STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345311	A. BUILDING _____ B. WING _____	C 01/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROXBORO HEALTHCARE & REHAB CENTER	901 RIDGE ROAD ROXBORO, NC 27573

(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 COVID-19 Focused Emergency Preparedness Survey was conducted onsite 1/20/21/-1/21/21 and remotely through 1/25/21. 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 ID# IVHL11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation was conducted onsite 1/20/21 - 1/21/21 and remotely through 1/25/21. The facility was found not in compliance with 42 CFR §483.80 infection control regulations and had not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID # IVHL11.	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	F 880		2/12/21

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

Electronically Signed | 02/07/2021

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F 880	Continued From page 1	F 880		

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;
(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.

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F 880	Continued From page 2 §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, record review, staff interviews, and a review of the facility's policy and procedures, staff failed to implement the guidelines regarding use of personal protective equipment (PPE) during COVID-19 when two staff members did not wear the full PPE required (Social Worker #1 and Housekeeper #1) while providing services in the resident's room for 1of 6 sampled residents who were on Enhanced Droplet Precautions (Resident #10). This failure occurred during the COVID-19 pandemic. Findings included: The facility's COVID-19 Preparation and Response Policy revised 12/28/20 defined enhanced precautions as; transmission-based precautions initiated empirically to control the spread of infection and combines Standard Precautions and Droplet Precautions and includes wearing eye protection. The policy guidelines included; universal transmission-based precautions must be used by all staff. Single use gowns should be used and discarded for all contact and enhanced precaution rooms. During an observation on 01/20/21 at 1:30 PM, PPE was observed in the supply cart outside of	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 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #10 was not affected by the deficient practice. Resident #10 remained on Enhanced Droplet Precautions through her 10th day at which time her Isolation precautions were discontinued and there were no complications identified. 2. How the facility will identify other	

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F 880	Continued From page 3 Resident #10's room. The PPE cart included masks, gloves and gowns. An Enhanced Droplet Precaution sign was posted on Resident #10's door which provided instructions to perform hand hygiene and don full PPE to include a mask, gown, gloves, and eye protection before entering the room. During an observation on 01/20/21 at 1:30 PM, Social Worker #1 and Housekeeper #1 were observed in Resident #10's room. Social Worker #1 was wearing a mask, and eye wear and was not wearing gloves, or a gown. Housekeeper #1 was observed wearing a mask, eye wear, and a gown but no gloves. Both staff members were observed moving items in the resident's room and placing them on a cart. They came out of the residents room and into the hallway without handwashing or hand sanitizing until questioned by the surveyor. During an interview on 01/20/21 at 1:35 PM, Social Worker #1 acknowledged that Resident #10 was on enhanced droplet precautions. She stated she did not realize the resident remained on enhanced precautions when she entered the room. She indicated she should have donned the required PPE to include gloves, and gown before entering the room, and performed hand hygiene immediately after exiting the room. During an interview on 01/20/21 at 1:35 PM, Housekeeper #1 acknowledged Resident #10 was on enhanced droplet precautions and agreed that he should have donned gloves before entering the resident's room. An interview was conducted on 01/20/21 at 3:00 PM with the Administrator along with the Director	F 880	residents having the potential to be affected by the same deficient practice: On 01/20/2021, The Staff Development Nurse who is also an Infection Preventionist completed a review to ensure appropriate isolation signs for Enhanced Droplet Precautions were on the doors of all residents who were currently on Enhanced Droplet Precautions. The result of the review completed by the Staff Development Nurse revealed that 4 of 4 residents who were on Enhanced Droplet Precautions had an isolation sign on their door. On 01/20/2021, The Staff Development Nurse educated Social Worker #1 and Housekeeper #1 on the facilities policy and procedures using the COVID □ 19 Preparation and Response Policy regarding use of personal protective equipment (PPE) during COVID □ 19, specifically on the policy related to donning/doffing PPE and hand hygiene practice when entering and exiting resident rooms on the Covid -19 Unit. On 01/20/2021, The Staff Development Nurse who is also an Infection Preventionist audited the COVID Unit to observe staff compliance with adherence to wearing the appropriate personal protective equipment in resident rooms and for appropriate hand hygiene practice when entering and exiting resident rooms. Results revealed compliance with current facility personal protective equipment policy.	

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F 880	Continued From page 4 of Nursing. The Administrator stated Resident #10 was on enhanced droplet precautions due to testing positive for COVID-19 and was on day 9 of isolation but had remained asymptomatic during that time. They both indicated that staff were required to follow the facility guidelines for PPE use and full PPE should be worn when entering a resident's room who was on enhanced droplet precautions.	F 880	3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: Education: On 02/01/2021, the Director of Nurses and the Staff Development Nurse/Infection Preventionist initiated education for all full time, part time, PRN staff, and agency staff on the CDC□s Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, Facemask Do□s and Don□ts for Healthcare Personnel, hand hygiene practice, and the facilities COVID -19 Preparation and Response v 19. As of 02/12/20 at 5pm, any employee who has not received this education will not be allowed to work until the training has been completed. This includes full time, part time, agency staff, and PRN staff. The in-service will be incorporated into the new employee general orientation. On 02/07/2021, the Staff Development Nurse/Infection Preventionist will initiate education to all department head staff who will assist with room changes/moves on a new communication system. This new communication system will allow the department head staff to verify the current COVID status of each resident by viewing a real time line listing report with the current COVID status of each resident. This education is for department heads and was initiated as a result of the root	

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F 880	Continued From page 5	F 880	cause analysis. All department heads will have completed this education as of 02/12/2021. As of 02/12/2021 at 5 pm, any department head who has not received this education will not be allowed to work until the training has been completed. Validation: On 02/01/2021, The Director of Nurses and the Staff Development Nurse/Infection Preventionist initiated Personal Protective Equipment (PPE) and Hand Hygiene Competency Validation to validate staff□s knowledge and understanding of the education. As of 02/26/2021 at 5pm, any employee who has not completed the validation of staff competency will not be allowed to work until the validation has been completed. This includes full time, part time, PRN staff, and agency staff. Root Cause Analysis: A Root Cause Analysis was initiated on 02/02/2021 that resulted in the corrective action implemented in this plan of correction. This Root Cause Analysis will be a part of our Performance Improvement Process. The team members participating in the Root Cause Analysis included staff members from the Nursing Department, Infection Preventionist, Environmental Services, Administration Staff, the Clinical Nurse Consultant, and the Medical Director all of who are members of the facility Quality	

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F 880	Continued From page 6	F 880	Assurance and Performance Committee. 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 and the Nurse Management Team including the RN Unit Manager, Staff Development Nurse, and Assistant Director of Nurses will monitor staff adherence to compliance with wearing appropriate PPE (to include donning/doffing of PPE) and hand hygiene practice by 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 Compliance Date: 02/12/2021 POC Compliance Date: 02/12/2021	