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	345307	A. BUILDING _____ B. WING _____	C 10/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

(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 onsite complaint investigation and COVID-19 focused survey were conducted on 10/05/2020. Additional information was obtained through 10/08/20. The survey team returned to the facility on 10/13/20 to validate the credible allegation; therefore, the exit date was changed to 10/13/20. 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# MSUG11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite complaint investigation and COVID-19 focused survey were conducted on 10/05/20. Additional information was obtained through 10/08/20. The survey team returned to the facility on 10/13/20 to validate the credible allegation; therefore, the exit date was changed to 10/13/20. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity (K). Immediate Jeopardy began on 09/22/20 and was removed on 10/11/20.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		11/23/20

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

Electronically Signed | 11/06/2020

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F 580	Continued From page 1	F 580		

physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 2 room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff and legal guardian interviews, the facility failed to notify the legal guardian of a resident's transfer to the hospital for evaluation of vomiting for 1 of 3 residents (Resident #1) reviewed for notification. The findings included: Resident #1 was admitted on 01/13/20 and was discharged to the local hospital on 04/28/20. The admission Minimum Data Set (MDS) assessment dated 03/10/20 revealed Resident #1 was moderately cognitively impaired. Review of Multidisciplinary meeting documentation dated 01/27/20, revealed any family members questions or concerns of care must be discussed with Resident #1's legal guardian. A progress note written by Nurse #4 dated 03/15/20 revealed Resident #1 was transferred to the local hospital to be evaluated for vomiting a moderate amount. The progress note further revealed that Nurse #4 contacted a family member and had not contacted the legal guardian with notification of the resident's transfer to the hospital. Attempts to interview Nurse #4 were unsuccessful. Nurse #3 was interviewed on 10/05/20 at 3:00 pm revealed if a resident had to be transferred that	F 580	1. Resident #1 no longer resides at the community as of 10/28/2020. No immediate corrective action taken for Resident #1 since the Legal Guardian was already aware of the transfer at the time of the survey. 2. The Social Worker and Admissions Coordinator A) Reviewed all resident's chart to determine if the Admission Profile correctly listed the Emergency Contact (Resident Representative, Legal Guardian or family member as designated by the Resident Representative or Legal Guardian. Any erroneous information in the Admission Profile was corrected by the Social Worker or Admission Coordinator, B) Residents who were identified with a change in condition within the past 2 weeks were reviewed by the Administrator/designee to determine if the legal guardian or appropriate Emergency contact was notified. Any outstanding notifications were completed and documented by the Unit Nurse Manager. Completion date: 11/23/2020 3. A) Director of Nursing educated all licensed nurses on where to obtain the correct emergency contact (resident representative, legal guardian or family member) as designated by the resident, resident representative or legal guardian as follows * licensed nurses instructed to look in PCC at the admission profile/face sheet for the RP/Emergency contact #1	

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F 580	Continued From page 3 she would log into the system and look up the residents designated person to be notified. An interview with the Administrator on 10/05/20 at 11:15 am revealed he had been the facility administrator for one week and did not work with Resident #1. The Administrator indicated the legal representative should be in the resident's chart in the electronic medical record. The Director of Nursing (DON) was interviewed on 10/05/20 at 1:45 pm. The DON revealed it was facility policy for nurses to contact the legal guardian if there were any changes in a resident's health. Resident #1's Legal Guardian was interviewed by phone on 10/06/20 at 4:30 pm. The Guardian revealed the facility failed to make contact when Resident #1 was transferred to the hospital on 03/15/20. The Guardian indicated there had been multiple emails, phone calls, and meetings with the facility that the Legal Guardian was to be contacted regarding any change of Resident #1's care. The interview further revealed the resident's family member had been the one the facility had notified about Resident #1's transfer to the hospital.	F 580	information, * Call this person, * Document in medical record attempts to contact and who was contacted. Completed 11/09/2020. B) All newly hired licensed nurses will receive this education upon hire as part of the Orientation Process. The DON added this to the Orientation Material for Licensed Nurses on 11/09/2020. C) The Admissions Coordinator will be responsible for entering new Admission Profiles to assure the appropriate emergency contact is listed in the profile. 4. A) Residents with changes in conditions will be audited to determine if the resident’s legal guardian or identified Emergency Contact was notified. The results will be recorded on an audit tool titled “Notification of Change of Condition.” The audits will be completed by the Director of Nursing and/or designee weekly for 4 weeks and monthly for two months. B) Admission profiles for new admissions will be audited to determine if the appropriate emergency contact is listed. The audits will be completed by the Community Social Worker. The results will be recorded on an audit tool titled “Admission Profile – Emergency Contact Information”. The Director of Nursing and Social Worker will report results of the audits in the quarterly Quality Assurance Performance Improvement Meeting the QAPI Committee will review, assess, and modify the action plan as needed to ensure continued compliance. 5. Completion Date: 11/23/2020	

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F 880	Continued From page 4	F 880		
F 880 SS=J	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, 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;	F 880		11/16/20

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F 880	Continued From page 5 (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. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and interviews with staff, and review of Centers for Disease Control and Prevention Center (CDC) guidelines for responding to COVID-19 in nursing homes and the facility's COVID-19 policy revealed the facility failed to implement CDC guidelines and facility COVID-19 policy when the facility failed to quarantine readmitted residents, require staff to wear all recommended Personal	F 880	1. Resident # 8 was no longer a resident as of 10/9/2020. Resident # 9 was sent out to the hospital on 10/10/2020. Resident was readmitted on 10/21/2020 after testing positive at the hospital. She was readmitted to our Covid-19 Unit. 2. Residents were transferred to either the Quarantine unit, Covid- 19 unit,	

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F 880	Continued From page 6 Protective Equipment (PPE) when caring for residents on enhanced droplet contact precautions, and post required transmission-based precaution signage for 2 of 5 readmitted residents reviewed for infection control (Resident #8 and Resident #9). These failures occurred during a COVID-19 pandemic. On 10/05/20 there were 14 residents in the facility who had tested positive for the COVID virus. Immediate Jeopardy began on 09/22/20 when the facility failed to quarantine a readmitted resident on enhanced droplet contact precautions and failed to follow their COVID-19 Policy/Plan for readmissions. Immediate jeopardy was removed on 10/11/20 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to complete employee education and ensure monitoring systems in place are effective. The findings included: The CDC guideline entitled "Responding to Coronavirus (COVID-19) In Nursing Homes" last reviewed and updated on 04/30/20 indicated the following statements: * Place signage at the entrance to the COVID-19 unit that instructs healthcare personnel (HCP) they must wear eye protection and an N95 or higher-level respirator (or facemask if respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. * All recommended COVID-19 PPE should be worn during the care of residents under	F 880	Persons Under Investigation (PUI) unit, and / or the Recovery Unit based on their Covid-19 status in accordance to CDC Covid-19 guidance. Each unit was segregated with plastic zippered barriers and appropriate signage to define those areas and staff were provided with the proper guidance to "don" and "doff" PPE as indicated. 3. A root cause analysis was completed and based upon those findings the Administrator, Director of Nursing, Infection Preventionist and Consultant made the following changes: • The Director of Nurses and/or Admissions Coordinator are aware of each admission prior to arrival the facility. They will then determine what room/unit is appropriate based on COVID-19 guidance and assign that room. The Director of Nurses and/or Admissions Coordinator will then set up the PPE bin outside the resident room and place the appropriate isolation precaution signage on the resident door. • The COVID-19 Policy was reviewed and will be implemented as follows: All residents will be isolated for a minimum of 14 days following admission or readmission into the community designated Quarantine Unit. Any resident placed in isolation for COVID-19 will be kept in Enhanced Droplet Isolation or Airborne precautions modified for available PPE until such time as the physician determines such isolation is no longer clinically appropriate. This isolation	

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F 880	Continued From page 7 observation which includes use of an N95 or higher-level respirator (or facemask if respirator is not available), eye protection, (goggles or a disposable face shield that covers the front and sides of the face), gloves and gown. * A single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted resident should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. * New residents could be transferred out of the observation (quarantine) area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). A review of the facility's COVID-19 Policy/Plan for Facilities updated 04/04/20 read in part: "All resident will be isolated for a minimum of 14 days following admission or readmission in an area of the building designated for residents at high risk. Any resident placed in isolation for COVID-19 for a positive COVID result or as a person under investigation will be kept in Enhanced Droplet Isolation or Airborne precautions modified for available PPE until such time as the physician determines such isolation is no longer clinically appropriate. This isolation utilizes private room or cohort with approved roommate situation with surgical mask or N95 respirator if available, eye protection, gloves, and gown at all times when in the presence of the resident. The Infection Preventionist (IP) will establish and monitor any isolation required including proper PPE and required posting of the type of isolation to serve as notice to others."	F 880	utilizes private room or cohort with approved roommate situation with N95 or KN95 respirator if available, eye protection, gloves, and gown at all times when in the presence of the resident. The Infection Preventionist (IP) will establish and monitor any isolation required including proper PPE and required posting of the type of isolation to serve as notice to others. • Education was provided by DON and RN designee to the staff and management on the "Donning and Doffing" of PPE "for enhanced droplet / contact precautions", "cohorting and quarantining readmitted residents", "posting appropriate signage for enhanced droplet / contact precautions", and "keeping policies and procedures updated consistent with CSC / CMS requirements for COVID-19". Completed 11/9/2020 • New staff will be provided infection control education during their orientation. Ongoing training will be provided by the Infection Preventionist as part of the annual in-services and more often as needs/changes in Infection Control practices/policy occurs. • Effective 11/12/2020, the facility has contracted with a Consultant who is certified by the NC Statewide Program for Infection Control and Epidemiology who will assist with the Root Cause Analysis, plan of correction, review of CMS LTC Infection Control Self-Assessment, and will complete routine visits to monitor infection control practices. This consultant contract will extend for six (6)	

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F 880	Continued From page 8 During the entrance conference on 10/05/20 at 8:45AM the Director of Nursing and Administrator indicated the 300 hall was the positive COVID-19 hall and the 100 hall was the quarantine hall for COVID-19 but also had negative residents on the hall. Residents on the 200 hall were residents that had tested negative at the facility. Prior to 09/26/20 all three halls were designated for skilled care, general population residents. 1. a. Resident #9 was readmitted to the facility from the hospital on 09/22/20 to a private room on the 300 hall but was moved 4 days later on 09/26/20 to a semi-private room on the 100 hall with a roommate. The roommate was not a new admission or readmission and did not require quarantine or transmission-based precautions. Resident #9 and the roommate were both tested for COVID-19 on 09/24/20 and 10/03/20 in the facility and their test results were negative. Observation on 10/05/20 at 9:00AM revealed Resident #9 was in a semi-private room on the 100 hall with no precautions posted. There was no signage on the door regarding enhanced droplet contact precautions and no PPE available outside the door to Resident #9's room. An interview on 10/05/20 at 10:00AM with Nurse #1 revealed this was her fourth day working at the facility. She stated she was responsible for all but two of the residents on the 100 hall including Resident #9. Nurse #1 indicated none of the residents under her care were on enhanced droplet contact precautions and none had been on these precautions for the last four days she had worked at the facility. Nurse #1 further indicated Resident #9 had not been on enhanced droplet contact precautions and stated there had	F 880	months. 4. The Administrator/DON will review all new admissions weekly for 4 weeks to assure appropriate bed placement according to CDC guidance and facility policy. The results will be recorded on an audit tool titled “New Admission – COVID 19”. Ongoing monitoring for appropriate infection control practices proper donning/doffing of personal protective equipment (PPE) and appropriate precaution signage on resident doors will be completed through observation/rounds by the Administrator and /or Infection Preventionist and / or designee. These observations / rounds will be performed 5 times a week for 2 weeks then weekly for 4 weeks. Results will be recorded on an audit tool titled “Infection Control Observations”. Ongoing monitoring will also be provided by the contracted Consultant during monthly visits for at least 6 months. Results of the above audits will be reviewed and discussed in the Quarterly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. 5. Completion date: 11/16/2020	

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been no PPE available outside her door. She stated she had not been offered a gown or protective eyewear when caring for any of the residents she had been assigned on the 100 hall including Resident #9. She stated she had not received education at the facility about COVID-19 but stated she had received education through her Agency.

An interview on 10/05/20 at 2:30PM with NA #3 revealed this was her second day working at the facility and she was the nurse aide for both the 100 hall and the 200 hall. She stated she was not aware Resident #9 needed to be on isolation and stated she had not been on isolation the past two days she had worked. NA #3 indicated she had not worn any PPE except a mask and gloves when providing care to Resident #9. She stated she had not received education at the facility about COVID-19 but stated she had received education through her Agency.

An interview on 10/05/20 at 4:01PM with the Director of Nursing (DON) revealed Resident #9 had originally been admitted to the facility from the hospital to a private room on the 300 hall on 09/22/20. She stated Resident #9 had been moved to a semi-private room on 09/26/20 (due to 300 hall being converted to COVID positive unit) and stated the resident was not placed on precautions when she was transferred to the 100 hall and had not been on Enhanced droplet contact precautions when she was on the 300 hall. The DON further stated she was not sure why Resident #9 had not been quarantined on enhanced droplet contact precautions for 14 days but stated the resident should have been since she was readmitted from the hospital. She indicated Resident #9 should have had available

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F 880	Continued From page 10	F 880		

PPE for the staff outside her door and stated she would make sure the appropriate PPE was placed in a bin outside her door.

A subsequent phone interview with the Director of Nursing (DON) on 10/06/20 at 12:21PM revealed the facility did testing of the residents and staff on 09/24/20 and received the results on 09/26/20 that 12 residents had tested positive for COVID-19. The DON further stated on 09/26/20 they had to convert the 300 hall to a COVID positive hall and move the 12 residents that had tested positive to that hall and move the residents on the 300 hall which included Resident #9 out to the other hallways. She indicated she had contacted the Health Department on 09/26/20 but there was no staff available to assist with the information regarding the positive residents. The DON stated she had since spoken with a nurse at the Health Department on 09/29/20 and had received multiple resources and guidance about testing, surveillance, CDC guidance and said she had briefly scanned the information but was not as familiar with the regulations or guidance as she needed to be to direct the staff and ensure the residents were appropriately quarantined.

An interview on 10/05/20 at 4:12PM with the Administrator revealed he had only been at the facility for about a week. He stated he was not fully familiar with the COVID-19 regulations but stated they were not taking admissions to the facility due to their outbreak status. The Administrator indicated he was aware that readmissions should be isolated, and staff should be wearing full PPE as if they were COVID positive. He stated he was not aware Resident #9 was not placed on quarantine for 14 days with enhanced droplet contact precautions following

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her readmission. The Administrator further stated he was not aware PPE had not been placed outside her door and stated he would remedy that immediately. The Administrator explained they had just implemented a clinical meeting during their morning meeting last Friday (10/02/20) and stated today was supposed to be the first day of their full meeting to include clinical information. He stated he was aware of where to locate information regarding regulations of COVID-19 and had a corporate liaison to reach out to with questions. The Administrator further stated he had not spoken with anyone at the local county Health Department.

b. Resident #8 was readmitted to the facility from the hospital on 09/28/20 to a private room on the 100 hall. A review of her medical record revealed she was tested for COVID-19 at the facility on 10/03/20 and her test result was negative.

Observation of Resident #8 on 10/05/20 at 9:00AM revealed her room was covered in a zippered plastic barrier held up with black support poles that extended out into the hallway approximately 4 to 5 feet. There was a sign on the plastic barrier outside her room that read "Contact Precautions." The sign indicated staff entering the room to provide patient care should perform hand hygiene, wear gloves when entering the room, wear isolation gown when entering the room and use patient-dedicated or single use disposable equipment or clean and disinfect equipment between patients. There was no available PPE on her door or in a bin outside of Resident #8 ' s room. An observation on 10/05/20 at 9:10AM of Nurse Aide (NA) #3 going in to assist Resident #8 revealed her wearing a mask, gown and gloves in the room but no

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protective eye wear or face shield.

An interview on 10/05/20 at 2:30PM with NA #3 revealed this was her second day working at the facility and she was the nurse aide for both the 100 hall and the 200 hall. She stated she was not aware Resident #8 needed to be on enhanced droplet contact precautions and stated she had not been on isolation the past two days she had worked. NA #3 indicated she had not worn any PPE except a mask, gown and gloves when providing care to Resident #8. She further indicated she had not been offered protective eye wear or a face shield to wear while caring for Resident #8. NA #3 stated she had not received education at the facility about COVID-19 but stated she had received education through her Agency.

An interview on 10/05/20 at 3:52PM with Nurse #4 revealed it was her second day working at the facility. She stated she had been told in report that Resident #8 was on contact precautions due to shingles. Nurse #4 indicated she and the nurse aide had worn a mask, gown and gloves into the room when providing care but stated neither of them had worn protective eye wear or a face shield and further indicated they were not aware they needed full PPE when going into Resident #8's room. Nurse #4 stated there had not been PPE available outside the door either of the days she had worked and stated she had to get gowns for she and NA #3 from the supply room when providing care to the resident. Nurse #4 further stated she did not know why available PPE had not been outside the resident's door. According to Nurse #4, she had not received education at the facility regarding COVID-19 but had received education through her Agency.

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F 880	Continued From page 13 An interview on 10/05/20 at 4:01PM with the Director of Nursing (DON) revealed Resident #8 was readmitted to the facility from the hospital to a private room on the 100 hall. She further stated Resident #8 had been placed under "Contact Precautions" for shingles. The DON stated Resident #8 had not been quarantined on enhanced droplet contact precautions but should have been since she was readmitted from the hospital. She further stated she must have misinterpreted the regulations but was not aware they needed to quarantine residents at the back of a hall or have a hall to quarantine residents readmitted from the hospital. A subsequent phone interview with the Director of Nursing (DON) on 10/06/20 at 12:21PM revealed the facility did testing of the residents and staff on 09/24/20 and received the results on 09/26/20 that 12 residents had tested positive for COVID-19. The DON further stated on 09/26/20 they had to convert the 300 hall to a COVID positive hall and move the 12 residents that had tested positive to that hall and move the residents on the 300 hall out to the other hallways. She indicated she had contacted the Health Department on 09/26/20 but there was no staff available to assist with the information regarding the positive residents. The DON stated she had since spoken with a nurse at the Health Department on 09/29/20 and had received multiple resources and guidance about testing, surveillance, CDC guidance and said she had briefly scanned the information but was not as familiar with the regulations or guidance as she needed to be to direct the staff and ensure the residents were appropriately quarantined.	F 880		

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An interview on 10/05/20 at 4:12PM with the Administrator revealed he had only been at the facility for about a week. He stated he was not fully familiar with the COVID-19 regulations but stated they were not taking admissions to the facility due to their outbreak status. The Administrator indicated he was aware that readmissions should be isolated, and staff should be wearing full PPE as if they were COVID positive. He stated he was not aware Resident #8 was not placed on quarantine for 14 days with enhanced droplet contact precautions following her readmission. The Administrator further stated he was not aware PPE had not been placed outside her door and stated he would remedy that immediately. The Administrator explained they had just implemented a clinical meeting during their morning meeting last Friday (10/02/20) and stated today was supposed to be the first day of their full meeting to include clinical information. He stated he was aware of where to locate information regarding regulations of COVID-19 and had a corporate liaison to reach out to with questions. The Administrator further stated he had not spoken with anyone at the local county Health Department.

3. The 300 hall was identified by the Director of Nursing (DON) and Administrator as the designated COVID-19 hall for positive residents and was converted on 09/26/20. There were 14 positive COVID-19 residents on the 300 hall.

a. On 10/05/20 at 9:20AM the Director of Nursing was observed talking with the 300 hall nurses in the nursing station on the COVID-19 positive hall and wearing a black cloth face mask.

An observation and interview were conducted in

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the conference room on 10/05/20 at 10:22AM with the Director of Nursing (DON). She was observed to be wearing a black cloth mask on her face and stated she was currently serving as the Infection Preventionist.

A second interview and observation were conducted with the Director of Nursing (DON) on 10/05/20 at 5:26PM in the conference room. The DON was observed wearing a black cloth mask. She revealed she had not donned her N95 mask because she had been assisting staff and had not taken the time to switch from her cloth mask she had been wearing since arrival to the facility this morning. The DON stated she was aware it was not appropriate and was not following the guidelines to wear a cloth mask in the facility and she would immediately go don her N95 mask.

b. An interview with NA #4 on 10/05/20 at 5:37PM revealed she had worked at the facility for 2 weeks on the 100 hall and the 200 hall. She was dressed in scrubs and a cloth face mask during the interview. NA #4 stated she had been provided a cloth face mask when she had started working at the facility. She further stated she had a surgical mask over the cloth mask but had discarded the surgical mask. According to NA #4 she had not been told she could not wear the cloth mask when caring for the residents on the 100 and 200 halls but stated she had used the surgical mask over the cloth mask at times.

A third interview was conducted with the DON on 10/05/20 at 6:00PM in the conference room. The DON was observed to be wearing an N95 mask and stated all staff caring for residents in the facility should be wearing an N95 mask and should not be wearing a cloth mask while taking

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care of the residents in the facility. The DON stated she would make sure NA #4 had an N95 mask to wear during her shift.

The Administrator was notified of the immediate jeopardy on 10/07/20 at 6:49PM. On 10/10/20 at 7:12PM, the facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.
All residents have the potential to suffer as a result of failure to implement Transmission Based Precautions for COVID 19 by not placing enhanced droplet contact precautions signs up and not ensuring staff are wearing all recommended Personal Protective Equipment to include gown and eye protection as well as gloves and N95 mask for Residents #8 and #9 when providing care. Residents were at increased risk due to not cohorting and quarantining residents whose COVID 19 status is unknown as well as dedicated staff not consistently assigned to the designed unit for admission of residents whose COVID 19 status is unknown.
Residents #8 and #9 had enhanced droplet contract precaution signs placed on the door of their rooms and isolation carts placed outside of the rooms with correct PPE in the carts. The facility's COVID 19 policies were not updated to current Centers for Disease Control guidance and Centers for Medicare and Medicaid requirements.
Date Completed: 10/7/2020
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and

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when the action will be complete.

1. Facility halls have been redesigned into 4 different units: an isolation unit for active symptomatic COVID 19 positive residents (100 unit back of hall); a quarantine unit for newly admitted/returning residents for 14-day quarantine (100 unit front of hall). These are separated by a double wall barrier, and a second double wall barrier at the entrance of this unit into the main common space; a recovery unit (300 unit) and a person under investigation unit or general population unit (PUI) (200 unit). This design allows us to ensure that residents are placed in the appropriate area based on test results, symptoms and admission status. Date of Completion 10/9/2020

2. Enhanced droplet contact precautions signs have been placed on all resident rooms in the isolation unit, quarantine unit, and recovery unit at this time. Date of Completion 10/9/2020

3. All Staff assigned in the facility have been given full PERSONAL PROTECTIVE EQUIPMENT (gowns, gloves, mask, eye protection, face shields) and instructed on use of the PERSONAL PROTECTIVE EQUIPMENT for all residents in the facility at this time. The education was provided by the Administrator and Director of Nursing on 10/8/2020 and 10/9/2020. Completion of this education will be done by the Regional Director of Clinical Services on 10/11/2020 for those staff who were not able to be educated prior. This education included all nursing, dietary, housekeeping, and therapy staff. Date of Completion: 10/11/2020

4. Any staff member not present when the

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training was provided will be trained by the Director of Nursing, the Regional Director of Clinical Services, and the Administrator before being allowed to return to work as well as any new hires. All new hires will be educated by the DON or designee on the use of enhanced precautions and proper PPE before taking shifts on the units. This training will include all nursing, dietary, housekeeping and therapy staff. Completion Date: 10/11/2020.

5. As of 10/8/2020 staff will be designated and dedicated to the isolation unit. The isolation unit will now house COVID 19 Positive residents (3 remaining) on one end with a double wall barrier that leads to the quarantine area on the other end of the unit and then another double wall barrier leading out to the common open space. The PUI unit will now be for residents under investigation of possible exposure and the Recovery unit will be for residents who are coming off 14-day COVID 19 positive symptom. The policy of the facility going forward will be that the Director of Nursing and Environmental Services Supervisor will assign dedicated staff to the isolation unit when at all possible based upon current crisis staffing contingencies as relates to industry staffing shortages. Every effort will be made to have assigned and dedicated staff for the isolation unit. Date of Completion: 10/9/2020

6. The facility's COVID 19 admissions policies and procedures will be updated by Regional Director of Clinical Services to include the current Centers for Disease Control (CDC) guidance and Centers for Medicare and Medicaid (CMS) requirements for 14 day quarantine with enhanced droplet contact precautions of all newly admitted residents. The new policy states that for

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all residents admitted to the facility, they will be placed on the quarantine unit for a period of 14 days, enhanced droplet contact precautions will be followed by all staff assigned to the quarantine unit and designated staff will be assigned to the unit. Date of Completion: 10/11/2020

7. Beginning on 10/8/2020 all facility staff in all departments have been in-serviced on location of isolation rooms, enhanced droplet precaution contact signage and its meaning and proper PERSONAL PROTECTIVE EQUIPMENT usage when providing care for residents in rooms with enhanced droplet precautions and contact isolation by the Director of Nursing and the Administrator. Date of Completion:10/11/2020

8. The Admissions Coordinator have been instructed and educated by the Facility Administrator on the facility policy that ALL admissions from an outside facility must be admitted to the quarantine unit for 14-day isolation period. Date of Completion: 10/11/2020

9. CDC recommended Personal Protective Equipment (gloves, gowns, N95 Mask, eye protection and face shields) has been placed on the outside of the rooms on enhanced droplet contact precaution units (COVID 19 positive, quarantine and recovery units). Date of Completion: 10/9/2020

10. All residents and staff have been tested weekly as required under the current requirements of the Center for Medicare and Medicaid Services and guidelines of Center for Disease Control (CDC) for current surveillance testing requirements. The next scheduled round of testing starts on 10/7/2020 and 10/8/2020.

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Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents will be tested, and all staff and residents that test negative will be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result. Date of Completion: 10/8/2020

11. Beginning 10/8/2020 the Director of Nursing will make daily rounds Monday-Friday and the Assigned Charge Nurse on Saturday and Sunday to ensure that Enhanced Droplet Contact Precautions Signs are posted on the doors of residents that are under a 14 day isolation period and that staff are following enhanced droplet contact precautions. The night nurse will round on the isolation, quarantine, and recovery unit to ensure that precautions are being maintained by all staff and that proper PPE is always worn. The charge nurses and night shift nurses were educated regarding this monitoring 10/9/2020.

12. The Director of Nursing and Environmental Services Supervisor will review schedules and assignment sheets daily Monday thru Friday and Friday for Saturday and Sunday to ensure that staff dedicated to the enhanced droplet contact precaution unit are assigned to that unit only for their entire shift. Staff assigned to the enhanced droplet contact precaution unit will stay on that unit for the entirety of that shift. Date of Completion: 10/9/2020

13. The Medical Supply Clerk will inventory the Personal Protective Equipment in the facility daily Monday - Friday and the weekend nurse will replace any Personal Protective Equipment that is

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in low supply on the Personal Protective Equipment Supply carts. Education was provided to the Medical Supply Clerk and the weekend nurses on 10/9/2020.

14. The Admissions Coordinator must report to the Administrator and the Director of Nursing all individuals being considered for admission, the room assignment for the individual and the medical history of the individual before an offer of admission can be made to an individual for admission. The Administrator and the Director of Nursing will ensure that all admissions are admitted to the quarantine unit for 14-day quarantine period. The Admissions Coordinator has been in-serviced on the procedure on 10/9/2020 by the facility Administrator. The Administrator and Director of Nursing will document on an Admission Acceptance Form, to be implemented by 10/11/2020 that the individual has been reviewed and will be admitted to the quarantine unit for the required 14-day quarantine period. Additionally, once admitted the Director of Nursing or designee will maintain a log of all admissions/readmissions to track and ensure that the new admit completes a 14-day quarantine period on the quarantine unit.

15. Regional Director of Clinical Services will update policies and procedures related to COVID 19
requirements to be current with CDC and CMS guidelines. Policies will include enhanced droplet contact precaution requirements with use of enhanced droplet PPE for use with residents on precautions with isolation and 14-day quarantine.

THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE PLAN

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F 880	Continued From page 22 OF CORRECTION: Administrator Regional Director of Clinical Services The Facility alleges the removal of the immediate jeopardy on 10/11/2020 On 10/13/20 the facility's plan for immediate jeopardy was validated by the following. Review of in-service training records revealed staff from all shifts and all disciplines had been in-serviced on 10/03/20, 10/06/20, 10/08/20 10/09/20 and 10/13/20 regarding designated area for residents admitted and readmitted and COVID-19 positive residents on the 300 hall and the back of the 100 hall with quarantined residents on the top of the 100 hall, all behind plastic zippered barriers clearly marked with signage indicating enhanced droplet contact precautions, appropriate PPE in plastic bins outside the doors, and signage for donning and doffing of full PPE. There were dedicated staff identified on both the 300 hall and the 100 hall. The 200 hall was now the COVID negative hall and residents on this hall were tested weekly as well as the other residents in the facility. Staff were being tested weekly as well. Residents admitted or readmitted were being quarantined on the top of the 100 hall for 14 days. The COVID negative residents were relocated to the 200 hall which was now the clean hall. The facility's COVID-19 Policy/Plan was reviewed, and revisions were noted. The facility's date of immediate jeopardy removal of 10/11/20 was validated.	F 880		