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	345126	A. BUILDING _____ B. WING _____	C 11/20/2020

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E 000	Initial Comments An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted on 11/18/2020 through 11/20/2020. The facility was found to be in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event # RJYX11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and Complaint investigation was conducted on 11/18-2020 through 11/20/2020. New citations were cited during this visit, F880 and F760. The F760 cite was associated to a complaint. The facility was found out of compliance with 42 CFR 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practives to prepare for COVID-19.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interview, the facility failed to administer insulin and Eliquis and for one (Resident #1) of three residents reviewed for significant medication errors. The facility failed to transcribe orders for insulin and Eliquis. Findings include:	F 760	F760 ¿ The medication error was corrected and reported to the family and the Medical Director at the time it was identified. ¿ Nurse managers conducted a 100% audit of all medication orders during the December physician order change over	12/21/20

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

Electronically Signed | 12/08/2020

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F 760	Continued From page 1 Resident #1 had a diagnosis of insulin dependent diabetes mellitus and coronary heart disease. Resident #1 was admitted to the facility on 10/27/2020 from the hospital status post hospital stay for open repair of right hip fracture. Documentation on a discharge summary printed by the facility on 10/27/2020, listed current discharge medications for resident #1 for the treatment of diabetes and heart disease. One of the orders was for insulin glargine 100 unit/milliliter (mL) to be administered as an injection of 20 units every night for diabetes. Another order was for apixaban 5mg to be administered by mouth two times a day for coronary artery disease. Documentation on the baseline care plan completed on 11/01/2020 revealed Resident #1 had Diabetes and prescribed insulin. In addition, it revealed Resident #1 had coronary artery disease and was prescribed apixaban for anticoagulation therapy. Documentation on an admission physician's progress note dated 10/30/2020 revealed Resident #1 was noted to have a diagnosis of diabetes and to be receiving insulin. Additional documentation also included Resident # 1 was noted to have a diagnosis of coronary artery disease and to be receiving anticoagulant therapy. Eliquis (apixaban) is a drug for anticoagulation therapy. Documentation on the Admission Medicare 5-Day Minimum Data Set (MDS) assessment completed on 11/03/2020 coded Resident #1 as cognitively intact and receiving two insulin injections, once on 11/01/2020 and once on 11/02/2020, and no	F 760	process to ensure prescribed medications have been accurately transcribed to the MAR. ¿ a.) The policy and procedure for transcribing medications has been reviewed and no changes are warranted at this time. b.) Licensed nurses were re-educated on 11/19/20 - 11/20/20 by the Director of Nursing, Assistant Director of Nursing and/or the Nursing Practice Educator on the policy and procedure for transcribing medications. PRN staff to be educated on their next scheduled shift and our 2 nurses out on medical leave will be re-educated upon returning from medical leave. c.) The on-duty nursing supervisor will review MARs from the prior shift admissions to ensure medication orders have been accurately transcribed. ¿ The Director of Nursing &/or designee will conduct a 100% medication transcription audit on all new admissions times four (4) weeks, a 50% medication transcription audit times four (4) weeks and a 25% transcription audit times four (4) weeks or until sustained compliance is achieved. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly, with the QAPI Committee responsible for ongoing compliance.	

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F 760	Continued From page 2	F 760		

anticoagulant medications during assessment period.

Documentation on the Medication Administration Record (MAR) revealed Resident #1 did not receive any insulin from admission 10/27/2020 to 11/01/2020. Documentation on the MAR revealed Resident #1 did not receive any apixaban from admission 10/27/2020 to 11/02/2020.

A review of physician orders revealed Levemir insulin 20 units injection at bedtime was started for Resident #1 on 11/01/2020. A review of physician orders revealed apixaban 5 mg twice a day was started for Resident # 1 on 11/02/2020.

A review of the MAR for Resident #1 revealed began receiving insulin, apixaban 11/01/2020 until discharge on 11/13/2020.

Review of the nursing progress notes did not reveal any signs or symptoms of hypoglycemia or hyperglycemia for Resident # 1 during her stay in the facility from 10/27/2020 - 11/13/2020.

An interview was conducted with Nurse #1 on 11/19/2020 at 5:18 pm. Nurse #1 stated he admitted Resident #1 to the facility on 10/27/2020 and explained when he reviewed the "continue these medications" listed on the hospital discharge summary dated 10/27/2020, he overlooked the two medications, insulin and apixaban. He stated after his shift on 10/27/2020, he went on vacation and did not return to work until 11/07/2020. He also stated when he returned to work on 11/10/2020, the Director of Nursing (DON) conducted counseling with him for inaccurate transcription of physician orders and

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discharge summary. The DON also provided him additional education for transcribing orders. He included, "I plan to be more careful in the future when transcribing orders."

An interview with the Director of Nursing (DON) on 11/19/2020 at 4:45 PM revealed she learned of the medication error on 11/01/2020 and notified the physician immediately of the error and obtained new orders to restart Resident #1's insulin and apixaban effective 11/01/2020. The DON stated she immediately started new actions and education for the facility staff on 11/01/2020. The actions included: 1.) The DON assumed the new admission meeting which provided the initial communication between families, residents and the facility interdisciplinary team, 2.) All families were called during the post-admission chart review regarding all medications, 3.) The facility Social Work Director assumed the responsibility of scheduling the new admission meetings for families.

An interview with the physician on 11/19/2020 at 5:45 PM revealed he was notified of the transcription and medication errors on 11/01/2020. He stated he immediately ordered Resident #1's insulin and apixaban. He also stated Resident #1 did not show signs and symptoms of hyperglycemia or hypoglycemia during the timeframe of admission date on 10/27/2020 through 11/01/2020 when the medications were restarted. He included Resident #1 did not show signs and symptoms of chest pain or blood clots during the timeframe of admission date on 10/27/2020 through 11/01/2020, did not require additional monitoring and suffered no negative outcomes as a result of the medication errors.

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F 760	Continued From page 4 An interview with the Administrator on 11/20/2020 at 11:30 PM revealed all ordered medications should be transcribed correctly to ensure all residents received all ordered medications.	F 760		
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, 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;	F 880		12/21/20

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F 880	Continued From page 5 (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. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of the facility's infection control and COVID-19 policies, the facility failed to implement their COVID-19 screening process for 1 of 2	F 880	F880 ¿ 1. The receptionist who screened the surveyor was educated by Infection	

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F 880	Continued From page 6 visitors upon entry into the facility. Additionally, the facility failed to implement their COVID19 personal protective equipment (PPE) policy when 1 of 5 staff failed to wear a mask while working on the facility's designated quarantine unit. This failure occurred during a COVID-19 pandemic. Findings included: 1. A review of the facility's COVID-19 Policy and Plan for screening for employees, medical personnel and visitors last updated 9/26/2020 stated facility staff are required to take the person's temperature, verbally ask the screening questions to both visitors and employees immediately upon entry to the facility and complete the designated facility form. On 11/18/2020 at 8:40 am, a facility employee unlocked the front door of the facility and permitted the surveyor to enter the building. The receptionist instructed the surveyor to proceed to the front desk. The receptionist used a thermometer to take the surveyor's temperature, asked the surveyor did she have any symptoms and had she been tested for COVID19. The clipboard and the facility's designated COVID-19 screening form to sign in the surveyor was located behind the front desk ' s sliding glass window and not accessible to the surveyor. On 11/18/2020 at 8:45 am, the surveyor was met in the front lobby by management staff and was escorted to a conference room in a nonresident area. An interview with the Administrator on 11/18/2020 at 9:40 was conducted regarding the lack of	F 880	Prevention Nurse on the importance of asking all questions on the screening form and to ask for assistance from other staff to answer the phone while she is engaged in the process of screening in employees, vendors or guests. The surveyor returned to the screener to answer the remaining questions. 2. The C.N.A. observed with her mask off donned the appropriate PPE for the Admissions Observation Unit (AOU). ¿ 1. The primary screener and back-up screeners have completed a Screener□s Competency Assessment. This assessment helps to ensure: a. The screeners□ understanding of their role as being our first line of defense in keeping COVID-19 out of our community. b. An understanding and the ability to provide those individuals whom she screens with an explanation of the importance of the screening process in helping us to identify an individual/s who should not be allowed to go further into the facility. c. All staff have been educated by the Infection Prevention Nurse (and other members of Nursing Administration) on the essential role effective screening plays in managing the spread of COVID-19 within our community. 2. A complete round was made of the facility by the clinical leadership team to ensure other staff were wearing the appropriate PPE for their assigned unit; no other discrepancies were noted.	

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F 880	Continued From page 7 screening questions performed by the receptionist when she screened the surveyor. The Administrator stated all visitors were to be screened thoroughly for COVID-19 by taking the visitor 's temperature and asking all screening questions defined by facility policy. At 9:55 am the surveyor returned to the front desk to ensure the screening process was completed prior to touring the facility. An interview with the receptionist on 11/19/2020 at 8:36 am revealed when she screened the surveyor on 11/18/20 she was distracted due to the phone ringing and did not complete a thorough screening process by not asking the appropriate questions listed on the facility's designated COVID-19 screening form. 2. A review of the facility's Infection Prevention Policy/Appropriate PPE last revised on 11/09/2020 revealed while on the quarantine unit, face shields were to be worn in resident's rooms and may be changed to goggles outside of the room and worn throughout the entire shift. Masks were to be worn throughout the entire facility at all times. Observations on 11/18/2020 at 10:44 am, revealed Nursing Assistant (NA) #1 was observed in the hallway near the nurse's station and was not wearing a mask on the facility's quarantine unit. An interview with NA#1 on 11/18/2020 at 10:46 am revealed she was "just getting some air" and had removed her mask. She stated the facility policy required all employees to always wear a mask, goggles and/or face shield while outside resident's rooms on the quarantine unit for any	F 880	¿ To determine if a change was needed in our policy and procedure a Root Cause Analysis (RCA) was conducted to determine causative factors leading to the deficient screening practice and improper wearing of PPE. The analysis revealed the following: 1. The policy and procedure was reviewed by the RCA QAPI Committee and there are no changes warranted in the screening policy and procedure at this time, however the team identified a process change that would be appropriate for the Mount Olive screening process. As the screener explained she became distracted during the screening process due to other job responsibilities i.e. answering the phone, or someone else waiting at the door. We have implemented the following changes to process: a) When the receptionist is screening she will notify other Business Office personnel to assist in answering the phone. b) Signage has been placed on the outside of the foyer door explaining to individuals wanting to enter the facility that if they observe the screener in the process of screening another person, to please be patient and practice social distancing while they wait to be properly screened for entrance to our community. c) Signage has been placed on the inside of the foyer door asking staff not to allow individuals in to the facility if someone is already been screened at the screening post but to step outside, apologize for the short wait and inform them we will be with	

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F 880	Continued From page 8 reason. She also stated additional PPE such as a gown was required if entering a resident 's room. An interview with the Assistant Director of Nursing, (ADON) on 11/18/2020 at 10:49 am revealed all employees were required to wear a mask, goggles and a face shield while on the quarantine unit per facility policy. On 11/18/2020 at 11:10 AM during an Interview with the Director of Nursing (DON), she stated the residents who currently resided on the facility's quarantine unit were either new admissions, returning from a hospital stay within the last 14 days or showing respiratory signs and symptoms and were all placed on enhanced droplet precautions with a sign on each resident's door. She also added there were a total of 24 residents on the quarantine unit. An interview with the Infection Preventionist on 11/18/2020 at 11:15 am revealed employees were aware and expected to follow facility guidelines by wearing a mask, goggles and a face shield while in the quarantine unit. An interview with the Administrator on 11/18/2020 at 11:52 am revealed all employees have been educated on the requirements per facility policy and are required to wear a mask, goggles and a face shield while on the quarantine unit.	F 880	them momentarily while we ensure the safety of our residents, staff and guests by following the CDC screening guidelines. 2. The current policy and procedure was reviewed by the Root Cause Analysis (RCA) QAPI Committee and no changes in policy and procedure are warranted at this time. The RCA QAPI Committee did identify two potential causative factors that led to one C.N.A. on the AOU not having on proper PPE when she was observed by the surveyor: a) As more information becomes knowledge about COVID-19, there have been rapid changes in the guidance around PPE requirements which have the potential to confuse even healthcare professionals regarding what is required on what unit of the facility. In addition to posting guidance on the units, a handout has been distributed to each employee clearly defining what is required on each unit. b) PPE fatigue is real and personified by the C.N.A.□s reply to the surveyor that she was just getting some air. As the PPE required on the AOU is cumbersome and can feel suffocating to staff, staff assigned to the AOU will be offered PPE rest periods, at which time they can step outside the AOU (one person at a time) and remove their PPE where no one else is around and just get some air. This planned rest period will result in consistent compliance with PPE requirements. c) All staff have been educated on the proper wearing of PPE, its role in	

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F 880	Continued From page 9	F 880	preventing the spread of COVID-19 (as well as other illnesses i.e. flu) and how wearing proper PPE protects residents, staff, ourselves and our families. ¿ 1. The Business Office Manager, Administrator and Maintenance Director will conduct a total of three random screening observations weekly times twelve (12) weeks or until sustained compliance is achieved. Audits will include different screeners and different Shifts. Monthly reports will be submitted to the QAPI Committee for review and to monitor compliance. 2. The Unit Manager of the AOU has been delegated the responsibility of maintaining PPE compliance on the AOU and providing staff exhibiting signs of PPE fatigue with the opportunity to take a five (5) minute PPE rest periods (up to 3 times during an 8-hour shift and 4 times during a 12-hour shift). The Director of Nursing and or her designee will make unannounced PPE compliance rounds five (5) times weekly times twelve (12) weeks or until sustained compliance is achieved. Unannounced rounds will be made over all three (3) shifts. Monthly reports will be submitted to the QAPI Committee for review and to monitor compliance.	