STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 The survey team entered the facility on 02/02/21 to conduct a recertification survey. The survey team was onsite 02/02/21 and 02/04/21. Additional information was obtained offsite on 02/03/21 and 02/05/21. The exit date was changed to 02/05/21. The facility was found in compliance with the requirement CFR.483.73, Emergency Preparedness. Event ID QJO011	E 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff, and physician interviews the facility failed to obtain oxygen orders for 1 of 1 residents reviewed for oxygen (Resident #40). The findings included: Resident #40 was admitted to the facility on 1/6/2021 with diagnoses of atrial fibrillation, asthma, and pelvic fracture. Review of medical record oxygen saturation levels listed in vital signs revealed Resident #40 was first documented wearing oxygen on 1/7/2021 at 8:30 PM.	F 695	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by both Federal and State laws. F695 CFR(s):483.25(i) (1) Orders for Oxygen were obtained and	2/26/21

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

Electronically Signed | 02/20/2021

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F 695	Continued From page 1 Review of the admission Minimum Data Set (MDS) dated 1/13/2021 revealed Resident #40 was cognitively intact and required no use of oxygen. Review of the care plan dated 1/18/2021 indicated Resident #40 had no care plan for oxygen use. Review of the physician orders for January 2021 and February 2021 revealed no order for oxygen to be administered. The Medication Administration Record (MAR) for the months January 2021 and February 2021 revealed no administration or monitoring of oxygen usage documented. Review of Resident #40's vital signs revealed from 1/6/2021 through 2/3/2021, Resident #40 wore oxygen via nasal cannula 22 of 29 days. Observation made on 2/2/2021 at 1:39 PM revealed Resident #40 was observed wearing oxygen with an oxygen concentrator beside his bed running. Observations made on 2/4/2021 at 8:33 AM and 2/4/2021 at 10:21 AM revealed an oxygen concentrator in residents room running at 3 liters of oxygen a minute. The nasal cannula was observed on the floor between Resident #40's bed and the oxygen concentrator. An interview conducted on 2/4/2021 at 8:33 AM with Resident #40 stated he does not need to use oxygen. An interview conducted on 2/4/2021 at 10:25 AM	F 695	implemented for resident #40 on 2/5/21. Oxygen saturation levels will be obtained each shift. Care plan for resident#40 has been updated to reflect resident□s status for oxygen use. (2) The Center Nurse Executive (CNE) and/or designee will audit on 2/22/21 all current residents to ensure that all residents that require oxygen have current physician orders in place. The Center Nurse Executive, RN supervisor, and/or designee will perform an audit on 2/22/21 for all residents that have oxygen orders and ensure care plans reflect the resident□s status. (3) The Center Nurse Executive (CNE), RN supervisor, or designee will educate all licensed nurses on policy and procedures for Oxygen use and obtaining physician orders, and ensuring that the care plan reflects resident□s status, starting 2/20/21 and completed by 2/25/21. All staff not in-serviced by 2/25/21 will be required to complete the in-service prior to working. The Center Nurse Executive (CNE), RN supervisor, or designee will review all new orders and new admissions 5 times weekly for three months in the morning clinical meeting, to ensure that residents requiring oxygen have current orders in place, and care plan reflects resident□s status for oxygen use. The Center Nurse Executive (CNE) will educate 2/19/21 the Clinical Reimbursement Coordinator on developing a comprehensive care plan to reflect the resident□s status.	

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F 695	Continued From page 2 with Nurse Aid #1 (NA) revealed Resident #40 had an oxygen concentrator in his room for at least a week. During this interview she stated she observed Resident #40 wearing the nasal cannula with the oxygen running multiple times. NA #1 also stated Resident #40 would often remove the oxygen and verbalize to staff he does not need it. She further stated staff continued to encourage Resident #40 to wear his oxygen. An interview conducted on 2/4/2021 at 10:35 AM with the acting Director of Nursing revealed Resident #40 did not have an order to receive oxygen. During this interview she stated an order should be obtained from a physician prior to staff administering oxygen to any resident. An interview conducted on 2/4/2021 at 11:00 AM with the physician revealed Resident #40's oxygen use was most likely started between 1/22/2021-1/24/2021 after Resident #40 received a new diagnosis of pneumonia. The physician further stated he may have had a conversation with staff about oxygen, but an order should be received prior to administering oxygen to a resident. An interview conducted on 2/4/2021 at 11:31 AM Administrator revealed staff should obtain an order from the physician prior to administering oxygen to a resident.	F 695	(4) The Center Nurse Executive (CNE), RN supervisor, or designee will review all new orders and admissions 5 times weekly for three months in the morning clinical meeting, to ensure that residents requiring oxygen have current orders in place, and care plan reflects status for oxygen use. Need to review all new orders in the clinical morning meeting as well in case a resident gets an order added for oxygen. All findings will be brought to the Quality Assurance Performance Improvement Committee monthly for ongoing compliance.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		2/26/21

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F 756	Continued From page 3 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff, pharmacy consultant and physician interview the facility failed to respond if not in agreement with the consultant pharmacist recommendation for	F 756	F756 CFR(s): 483.45(c)(1)(2)(4)(5) (1) The physician was made aware of the missed GDR for Resident# 157, and the	

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F 756	Continued From page 4 gradual dose reduction (GDR) for a psychoactive medication for 1 of 5 sampled residents reviewed for unnecessary medication review (Resident #157). Findings included: Resident #157 was admitted to the facility on 04/08/19 with diagnoses that included depression, insomnia, anxiety, and dementia without behavioral disturbance. Review of the quarterly Minimum data Set (MDS) dated 01/07/21 revealed Resident #157 was cognitively impaired and had no behaviors. Review of the physician order dated 09/19/19 revealed an order for Trazadone 100mg every night at bedtime. The order remained active until 12/02/20. Review of the medical record revealed on 9/25/20 the consultant pharmacist recommended that the physician consider a GDR of Resident #157's use of Trazadone from 100mg to 75mg. A review of Resident #157's medical record and physician orders revealed the physician had not responded with documentation or provided a rational for the consultant pharmacist recommendation on 9/25/20 for consideration of a GDR for the use of Trazadone for insomnia. An interview with the Assistant Director of Nursing (ADON) on 02/05/21 at 3:45 PM revealed the Director of Nursing (DON) had been receiving the recommendations from pharmacy monthly and would give them to the physician and he would act upon them during his next visit. He made	F 756	reduction was completed on 12/2/20. (2) Any resident with pharmacy recommendations has the potential to be affected. A 30-day look back of 100% of the pharmacy recommendations for current residents was completed by the Administrative Nursing Team on 2/19/21 to ensure pharmacy recommendations were completed. If any pharmacy recommendation was determined not to be completed, the physician was notified to obtain orders for further direction. (3) The Administrative Nursing Team was in-serviced by the Regional Resource Nurse on 2/19/21 regarding the pharmacy recommendation process of running the summary report and reviewing the recommendations with the physician. (4) The pharmacy recommendations will be audited weekly by the Director of Nursing to determine if they were addressed and completed timely. When the recommendations are received by the Director of Nursing, they will be reviewed with the physician. Once reviewed the physician will address recommendations and implement orders if needed. The completed form will be faxed to the pharmacy and uploaded into the medical record. The audit will be completed twice weekly for four weeks, then weekly until 100% compliance is met for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified	

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F 756	Continued From page 5	F 756		

visits 3 times a week. She stated that after a pharmacy recommendation was made, and the physician wanted to change the resident's order, a new order would be implemented.

An interview with the consultant pharmacist on 02/05/21 at 4:45 PM revealed she had remote access to the electronic health record, and she would send pharmacy recommendations to the DON each month electronically. She further stated she reviewed the resident's medical record to see if recommendations had been followed up on but did not know why the recommendation for a GDR of Trazadone for Resident #157 was not addressed for recommendation sent on 9/25/20. She indicated she had documentation that identified in October 2020 no changes had been made by the physician to Resident #157s Trazadone. The pharmacist further revealed she must have missed following up on it.

An interview with the Administrator on 02/05/21 revealed pharmacy would electronically send the recommendations to the DON and the DON would give them to the physician. The physician would review the pharmacy recommendations and sign them identifying whether he agreed or disagreed with the recommendation during his next visit to the facility. He made visits 3 times a week.

An interview with the Medical Director on 02/05/21 at 6:10 PM revealed the DON would give him the pharmacy recommendations, and he would review and sign them. He stated if he made changes, he entered the order into the electronic health record himself and a nurse would confirm the order. Recommendations for Resident #157 were not addressed when initially based on findings.

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F 756	Continued From page 6 made. He stated he did not recall why the Trazadone was not decreased when the recommendation was made but it had since been decreased to 50mg. He further stated that the pharmacy would make the recommendation and they were supposed to get new orders back from the facility. If the pharmacy did not get orders back, they should contact the facility. A review of the record revealed the Trazadone was decreased over 2 months later following the pharmacist's recommendation to consider the drug reduction. The new order, of Trazadone 50 mg daily, was dated 12/2/20.	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		2/26/21

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F 761	Continued From page 7 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and an interview with the pharmacist the facility failed to remove expired medications from 1 of the 2 medication carts, failed to document open dates of medication in 2 of 2 medication carts, and failed to secure and label unidentified loose pills in 2 of the 2 medication carts. The findings included: 1. An observation on 02/04/21 at 2:34 PM, of Medication Cart #1 on the 100 hall with nurse #2 present, revealed 2 opened containers of Geri Care Artificial Tears, one expired 10/2020 and the second expired 12/2020, 1 opened container of Durazol Eye Drops with an opened date of 12/31/20, and an opened bottle of liquid Morphine was not labeled with an opened date. An additional observation at this time revealed 6 and ½ unidentified loose pills in the back of the top left drawer. In an interview was conducted with Nurse #2 on 02/04/21 at 2:34 PM. During this interview, Nurse #2 verified that all the eye drops found in the cart were expired and stated these expired medications could have been used on a resident. Nurse #2 stated she is unsure how long any medications were good for once opened and she did not know the process on how or when medication carts were checked. Nurse #2 stated there should not be loose pills in the medication cart, and she threw them away in the sharp's	F 761	F761 CFR(s): 483.45(g)(h)(1)(2) (1) No residents were found to be affected by the expired, undated, or loose medications located on the medication carts. The medications were removed upon notification from the surveyor. (2) Any resident receiving medication has the potential to be affected. A thorough inspection of all facility medication carts and medication rooms was conducted by the Administrative Nursing Team on 2/19/21 to ensure there were no expired or undated medications noted on the medication carts, any discrepancies were corrected upon discovery. (3) The licensed nurses were in-serviced by the Nurse Practice Educator (NPE) or designee regarding dating medications when opened, checking the medication cart prior to the start of their medication pass for expired, loose and undated medications on 2/15/21-2/25/21, and education will be added to the orientation agenda. All staff not in-serviced by 2/25/21 will be required to complete the in-service prior to working. A reference chart for medication expirations was placed on the medication carts by the Center Nurse Executive (CNE) on 2/19/21. The medication carts will be	

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F 761	Continued From page 8 container. 2. An observation on 02/04/21 at 4:00 PM, of Medication Cart #2 on the 200 hallway, with Nurse #1 present, revealed, 1 an opened container of Brimonidine Tartrate eye drops with no open date, 1 opened bottle on Nitroglycerin with no open date, 1 opened bottle of Ultra Tus with no open date, 1 opened bottle of Milk of Magnesia with no open date. An additional observation at this time revealed 1 and ½ loose pills in the back of the top left drawer. Interview with Nurse #1 on 02/04/21 at 4:00 PM, and she stated the medication carts were to be checked every shift for expired medications. She stated when medications are opened there should be an open date documented. Nurse #1 stated the loose pills should have been removed from the medication cart. She stated the medications carts are checked every shift by the nursing staff. Nurse #1 also stated the pharmacy checked the carts, but she is unsure of when they check the carts. During the interview Nurse #1 removed the open medications containers that were not dated and disposed of the loose pills in the sharp's container. An interview was conducted with the Assistant Director of Nursing on 02/04/21 at 4:45PM. During this interview, she stated she did not know the expiration date of the opened eye drops in medication cart #1 but would investigate and verify. She also stated that medications should be labeled with the opened date and that nursing should check the carts weekly for expired medications and ensure there are no loose pills. During an interview with the Regional Nurse	F 761	checked every Wednesday on first shift 7:00AM-7:00PM by the licensed nurses for expired, loose, or undated medications as part of the medication reorder review. (4) The Director of Nursing or designee will complete audits of all medication carts and medication rooms weekly to check for expired, loose, or undated mediations until 100% compliance is maintained for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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F 761	Continued From page 9 Manager on 02/05/21 at 1:35 PM, she stated they investigated the expiration dates of the open eye drops in medication cart #1, and they were all expired and should not have been in the medication cart for use. An interview on 02/05/21 at 4:45 PM the contracted Pharmacist, revealed they have no responsibility or procedures in place to check the facility medication carts for labeling, expirations or storage.	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and physician interviews, the facility failed to obtain lab work per physician orders for 1 of 5 sampled residents reviewed for lab services (Resident #157). Findings included: Resident #157 was admitted to the facility on 04/08/19 with diagnoses that included congestive heart failure (CHF), chronic respiratory failure, atherosclerosis, muscle weakness, obesity and Vitamin D deficiency.	F 770	F770 CFR(s): 483.50(a)(1)(i) (1) The physician was made aware of the missed lab for resident# 157 and was instructed regarding entering the order so that it appeared on the Medication Administration Record (MAR) in order for the nurse to be aware of an order for that date and time. The BMP was obtained for resident# 157 by the facility on 2/9/21. (2) Any resident with ordered labs has the potential to be affected. A 30-day look	2/26/21

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F 770	Continued From page 10 Review of physician order dated 03/02/20 revealed an order for a Basic Metabolic Panel (BMP), lab test to monitor metabolism, was to be completed every 6 months. Review of Resident #157's medical record revealed the last BMP was obtained on 06/03/20. The results showed Resident #157 had a slightly elevated creatinine level. There was no record of a BMP being obtained for Resident #157 since 6/03/20. Resident #157's current plan of care, which was most recently revised by staff on 09/04/20 had a care plan for nutritional risk related to obesity and CHF. The goal specified Resident #157 would maintain a stable weight, have no signs and symptoms of dehydration, and have labs within normal limits. The interventions included monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss or gain, abnormal labs) and report to the nutritionist and physician. An interview with the Assistant Director of Nursing (ADON) on 02/05/21 at 3:45 PM revealed labs were placed on the medication administration record (MAR) so the nurse would know to draw the lab. She further indicated she did not have any unfiled lab results, and all completed labs should have been in the resident's medical record. An interview with the Administrator on 02/05/21 at 5:10 PM indicated she did not have any unfiled lab results and they should be in the resident's record. She further indicated the facility recently noticed they had a problem with obtaining resident labs as ordered and were working on the	F 770	back of lab orders for current residents was completed by the Administrative Nursing Team on 2/18/21 to ensure ordered labs were completed as ordered and results were received for the correct labs ordered. If any lab was determined not to be completed, the physician was notified to obtain orders for further direction. (3) The Administrative Nursing Team was in-serviced by the Regional Resource Nurse on 2/19/21 regarding the clinical process of reviewing labs in the morning clinical meeting to ensure the correct lab is drawn and correct results are received. The licensed nurses were in-serviced by the Nurse Practice Educator, Director of Nursing, or designee on 2/19/21 through 2/25/21 regarding the order entry process for labs and indicating the lab to go to the MAR so they are aware of lab orders and to ensure completion. (4) The lab orders will be audited in the daily clinical meeting by the Director of Nursing, Nurse Practice Educator, or designee to determine if the correct lab was drawn. When results are received, the results will be checked against the provider order to ensure the results are for the ordered lab. The audit will be completed daily for four weeks, then weekly until 100% compliance is met for two consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	

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ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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
F 770	Continued From page 11 lab policy. An interview with the Medical Director on 02/05/21 at 6:10 PM revealed a problem with obtaining labs was identified a few weeks ago when he discovered he was missing lab results. He was recently informed that he needed to enter lab orders in the MAR of the electronic record so they would show up on the MAR and the nurses would see the order.	F 770		
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 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		2/26/21

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F 880	Continued From page 12	F 880		

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

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

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

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F 880	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement their personal protective equipment (PPE) policy when 4 of 4 staff failed to don gloves when entering the rooms of residents who were on Patient-Specific Contact Plus Airborne Precautions and resided on the facility's quarantine hallway. (Nurse #3, Nurse Aide #2, Nurse Aide #3, and Therapy Staff #1) This failure happened during a COVID-19 pandemic. Findings included: Facility Policy IC301 titled, Contact Precautions, revealed staff are required to wear gloves when entering residents ' rooms. The policy effective date was 02/15/01, revised 6/15/19, and reviewed on 11/15/20. 1. Observations of the facility's 200 hallway (quarantine hall) revealed the following: a. On 02/02/21 at 4:30 PM, Nurse #3 was observed to enter room #220 and was not wearing gloves. While in the resident's room Nurse #3 was observed to administer medications to the resident without wearing gloves. A sign was observed posted at the entrance to room #220 titled Patient-Specific Contact Plus Airborne Precautions, instructed that upon entering the room all must be wearing a mask, gown, face shield and gloves. On 02/02/21 at 4:42 PM Nurse # 3 was observed to enter room #211 and was not wearing gloves. While in the resident's room Nurse #3 was observed to administer medications to the	F 880	F880 CFR(s): 483.80(a)(1)(2)(4)(e)(f) (1) Nurse #3, Nurse Aide #2, Nurse Aide #3, and Therapy Staff #1 were re-educated by the Nurse Practice Educator on 2/19/21 regarding isolation precautions for Patient-Specific Contact Plus Airborne Precautions to include wearing gloves when entering a room on those specific precautions. There were no negative outcomes for the residents related to those employee□s failure to don gloves when entering their rooms. (2) Any residents on isolation precautions have the potential to be affected. Facility staff was educated by the Regional Resource Nurse Manager during the survey regarding isolation precautions and isolation requirements for Personal Protective Equipment (PPE) specifically Patient-Specific Contact Plus Airborne Precautions to include wearing gloves when entering the rooms. (3) All facility staff were re-educated by the Director of Nursing, Nurse Practice Educator, or designee on 2/19/21-2/25/21 regarding the importance of adhering to isolation precautions, the PPE required for each types of isolation, specifically Patient-Specific Contact Plus Airborne Precautions to include wearing gloves when entering the rooms, and the importance of reviewing isolation signs prior to entering rooms to ensure the proper PPE is donned. All staff not	

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F 880	Continued From page 14 resident without wearing gloves. A sign was observed posted on the entrance to room #211 titled Patient-Specific Contact Plus Airborne Precautions, instructed that upon entering the room all must be wearing a mask, gown, face shield and gloves. On 02/02/21 at 4:44 PM an interview was conducted with Nurse #3 and she stated she did not need to wear gloves to administer medications to residents. Nurse #3 stated she did not think the precaution signs posted at the entrances to room #220 and room #211 instructed all to wear gloves. Nurse #3 reviewed the precautionary signage on the door of rooms 220 and 211 she stated she should always be wearing gloves when entering a resident room. b. On 02/04/21 at 9:10 AM Nurse Aide (NA) #2 was observed to enter room #217 and was not wearing gloves. The resident was in the room while in the room NA #2 was observed to change the bed linens while not wearing gloves. There was a sign on the room ' s door titled Patient-Specific Contact Plus Airborne Precautions, instructed that upon entering the room all must be wearing a mask, gown, face shield and gloves On 02/02/21 at 9:13 AM in an interview was conducted with Nurse Aide #2 and she stated that she did not wear gloves while changing resident's bed linens. When Nurse Aide #2 reviewed the precautionary signage posted on the resident ' s room door, she stated she knew she should have be wearing gloves when she entered the room. c. On 02/04/21 at 10:05 AM Nurse Aide # 3 was observed to enter room #207 with no gloves on	F 880	in-serviced by 2/25/21 will be required to complete the in-service prior to working. This education will be completed for all newly hired staff during the orientation process and will be repeated at least quarterly. (4) Random audits of three staff entering isolation rooms will be completed by the Administrative Nursing Team or designee on every shift at least three times per week until 100% compliance is maintained for two consecutive weeks then on every shift weekly for two additional months. Outcomes of those audits will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 880	Continued From page 15	F 880		

and was carrying a container of juice. While in the room NA #3 was observed to serve juice to a resident while not wearing gloves. A sign posted on the door of room #207 titled Patient-Specific Contact Plus Airborne Precautions, instructed that upon entering the room all must be wearing a mask, gown, face shield and gloves.

On 02/04/21 at 10:07 AM an interview was conducted with Nurse Aide #3. When asked when she should wear gloves upon entering the patent ' s room she immediately replied "always". Nurse Aide #3 stated the sign on the resident's door tells her to wear gloves. She then stated, "It's my bad, I forgot."

d. On 02/04/21 at 10:32 AM Therapy Staff #1 was observed to enter room #211 and was not wearing gloves. While in the resident's room Therapy Staff #1 was observed to provide therapy, which involved touching the resident, without wearing gloves. A sign posted on the door titled, Patient-Specific Contact Plus Airborne Precautions, instructed that upon entering the room all must be wearing a mask, gown, face shield and gloves.

On 02/04/21 at 11:05 AM in an interview with Therapy Staff revealed he would wear gloves to provide therapy if the resident had open wounds or an infection like C-Diff. Upon reviewing the posted signage on the resident's door, he stated "I guess I should have worn gloves." He stated he had not really read the precautionary sign.

On 02/04/21 at 11:40 AM in an interview with the facility Administrator she revealed that it was her expectation all staff wear gloves when entering a resident's room regardless of the reason they are

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F 880	Continued From page 16 going into the room.	F 880		