STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	10/01/2020

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WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 000	INITIAL COMMENTS An unannounced on-site COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 09/23/2020 through 9/24/20. Additional information was obtained through 10/01/2020. Therefore, the exit date was changed to 10/01/20. There was a total of 14 complaint allegations investigated and 6 allegations were substantiated. Event ID #VGKW11.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §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 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		10/23/20

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

Electronically Signed | 10/23/2020

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F 880	Continued From page 1	F 880		

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.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and review of the facility's policies and procedures, the facility staff failed to follow infection control procedures by not donning and doffing personal protective equipment (PPE) and performing hand hygiene for 2 of 3 sampled residents (Resident #12 and Resident #13) and failed to disinfect reusable medical equipment (Oximeter) between uses for 1 of 3 sampled residents (Resident #17) reviewed for infection control practices. These failures occurred during a COVID-19 pandemic. The findings included: 1. Review of facility's infection control policy and procedures titled, "Infection Control Measures During Pandemic", revised 04/30/20 indicated when visiting a resident's room under transmission-based precaution, the staff were required to follow the instructions and don PPE as specified on the signage. All the staff were expected to remove gloves and gown and discard them into the designated waste receptacle inside the room before leaving the room. Resident #12 was admitted to the facility on 11/06/19 with diagnoses included non-Alzheimer's dementia, and high blood pressure. The significant change in status Minimum Data Set (MDS) assessment dated 07/06/20 revealed Resident #12's cognition was severely impaired. Review of progress notes dated 09/21/20 indicated Resident #12 was placed in enhanced droplet/contact isolation due to potential exposure to the COVID-19 virus.	F 880	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1) Housekeeper #1 acknowledged to the surveyor on 9/24/20, that she should have removed her gown and gloves prior to exiting the room. The Director of Nursing (DON) provided education to housekeeper #1 on 10/22/20, regarding Use of PPE, to include when to don and doff PPE and hand hygiene. 2) NA #1 acknowledged to the surveyor on 9/24/20, that she should have donned PPE prior to entering room. The DON provided education to the NA #1 on 10/21/20, regarding Use of PPE, to include when to don and doff PPE and hand hygiene. 3) Nurse #4 acknowledged to the surveyor on 9/23/20, that she should clean the pulse oximeter with the disinfectant wipes between residents. The DON provided education to Nurse #4 on 10/22/20, regarding Cleaning and disinfection of equipment between each resident use. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that are in	

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F 880	Continued From page 3 On 09/24/20 at 9:15 AM, Housekeeper #1 was seen performing housekeeping tasks in Resident #12's wearing PPE which included a gown, gloves, N-95 face mask, and face shield. An observation of Resident #12's room revealed signage titled, "Enhanced Droplet-Contact Precautions" was posted on the door and indicated all visitors required to perform hand hygiene, wear surgical mask, eye protection, gown, and gloves when entering room, and keep the door closed. After Housekeeper #1 had completed mopping the floor, she went directly to the housekeeping cart parked in the hallway to rinse the mop head without doffing the gown and gloves or performing hand hygiene. Then, she returned to the room to remove her gown and gloves, discard them into the trash container inside the room, and applied hand sanitizer before exiting the room. An interview was conducted with Housekeeper #1 in the hallway outside Resident #12's room on 09/24/20 at 9:21 AM. She stated she had forgotten to remove the gown and gloves before exiting the room because she was nervous when observed by the surveyor. She added she had received in-services related to PPE and hand hygiene. An interview was conducted with the Environmental Services Manager on 09/24/20 at 9:39 AM. He acknowledged that Housekeeper #1 should remove her gown and gloves and performed hand hygiene before exiting the room, especially for rooms under transmission-based precaution. 2. Resident #13 was admitted to the facility on 03/17/13 with diagnoses included anxiety,	F 880	isolation are at risk to be affected by the alleged deficient practice of failure to don and doff PPE upon entering and exiting the residents room. Current facility residents that are tested with the facility pulse oximetry machine are at risk to be affected by the alleged deficient practice of failure to clean and disinfect the equipment between each resident use. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing and/or the Administrator provided in service education on 10/10/20, for current facility staff, regarding Use of PPE, to include when to don and doff PPE and hand hygiene. Staff also watched the You Tube video Use of PPE correctly for Covid 19. Staff not present will be educated upon return to work. Newly hired staff will be educated during new hire orientation. The Director of Nursing and/or the Administrator provided in service education on 10/10/20, for licensed nurses and nursing assistants, regarding Cleaning and disinfecting of equipment between each resident use. Licensed nurses and nursing assistants also watched the you tube video Sparkling Surfaces-Protect our Residents. Staff not present will be educated upon return to work. Newly hired staff will be educated	

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F 880	Continued From page 4	F 880		

depression, and high blood pressure. The quarterly MDS assessment dated 08/14/20 revealed Resident #13's cognition was severely impaired. Review of progress notes dated 09/17/20 indicated Resident #13 was placed in enhanced droplet/contact isolation due to potential exposure to the COVID-19 virus.

On 09/24/20 at 11:11 AM, an observation was made of Nurse Aide (NA) #1 entering Resident #13's room with only N95 face mask and face shield to give Resident #13 water. She was observed using hand sanitizer before exiting the room. An observation of Resident #13's room revealed signage titled, "Enhanced Droplet-Contact Precautions" was posted on the door and PPE was available by the door. During the interview, NA #1 stated she had forgotten to review the signage posted on the door before entering the room. She added she had received training related to PPE and hand hygiene.

An interview was conducted with the DON on 09/24/20 at 12:17 PM. She stated all the staff were expected to don and doff the PPE when entering or exiting a room under transmission-based precaution as specified by the signage. Housekeeper #1 should have doffed the gown, gloves and performed hand hygiene before exiting Resident #12's room. It was her expectation for all the staff to follow the guidelines outlined in the infectious disease control policies & procedures.

3. A review was completed of a facility policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment", revised 09/04/18. The policy stated, "resident-care equipment, including reusable items and durable

during new hire orientation.

The Quality Assessment and Performance Improvement Committee created a Performance Improvement Group and met on10/20/20, to complete a Root Cause Analysis for the problems identified by the Surveyor on 09/23/20 through 10/01/20. Root causes identified for each problem included:
Problem #1- Failure to doff PPE and perform hand hygiene prior to exiting a residents room.
" nervous when being observed by surveyor
" Staff failure to follow protocols despite training/education
" rushing to get finished

Corrective action: Re-evaluate training methods to ensure that staff are able to comprehend and provide return demonstration of infection control tasks.

Problem #2- Failure to don PPE prior to entering a residents room on isolation precautions.

" Rushing to take care of residents needs
" Didn□t pay attention to signage on door

Corrective action: Will use over the door isolation kits or rolling cabinet isolation kits and change the color of the isolation sign to be more visible on the residents door.

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F 880	Continued From page 5 medical equipment will be cleaned and disinfected according to current Centers for Disease Control and Prevention (CDC) recommendations for disinfection and the Occupational and Safety Hazards (OSHA) Bloodborne Pathogens Standard". The policy further stated in part, "reusable items are cleaned and disinfected between residents". A continuous observation of Nurse #4 on 09/23/20 at 3:00 PM revealed she entered Resident #16's room, placed the pulse oximeter on Resident #16's finger, and checked her oxygen saturation. Nurse #4 removed the pulse oximeter from Resident #16's finger, exited the room, used hand sanitizer on her hands, and took the pulse oximeter to Resident #17's room. Nurse #4 was observed placing the pulse oximeter on Resident #17's finger, checking her oxygen saturation, removing the pulse oximeter from Resident #17's finger, and exiting the room. An interview with Nurse #4 on 09/23/20 at 3:07 PM revealed she should have cleaned the pulse oximeter with a disinfectant wipe between residents. Nurse #4 did not offer a reason why she did not clean the pulse oximeter between residents. An interview with the Director of Nursing (DON) on 09/24/20 at 8:45 AM revealed it was best practice to clean reusable resident-care equipment between residents but all residents on the unit Nurse #4 was assigned on 09/23/20 were positive for COVID-19. An interview with the Administrator on 09/24/20 at 1:00 PM revealed he expected staff to follow facility and CDC guidelines for cleaning reusable	F 880	Problem #3 Failure to clean/disinfect pulse oximeter between resident uses. " wipes not nearby to clean between residents " Rushing to complete vital signs Corrective action: Wipes will be readily available on medication carts or on vital sign machine cart to clean and disinfect the equipment after each resident use. When a resident has been identified to be placed on isolation precautions, signage will be placed on the residents door, to indicate the type of isolation and the required PPE to be worn. An isolation kit will be placed on the residents door or in a rolling cabinet outside the residents door. Staff are expected to don the appropriate PPE and perform hand hygiene prior to entering the residents room. Prior to exiting the room, staff are expected to doff the PPE and place in trash receptacle inside of room and perform hand hygiene. When medical equipment is shared amongst residents, such as pulse oximeter, the equipment should be cleaned and disinfected after each use, using the cleaning/disinfecting wipes. Wipes are available on the medication cart or on the vital sign machine. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The DON and/or nursing supervisors will	

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F 880	Continued From page 6 resident equipment.	F 880	observe 10 staff members weekly for 4 weeks then 20 staff members monthly for 2 months, to validate that staff members are donning/doffing PPE according to the isolation precautions requirement. The DON and/or Nursing supervisors will observe 5 nursing staff weekly for 4 weeks then 10 monthly for 2 months, to validate that pulse oximeter and other medical equipment is cleaned and disinfected between resident uses The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; October 23, 2020	
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms	F 885		10/23/20

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F 885	Continued From page 7 occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interview, the facility failed to inform Resident's Responsible Party (RP) by 5:00 PM the next calendar day following the occurrence of confirmed Resident COVID-19 infections for 1 of 1 of resident (Resident #15) and also failed to report cumulative updates on subsequent confirmed COVID-19 positive results for other residents within the facility to the RP as required for 4 of 4 resident reviewed for COVID-19 reporting (Resident #6, #9, #11, and #15). These failures occurred during a COVID-19 pandemic. The findings included: 1. Resident #15 was admitted to the facility on 02/15/17 with diagnoses included non-Alzheimer's dementia, anxiety, and atrial fibrillation. The significant change in status MDS assessment dated 07/06/20 revealed Resident #15's cognition was severely impaired. Review of	F 885	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; 1)The licensed nurse notified Resident #15□s RP on 9/22/20 regarding Covid-19 positive results obtained on 9/19/20. The Administrator mailed an updated letter to Resident #15□s RP on 9/25/20, to include the facility□s current cumulative Covid-19 positive numbers. 2)The Administrator mailed an updated letter to Resident # 6□s RP on 9/25/20, to include the facility□s current cumulative Covid-19 positive numbers. 3)The Administrator mailed an updated letter to Resident #9□s RP on 9/25/20, to include the facility□s current cumulative	

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F 885	Continued From page 8 facility's COVID-19 tracking log revealed Resident #15 was confirmed positive on 09/19/20. Review of progress notes from 09/19/20 through 09/22/20 did not indicate Resident #15's RP was notified of the positive COVID-16 test results. A phone interview was conducted with Resident #15's RP on 09/25/20 at 2:14 PM. She stated when she called the facility on 09/22/20, she was told by a nurse that Resident #15 was doing well except having running nose, which was expected for someone tested positive of COVID-19. She was upset to learn that Resident #15 was tested positive of COVID-19 on 09/19/20 and the facility did not notify her until she called 09/22/20. She stated she had received weekly updates from the facility via US mail in the past couple months and added the weekly updates dated 09/04/20 and 09/10/20 did not include cumulative updates on subsequent confirmed COVID-19 infections for other residents within the facility. A phone interview was conducted with Nurse #1 on 09/28/20 at 10:12 AM. She stated she was the nurse who provided care for Resident #15 second shift on 09/19/20. She indicated it was DON's responsibility to notify the RP when a Resident confirmed positive of COVID-19. She added she had never been instructed to notify the RPs when a Resident confirmed positive of COVID-19. A phone interview was conducted with Nurse #2 on 09/28/20 at 10:17 AM. She stated she was the nurse who provided care for Resident #15 third shift on 09/19/20 and indicated it was DON's responsibility to notify the RP when a Resident confirmed positive of COVID-19. She added she had never been instructed to notify the RPs when a Resident confirmed positive of COVID-19.	F 885	Covid-19 positive numbers 4)The Administrator mailed an updated letter to Resident #11□s RP on 9/25/20, to include the facility□s current cumulative Covid-19 positive numbers. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents and resident representatives have the potential to be affected by the alleged deficient practice of failure to notify RP by 5pm the following day and failure to report cumulative updates to the RP. The Administrator mailed an updated letter to current facility resident representatives on 9/25/20, that included the facility□s current Covid-19 positive numbers. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Regional Operations Manager provided education to the Administrator on 9/23/20, regarding protocol for updating the letter with cumulative Covid-19 positive results and to be mailed to the resident representatives at least weekly. The Director of Nursing completed education for the licensed nurses on	

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F 885	Continued From page 9 A phone interview was conducted with the DON on 09/28/20 at 10:36 AM. She stated when the facility obtained the test results for COVID-19, she would inform the hall nurses to notify the RPs. She did not notify the hall nurses regarding Resident #15's COVID-19 test results on 09/19/20 as she was out. She added the Administrator was expected to take over the notification process during her absent and assigned the task to the hall nurses. A phone interview was conducted with the Administrator on 10/01/20 at 9:00 AM. He confirmed the DON was not working in the facility on 09/19/20. He could not recall whether he had notified the hall nurse or Resident #15's RP regarding the positive result of COVID-19 on 09/19/20. He stated once the hall nurses were notified of the test results, they would be responsible to notify the RPs. It was his expectation for all the RPs to be notified by 5:00 PM the next calendar day following the occurrence of confirmed Resident COVID-19 infections and provided with the cumulative updates on subsequent confirmed COVID-19 infections for other Residents within the facility in timely manner as required by regulations. 2. Resident #6 was admitted to the facility on 11/12/19 with diagnoses that included heart failure, neurogenic bladder, and respiratory failure. The quarterly Minimum Data Set (MDS) assessment dated 07/01/20 indicated Resident #6's cognition was intact. Review of progress a note dated 09/12/20 indicated Resident #6's RP was notified by phone that his COVID-19 test result was positive, and he would be moved into isolation unit.	F 885	10/23/20, regarding notification of resident and/or resident representative with resident changes and results of Covid-19 testing and document in the residents progress notes. The Administrator will update the weekly cumulative letter on Fridays with the facility□s current numbers for staff and residents that are Covid-19 positive. The letter will be mailed to the resident representatives every Friday. The Licensed nurses will notify the resident and/or the resident representative when they are notified by the laboratory regarding a Covid-19 positive test result. The resident and/or the resident representative will be notified no later than 5pm the next calendar day, after receiving positive test results. The licensed nurse will document the notification in the electronic medical record progress notes. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator will submit the letter to the Regional Director of Operations (RDO) and/or the Regional Clinical Director (RCD) weekly for 12 weeks to audit and validate that the cumulative numbers are accurate. The RCD and/or the RDO will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to	

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F 885	Continued From page 10 A phone interview was conducted with Resident #6's RP on 09/24/20 at 1:17 PM. She stated she was notified by facility staff on 09/12/20 that Resident #6 had tested positive for COVID-19. She had received weekly updates from the facility via U.S. mail in the past few months. However, the weekly updates dated 09/04/20 and 09/10/20 did not include cumulative updates on subsequent confirmed COVID-19 infections for other residents within the facility. 3. Resident #9 was admitted to the facility on 04/10/20 with diagnoses that included Alzheimer's disease and cerebrovascular accident. The quarterly MDS assessment dated 07/06/20 revealed Resident #9's cognition was severely impaired. Review of facility's COVID-19 tracking log revealed Resident #9 was confirmed positive on 09/19/20. A phone interview was conducted with Resident #9's RP on 09/25/20 at 12:23 PM. He stated he was notified by facility staff on 09/20/20 that Resident #9 had tested positive for COVID-19. He had received weekly updates from the facility via U.S. mail in the past few months. However, the weekly updates dated 09/04/20 and 09/10/20 did not include cumulative updates on subsequent confirmed COVID-19 infections for other residents within the facility. 4. Resident #11 was admitted to the facility on 09/28/16 with diagnoses that included anxiety and depression. The annual MDS assessment dated 08/18/20 revealed Resident #11's cognition was moderately impaired. Review of facility's COVID-19 tracking log revealed Resident #11 was confirmed positive on 09/19/20.	F 885	maintain compliance. The Administrator will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. The Director of Nursing and/or the nursing supervisors will audit Covid-19 lab results daily for 4 weeks then twice weekly for 2 months, to identify residents that have tested positive for Covid-19 and will validate that the resident and/or the resident representative has been notified regarding the test results and documented in the progress notes. The DON will review the audits monthly to identify patterns/trends and will adjust the plan as necessary to maintain compliance. The DON will review the plan during the monthly QAPI meeting and the audits will continue at the discretion of the QAPI committee. Indicate dates when corrective action will be completed; Oct 23, 2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345197	A. BUILDING _____ B. WING _____	10/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW RIDGE OF NC	237 TRYON ROAD RUTHERFORDTON, NC 28139

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F 885	Continued From page 11	F 885		

A phone interview was conducted with Resident #11's RP on 09/25/20 at 10:24 AM. She stated she was notified by facility staff on 09/20/20 that Resident #11 had tested positive for COVID-19. She had received weekly updates from the facility via U.S. mail in the past few months. However, the weekly updates dated 09/04/20 and 09/10/20 did not include cumulative updates on subsequent confirmed COVID-19 infections for other residents within the facility.

Review of the facility's resident list of confirmed positive COVID-19 cases provided by the Director of Nursing (DON) on 09/23/20 revealed 42 current residents out of 100 had confirmed positive of COVID-19 infections during testing that occurred from 8/31/20 through 09/21/20. Review of the list revealed the facility had a cumulative of at least 2 residents confirmed positive of COVID-19 by 09/04/20 and 5 residents by 09/10/20. Review of the weekly updates sent to families or RPs dated 09/04/20 and 09/10/20 indicated only 1 confirmed case of COVID-19 of employee an on each respective week. No cumulative updates on subsequent confirmed COVID-19 infections for other residents within the facility was reported in both weekly updates for the residents reviewed.

An interview was conducted with the Administrator on 09/24/20 at 2:25 PM. He stated he was responsible for the content of the weekly updates and acknowledged that the updates dated 09/04/20 and 09/10/20 had failed to provide cumulative updates at least weekly following the subsequent occurrence of a confirmed COVID-19 infection was identified. The Administrator could not offer any explanations for the exclusion of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 885	Continued From page 12 cumulative updates in the weekly updates.	F 885		