PPE, competency quizzes to ensure staff can verbalize the company policy as well as	

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F 880	Continued From page 9 equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies. *Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. *Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an Environmental Protection Agency (EPA)-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed. The CDC's guidelines entitled "Environmental Cleaning Procedures" last updated 04/21/2020 and reviewed on 09/22/2020 indicated the following statements: *Isolation or cohorted areas with suspected or confirmed cases of infections requiring transmission-based precautions are considered high-risk areas, particularly for: 1. environmentally hardy pathogens (resistant to disinfectants) 2. multidrug-resistant pathogens that are highly transmissible and/or are associated with high morbidity and mortality. The three types of transmission-based precautions are: 1. airborne 2. contact 3. droplet	F 880	demonstrating the use of good PPE utilization and adherence to policy and best practices while providing patient care and while on the isolation/intake unit. " DON and SDC began In-service/reeducation for all staff related to the Centers for Disease Control (CDC), State Guidelines and Company policy and expectations related to Infection Prevention and Control. • DON and SDC began In-service/reeducation for all staff related to the Centers for Disease Control (CDC), State Guidelines and Company policy and expectations related to Infection Prevention and Control. This in-service - reeducation and continued education included: when to perform hand hygiene – before and after entering a resident room, proper disposal of used gloves, wearing a face mask properly and continuously wearing of PPE while on the isolation unit, proper use of gowns and cleaning and disinfecting of equipment between uses. Education will be completed by the DON/IP or SDC by 11/5/20. " Increased surveillance rounds during Room Round audits 5 times per week to include a weekend day will be completed by Nursing Supervisor and Department Managers for 1 month; then at least weekly for 3 months to identify any variance from policy with regard to adhering to the policy and procedure for Infection Prevention and Control. " Directed Plan of Correction (DPOC)	

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F 880	Continued From page 10 *Transmission-specific PPE is required for all cleaning sessions in areas under transmission-based precautions, according to facility policy. *PPE should always be put on and removed following the indications posted / recommended by Infection Control and Prevention (ICP). *These are the best practices for environmental cleaning in transmission-based precaution areas: *Clean these areas after non-isolation areas. *Change environmental cleaning supplies and equipment, including PPE, directly after cleaning these areas. *If resources permit, dedicate supplies and equipment for these areas *Post the type of precaution and required procedures, including required PPE, on visible signage outside the isolation area, ensuring that these indications are understood by cleaning staff. *Do not bring cleaning carts into the area-keep them at the door and only bring the equipment and supplies needed for the cleaning process. A review of the facility's Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed COVID-19 revised on 05/26/2020 indicated the following statements: *Prevention of infection to include educating staff and ensuring that they adhere to proper	F 880	steps are being implemented by the facility as recommended and will be completed by the NHA, The Governing Body for the Company and Regional Clinical Manager. Part of this DPOC includes education in the form of the following training/education: o http://youtu.be/t7OH8ORrg - Sparkling Surfaces o http://youtu.be/xmYMUly7qiE - Clean Hands o https://youtu.be/1ZbT1Njv6xA - Closely Monitor Residents o https://youtu.be/7srwrF9MGdw -Keep COVID-19 Out! o https://youtu.be/YYTATw9yav4 - Lessons " Facility held an impromptu Quality Assurance meeting to conduct a Root Cause Analysis on 10/14/20 with the Medical Director, DON/Infection Preventionist, Staff Development Coordinator, Regional Operations Manager, the Regional Clinical Manager, Administrator and select members of the QAPI committee. 4. The DON/Infection Preventionist and/or SDC will review data obtained during rounds, analyze the data and report patterns/trends to the QAPI committee every month for 6 months. The QAPI committee and Governing Body will evaluate the effectiveness of the above plan, and will add additional interventions, based on identified outcomes, to ensure	

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F 880	Continued From page 11 techniques and procedures; and following established general and disease-specific guidelines such as those of the CDC. *Hand hygiene must be done before entering and leaving resident room. *Do hand hygiene before and after entering the room. Clean gloves need to be put on before entering each room and should be removed when leaving each room with hand hygiene completed after leaving room. *When gowns are used, they must be used only once and discarded into appropriate receptacles located in the room in which the procedure was performed. *Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. *Residents will be on contact isolation for twenty days after admission/readmission and 300 hall rooms are designated for all new admissions and return from hospital residents. If direct care is provided you should wear a reusable isolation gown and a clean gown should be hung on the resident's door at the beginning of each shift to be used for that shift by that staff caring for the resident that shift and removed before leaving the shift. During the entrance conference on 09/21/2020 at 09:20 AM, the Director of Nursing (DON) indicated the 300 hall was the isolation unit designated for newly admitted or readmitted residents to be quarantined for twenty days and for COVID-19 positive residents. The DON stated	F 880	continued compliance.	

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	345255	A. BUILDING _____ B. WING _____	C 09/22/2020

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staff were required to wear full PPE that included face mask, eye protection, gown, and gloves when providing care to residents under quarantine or positive for COVID-19 because all these residents were on enhanced droplet-contact precautions. The DON further stated there were currently no positive cases of COVID-19 in residents in the facility. The DON indicated she was also acting in the role of the Infection Prevention and Control Professional (IPCP).

1. A review of the facility's list of Admissions/Readmissions indicated:

Resident #3 was admitted on 09/15/2020 from the hospital to room 303 (private room on quarantine hall).
Resident #6 was admitted on 09/09/2020 from the hospital to room 304 (private room on quarantine hall).

Review of the medical records of the above-listed residents revealed they both had a negative test for COVID-19 prior to coming to the facility. The medical records further revealed both residents were placed on enhanced droplet-contact precautions.

A continuous observation was made on 09/21/2020 from 10:44 AM to 10:53 AM of Physical Therapist (PT) #1. PT #1 was observed in Resident #3's room wearing gloves waiting for a transport wheelchair to be cleaned in the room by the Director of Housekeeping (DOH). PT #1 proceeded out of Resident #3's room, room 303, and entered Resident #6's room, room 304, with the transport wheelchair. The PT came out of Resident #6's room wearing gloves and without

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the transport wheelchair and threw away her gloves in a trash can in the living room area across the hall from Resident #6's room. PT #1 was not observed performing hand hygiene after coming out of room 303 and before entering room 304 or after discarding gloves.

An interview on 09/21/2020 at 11:00 AM with PT #1 revealed she had received education on hand hygiene and was told to wash her hands for twenty seconds or use ABHS before and after providing care to each resident. PT #1 revealed she had come onto the 300 hall for the first time and had washed her hands before going into Resident #3's room and was going into the room to get the transport wheelchair for Resident #6 because Resident #6 has asked to go to the bathroom. PT #1 stated she did not touch anything in Resident #3's room and rolled the wheelchair to Resident #4's room wearing gloves and did not touch anything in the room or Resident #6. PT #1 said she came out after taking in the wheelchair to get more supplies to take back to Resident #6's room. PT #1 indicated she thought because she was wearing gloves and the transport wheelchair had been cleaned with germicidal wipes and she had not touched either Resident #3 or Resident #6, she did not have to perform hand hygiene between these two rooms in this instance. PT #1 stated there were no ABHS stations in resident rooms and the facility's policy was not to put gloves in the resident's trash can.

An interview on 09/21/2020 at 1:15 PM with the Director of Nursing (DON) revealed PT #1 should have washed her hands or used ABHS after coming out of Resident #3's room and before entering Resident #6's room. The DON stated it is

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the facility's policy not to dispose of gloves in the residents' waste can in the room. She stated that if the Resident #3 and Resident #6 had been on true isolation and positive for COVID-19, there would have been soiled linen and trash bins in the residents' rooms. The DON stated that all new admissions were tested prior to admission or leaving the hospital and residents who tested positive for COVID-19 were not admitted. According to the DON, newly admitted residents were kept on enhanced droplet-contact precautions for twenty days and staff wore reusable cloth gowns that were hung on the back of the residents' doors on a hook. She said that one gown was used per staff for each resident and changed each shift. The DON stated PT #1 could have used the ABHS on the wall near Resident #3's room to perform hand hygiene before going into Resident #6's room.

2. A continuous observation was made on 09/21/2020 from 3:13 PM to 3:18 PM of Nurse #3. Nurse #3 was at the nurse's station on the 300 hall where newly admitted/readmitted residents were isolated for twenty days and was not wearing any face mask. A second continuous observation was made on 09/21/2020 from 3:26 PM to 3:31 PM of Nurse #3. Nurse #3 continued to wear no face mask at the nurses' station while she talked to staff and others. Nurse #3 was greater than six feet from another person.

A continuous observation was made on 09/21/2020 from 3:19 PM to 3:25 PM of Nurse Aide (NA) #1. NA #1 obtained a cloth reusable gown hanging on double doors in hallway and wore it into a resident's room on the 300 hall and returned it to the hook on the double doors after she used it.

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F 880	Continued From page 15 An interview on 09/21/2020 at 3:32 PM with NA #1 revealed she worked as needed at the facility and had just returned to work recently. NA #1 was asked about the use of PPE in resident rooms who were on isolation and stated she could not answer because she only worked occasionally and not every day and had not received any in-service on how to use PPE correctly. An interview on 09/21/2020 at 3:35 PM with Nurse #3 revealed she used a reusable white lab coat during her shift when she went into resident rooms on the 300 hall and would wear the same one into multiple resident rooms. Nurse #3 stated there were two NAs assigned to the 300 hall and they used reusable gowns during the shift and used one per resident and kept them in the residents' rooms on a hook on the back of the door. Nurse #3 indicated the reusable gowns were discarded in the soiled laundry at the end of the shift. Nurse #3 further stated the reusable gowns hanging on the back of the double doors in the middle of the 300 hall were used by the therapists. An interview on 09/22/2020 at 09:38 AM with Nurse #1 revealed nurses and nurses' aides used reusable gowns on the 300 quarantine hall and used one gown per resident per nurse or nurse aide and discarded at the end of the shift. Nurse #1 indicated she was the unit coordinator for the facility and provided education to the nursing staff regarding the use of PPE and hand hygiene. Nurse #1 stated that all staff should wear a face mask at all times in the facility. Nurse #1 further stated as needed (PRN) staff were educated at staff meetings and mandatory education in-services.	F 880		

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An interview on 09/22/2020 at 10:31 AM with the Rehab Director revealed therapists provided therapy services to residents on the 300 hall in each resident's room. The Rehab Director further indicated the therapists retrieved a clean gown from the clean linen closet at the beginning of the day and used the same gown all day when providing therapy to multiple residents on the 300 hall unless the resident was on isolation precautions such as for Clostridium Difficile (C-diff) for which they would use a disposable gown. The Rehab Director further stated she expected therapy staff to perform hand hygiene between residents and resident rooms.

A review of the facility's inventory supply log as of 09/21/20 indicated the facility had 1,650 disposable gowns in stock.

An interview on 09/22/2020 at 12:17 PM with Nurse #3 revealed she thought it was acceptable to remove her face mask at the nurses' station if she was greater than six feet away from another person. Nurse #3 stated she had been advised by her doctor that wearing a face mask all the time could cause her harm because she had chronic bronchitis. Nurse #3 further stated she took her mask off when she was greater than six feet away from another person to get a break from wearing the mask all the time.

An interview on 09/22/2020 at 12:10 PM with the DON revealed she expected all staff to wear face masks at all times in the facility. The DON stated reusable gowns were being used on the quarantine hall (300 hall) because they were attempting to preserve the disposable gowns for use in case of positive COVID-19 cases. The

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DON stated she had pulled the lab coats that were being used by the nurses and updated the facility's policy to reflect the same gown would be worn by the same healthcare professional when interacting with residents on the admission unit. The DON further stated education had been provided one on one with NA #1 who had started back to work on as needed basis.

3. A continuous observation was made on 09/21/2020 from 10:44 AM to 10:48 AM of the DOH finishing cleaning a transport wheelchair in Resident #3's room and giving it to PT #1. The DOH was in the process of cleaning the transport wheelchair with wipes. After he gave the wheelchair to PT #1, he performed hand hygiene.

An interview on 09/22/2020 at 09:38 AM with the DOH revealed he would have normally taken the wheelchair to an outside location
where he cleaned them but he was bringing Resident #3 a bigger wheelchair so he cleaned the transport wheelchair with Flex wipes in the room because PT #1 needed it for another resident. The DOH stated he knew he should have taken the transport wheelchair outside of the room to be cleaned and that it was not considered to be clean because he cleaned it in the room even though he stated he wiped it down thoroughly. According to the DOH, he should have taken the transport chair to the outside area behind the facility where they have water and an area to clean equipment.

An interview on 09/22/2020 at 11:18 AM with the DON revealed she did not expect a wheelchair to be cleaned in a resident's room who was newly admitted and on enhanced droplet-contact precautions and expected it would be cleaned

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F 880	Continued From page 18 outside of a resident's room before being used for another resident. A phone interview on 09/22/2020 at 12:41 PM with the Administrator revealed she expected staff to follow the facility's policies and procedures for infection prevention and control. The administrator stated she expected staff to wear masks at all times, perform hand hygiene between each episode of resident care, wear PPE appropriately and based on the specific isolation precautions indicated, and clean medical equipment per the facility's policy and per infection prevention guidelines recommended by the CDC.	F 880		