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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted onsite on 10/13/20 and continued offsite on 10/14/2020. 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#4YJB11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted onsite on 10/13/20 and continued offsite on 10/14/20. One of one complaint allegation was substantiated resulting in a deficiency (F880).	F 000		
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	F 880		11/20/20

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

Electronically Signed | 10/29/2020

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conducted according to §483.70(e) and following accepted national standards;

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

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F 880	Continued From page 2 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 observations, staff interview, record review, review of facility's COVID 19 policy and personal protective equipment (PPE) policy, the facility failed to implement their COVID 19 policy and PPE policy when staff did not perform hand hygiene when entering/exiting residents rooms (Nurse Aide (NA) #1), failed to remove their used gloves and perform hand hygiene before exiting residents rooms (Nurse #1, NA #1, NA #2, NA #3 & Maintenance Director) and failed to wear face shield or goggles when entering a resident room (NA #4) for 6 of 6 staff observed on the facility's COVID-19 positive unit and quarantine unit (new admission/readmission). The facility also failed to implement their policy on door signage by not posting isolation precaution signage on the doors of the rooms for 3 of 11 resident rooms observed for isolation precautions (Rooms # 103, #, #104 and # 109). These failures occurred during a COVID 19 pandemic. The findings included: The facility's COVID-19 Preparation and Response policy and procedure which was updated on 10/5/20 was reviewed. The policy under personal protective equipment (PPE) (page 12) revealed "eye protection may be worn by staff at all times but at a minimum must be worn during high risk activities. This includes times when there is a risk of exposure. This includes providing care to resident that is not wearing a	F 880	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 880 The facility failed to implement their COVID 19 policy and PPE policy when staff did not perform hand hygiene when entering/exiting residents rooms (Nurse Aide (NA) #1), failed to remove their used gloves and perform hand hygiene before exiting residents rooms (Nurse #1, NA #1, NA #2, NA #3 & Maintenance Director) and failed to wear face shield or goggles when entering a resident room (NA #4). The facility also failed to implement policy on door signage by not posting isolation precaution signage on the doors of the isolation rooms # 103, #, #104 and # 109. 1. How corrective action will be accomplished for those residents found to have been by the deficient practice: No residents were identified as affected. On 10/13/2020 the Director of Nurses	

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F 880	Continued From page 3 mask, when feeding a patient, when providing oral medication to a patient, during oral care or when suctioning or providing trach care." The facility's policy on "sequence for removing personal protective equipment (PPE)" (undated) indicated to remove PPE at doorway or in anteroom (a small room or entry way to a larger room) and to perform hand hygiene immediately after removing all PPE. The facility's policy on door signage (undated) revealed to use "enhanced droplet-contact precautions" red sign to be posted on resident's doors on the COVID unit and to use "enhanced droplet-contact precautions" orange sign to be posted on resident's doors on the quarantine unit (new admission/readmissions). The door signage (red and orange) indicated to wear full PPE when entering resident rooms. 1a. Continuous observations on 10/13/20 from 10:18 AM through 12:52 PM was conducted on the COVID unit. NA #1 was working on the facility's COVID 19 unit (Rooms #105 to #111). On 10/13/20, NA #1 was observed to enter and exit resident room #108 at 10:18 AM, room #109 at 10:21 AM, room #110 at 10:35 AM and room #106 at 10:50 AM to provide care. NA #1 was wearing full PPEs including gown and gloves prior to entering the rooms. After providing the care, the NA was observed to step out of the resident's room into the hallway, removed her gloves and disposed of them in the trash can located on the hallway. NA #1 was interviewed on 10/13/20 at 12:53 PM. She stated that she received training to dispose gloves in the trash can located on the hallway.	F 880	audited to assure appropriate isolation signage for enhanced droplet precautions had been placed on the doors of rooms #103, #104 and #109 and educated staff working on the Covid unit on assuring Enhanced Droplet Precaution signs are maintained on doors for the required residents on precautions. On 10/13/2020 the Director of Nurses educated Nurse #1, NA # 1, NA #2, NA #3 and the Maintenance Director on facility policy related to donning/doffing PPE and hand hygiene practice when entering and exiting resident rooms on the Covid 19 unit. NA # 4 was educated on 10/13/2020 by the Director of Nurses on facility policy related to the appropriate PPE to be worn for residents on enhanced droplet precautions. Root Cause Analysis was completed on 10/16/2020 with the following staff in attendance: Administrator, Director of Nurses, Infection Control Preventionist, Nursing, Dietary Staff, House Keeping, Therapy and the Business Office Manager. The root cause analysis was done related to staff not wearing all of the required Enhanced Precaution PPE in Covid 19 designated area and not following hand hygiene practices when entering/exiting rooms on enhanced droplet precautions. Staff as well did not monitor that isolation signage was maintained in place on all doors in the Covid 19 designated area. Upon interview of staff it was determined that the root cause for failure to follow facility policy was due to a knowledge deficit of need for	

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F 880	Continued From page 4 The NA indicated that she could not recall any training to remove used gloves prior to exiting the resident's rooms after providing care. NA #1 verified that on 10/13/20 she had provided care to residents in rooms #108, #109, #110 and #106 and did not remove her gloves or perform hand hygiene when she exited the resident rooms. The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he expected the staff to remove used gloves on the point of exit, that is before exiting the resident room on the COVID unit. He understood that the trash cans were located on the hallway and the staff had to step out on the hall to dispose their gown and gloves and this needed to be corrected. The DON indicated that he was new to the facility, almost 2 weeks and he was not sure what training was provided by the previous DON, but he would provide ongoing education to the staff on the proper use and disposal of personal protective equipment (PPE). b. NA #1 was observed on 10/13/20 between 1:18 PM and 1:23 PM collecting lunch trays from the resident rooms on the COVID unit. She was wearing N95 mask, face shield, disposable gown and gloves. During this time period, NA #1 was observed to enter 6 resident rooms including; Rooms #105, #106, #108, #109, #110 and #111. She was observed to remove and to change her gloves in between rooms but she did not perform hand hygiene after removing her gloves and when entering and exiting resident rooms. NA #1 was interviewed on 10/13/20 at 1:24 PM. She reported that she was told to change gloves between rooms but not to perform hand hygiene	F 880	hand hygiene when entering/exiting resident rooms on the Covid 19 unit. The root cause of isolation signs not being in place on all doors for those on the Covid 19 unit was human error and staff forgot to check that signs were maintained on doors. Staff stated they were aware signs were required. The root cause of the failure to wear googles/face shield by the staff person was human error. Interview revealed that the nursing assistant was nervous due to survey observation and had glasses on but forgot to don face shield/goggles. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/13/2020 the Director of Nurses audited all resident care areas for staff compliance with wearing of the appropriate PPE in resident rooms and for hand hygiene practice when entering/exiting resident rooms. Results: No other breaches in practice observed. On 10/13/2020 the Director of Nurses audited all resident rooms on enhanced droplet precautions to assure isolation signage was in place on doors. Results: 11 of 11 rooms had the appropriate isolation signage in place. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: On 10/19/2020 the Director of Nurses/Nurse Consultant initiated education for all registered nurses,	

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F 880	Continued From page 5 when serving and collecting resident's meal trays. NA #1 stated that she received training from the previous DON. The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he expected the staff to don and to doff gloves prior to exiting resident rooms and then perform hand hygiene on the COVID unit. c. The Maintenance Director was observed on 10/13/20 at 10:36 AM to enter the COVID unit. He was wearing full PPE including N95 mask, face shield, disposable gown and gloves. On 10/13/20 at 10:36 AM, the Maintenance Director was observed to enter Resident room #109, stepped out of the room into the hallway, went back into the resident's room #109, stepped out of the room to the hallway, entered room #112 (staff breakroom), stepped out room #112 and returned to room #109. The Maintenance Director was observed wearing the same gloves during his entire stay on the COVID unit. He was not observed to remove and to change his gloves and to perform hand hygiene before exiting room #109. The Maintenance Director was interviewed on 10/14/20 at 10:05 AM. He stated that he was confused with regards to the use of PPE on the COVID unit. He was always told to wear PPE when in the COVID unit. He also learned from his previous job to remove gloves before exiting isolation rooms. He verified that he was on the COVID unit on 10/13/20, entered room #109 to fix the call light, out on the hallway and entered room #112 without removing or changing his gloves and did not perform hand hygiene when exiting	F 880	licensed practical nurses, certified nursing assistants, maintenance staff, housekeeping staff and agency on: Covid 19 version 17 facility policy, CDC recommended practice on donning/doffing of PPE, hand hygiene policy, and re-education on ensuring isolation signage is in place at all times on enhanced droplet precaution room doors. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff as identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. On 10/19/2020 the Administrator, Director of Nurses and Infection Control Preventionist implemented IC rounds to include appropriate PPE utilization and donning/doffing of PPE, hand hygiene practices and the presence of appropriate enhanced droplet isolation signage on all doors for those residents on enhanced droplet precautions. The training will be validated with return demonstration observed by the Director of Nurses/Infection Control Preventionist on: hand hygiene and PPE use and practice for the above identified staff. Education and validation of skills will be completed by 11-19-2020. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing or designee will monitor staff adherence to compliance	

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F 880	Continued From page 6 room 109. The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he expected the staff to don and to doff gloves prior to exiting resident rooms and then perform hand hygiene on the COVID unit. d. On 10/13/20 at 12:41 PM, Nurse #1 was observed to enter Resident room #108 with a door signage "enhanced droplet/contact precaution" wearing full PPE. She was observed to exit resident's room #108 at 12:44 PM, stepped out into the hallway towards the trash can, removed her gloves and disposed them in the trash can. At 12:53 PM, when interviewed, Nurse #1 stated that this was the training she received from previous DON, to remove gloves and to dispose of the used PPE in the trash can located on the hallway. She could not recall receiving a training to remove gloves and to perform hand hygiene prior to exiting the resident rooms on isolation. The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he expected the staff to don and to doff gloves prior to exiting resident rooms and then perform hand hygiene e. On 10/13/20 at 10:55 AM, NA #2 was observed to enter resident room #104 (quarantine room) with full PPE including disposable gown and gloves with NA #3. At 10:58 AM, she was observed to exit the resident room, stepped out into the hallway towards the trash can, removed gloves and disposed them in the trash can. When	F 880	with wearing of appropriate PPE(to include donning/doffing), hand hygiene practice and appropriate placement of isolation signage for enhanced droplet precaution rooms by all staff utilizing the QA tools titled Enhanced Droplet Precautions. The Quality Assurance tool will be completed weekly for 4 weeks then monthly for 3 months. Monitoring will be conducted across all three shifts and include weekends. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, Dietary Manager and the Infection Control Preventionist. A Directed Plan of Correction was completed on 10/16/2020 and alleged compliance will be in place by 11/20/2020.	

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interviewed on 10/13/20 at 11:05 AM, she stated that this was how she was trained by the previous DON, remove gloves and dispose them in the trash can. She was not told to remove gloves and perform hand hygiene before exiting the resident room on isolation.

The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he expected the staff to don and to doff gloves prior to exiting resident rooms and then perform hand hygiene.

f. On 10/13/20 at 10:55 AM, NA #3 was observed to enter resident room 104 (quarantine room) with full PPE including gown and gloves with NA #2. At 10:58 AM, she was observed to exit the resident room, stepped out into the hallway towards the trash can, removed her used gloves and disposed them in the trash can. When interviewed on 10/13/20 at 11:06 AM, she stated that this was how she was trained, remove gloves and dispose them in the trash can outside of the resident's room. She was not told to remove gloves and to perform hand hygiene before exiting the isolation room.

The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he expected the staff to don and to doff gloves prior to exiting resident rooms and then perform hand hygiene.

g. NA #4 was observed on 10/13/20 at 10:27 AM to answer the call light in resident room #101 (quarantine room) with a door sign of enhanced observation precaution indicating to use a face

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shield when entering the room. She was observed to enter the resident room #101 without a face shield. When interviewed on 10/13/20 at 10:29 AM, she stated that she went in room #101 to answer the call light and the resident requested to be assisted back to bed. She indicated that she did not expect to enter a resident's room, so she didn't wear her face shield.

The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he always expected the staff to wear N95 mask and face shield or goggle when in the quarantine and COVID unit and to wear full PPE including face shield when entering resident's rooms on isolation.

2 a. On 10/13/20 at 10:18 AM, observation of the quarantine unit (rooms #101-#104) was conducted. Residents who were new admit and readmit were placed on the quarantine unit. Room #101 was observed to have a door signage "enhanced observation precaution" which indicated to perform hand hygiene, wear surgical mask when entering the room, eye protection when entering the room, gowns for direct care, gloves when entering the room and private room and keep door closed. Rooms #103 and #104 were observed with no door signage.

Nurse #2 was interviewed on 10/13/20 at 10:25 AM. She stated she didn't know why rooms #103 and #104 had no isolation sign on the door. She was told on the report that these residents were new admit. She reported that residents who were new admit were on enhanced observation precaution and staff should wear full PPE when entering the room. Nurse #2 indicated that she

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didn't notice that rooms #103 and #104 did not have door signage.

The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he provided an in-service for all staff last week that residents on enhanced precaution (new admissions/readmission) should have signs on their doors indicating what kind of PPE to be worn. The DON further indicated that residents who were new admission/readmission should have "enhanced observation precautions" sign on their doors indicating staff to perform hand hygiene, wear surgical mask, eye protection and gloves when entering room, wear gown for direct care and private room and keep door closed. He revealed that the admission Nurse was responsible for posting the door sign however any staff who noticed that the door sign was missing should inform the Nurse

b. On 10/13/20 at 10:30 AM, the COVID unit (rooms #105-#111) was observed. All the rooms except room #109 was observed to have a door signage "enhanced droplet-contact precaution".

Nurse #1 assigned on the COVID unit was interviewed on 10/13/20 at 10:33 AM. She stated that she didn't know why room #109 had no door signage as to what type of isolation precaution. Nurse #1 indicated that she didn't notice that the sign was missing. She revealed that the admission Nurse was responsible for posting the door sign. Nurse #1 verified that both residents in room #109 were COVID positive and should have an enhanced droplet/contact precaution signage on their door.

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F 880	Continued From page 10 The Director of Nursing (DON) was interviewed on 10/14/20 at 10:16 AM. The DON was acting as the Infection Control Preventionist (ICP). He stated that he provided an in-service for all staff last week that residents on enhanced precaution (positive with COVID 19) should have signs on their doors indicating what kind of PPE to be worn. He reported that residents on the COVID unit should have "enhanced droplet-contact precautions" sign on their doors which indicated that staff to perform hand hygiene, wear surgical mask, eye protection, gown and gloves when entering room, private room and keep door closed. He revealed that the admission Nurse was responsible for posting the door sign however any staff who noticed that the door sign was missing should inform the Nurse.	F 880		