STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345526	A. BUILDING _____ B. WING _____	C 04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA REHAB CENTER OF BURKE	3647 MILLER BRIDGE ROAD CONNELLY SPG, NC 28612

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E 000	Initial Comments An unannounced Recertification survey was conducted on 4/12/21 through 4/15/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MTT611.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 4/12/21 to conduct a recertification and complaint survey and exited on 4/15/21. A total of 9 allegations were investigated and all of them were unsubstantiated. Event ID# MTT611	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with staff, resident, Nurse Practitioner and Physician, the facility failed to administer a medication as prescribed for 1 of 3 residents (Resident #76) reviewed for medication administration. Resident #76 did not receive Senna S that was prescribed to be given twice a day starting on 3/31/21 and missed a total of 28 doses. The findings included:	F 684	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s	5/9/21

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

Electronically Signed | 05/04/2021

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F 684	Continued From page 1 Resident #76 was admitted to the facility on 2/20/21 with diagnoses that included abdominal wall abscess and diabetes. The Admission Minimum Data Set (MDS) assessment dated 2/26/21 indicated Resident #76 was cognitively intact, required extensive physical assistance with toileting and was always incontinent of bowel. A review of Resident #76's medical record indicated an order written by the Nurse Practitioner on 3/31/21 to stop current Senna S and start Senna S po (by mouth) BID (twice a day) for hard stools/constipation. A review of Resident #76's Medication Administration Record from 3/31/21 to 4/14/21 indicated U-SA (unsupervised self-administration) marked for Senna S on the days and times that it was supposed to be given. A review of Resident #76's Bowel Elimination Report from 3/31/21 to 4/14/21 revealed no recorded bowel movement for Resident #76 from 4/1/21 to 4/5/21. An observation was made of Nurse #2 administering medications to Resident #76 on 4/14/21 at 8:38 AM. Nurse #2 was observed giving 14 of 15 medications by mouth to Resident #76. Nurse #2 did not give Resident #76's Senna S dose. An interview with Nurse #2 on 4/14/21 at 10:06 AM revealed she did not give Resident #76's Senna S dose at 8:38 AM because it had not been marked on the EMR (electronic medical	F 684	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nurse received order change for a medication (senna plus) when transcribing order self-administration was checked versus clinician therefore showing up on eMAR as self-administration this resulting in patient not receiving medication during this time. Patient missed 14 days of senna plus, no harm resulting to patient during this time. Patient continued to have no issue with bowel movements during this time. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice: Completion: 100% initial audit be completed on all residents' orders to ensure accuracy of transcription for dates April 1-April 20th. Audits began daily after April 20th 2021. All licensed nursing staff in-serviced on facility receiving and accuracy of order transcription. All newly hired licensed nurses will receive in-service training on facility policy/procedure for receiving/transcribing orders. All licensed nursing staff will receive this education by the Director of Nursing or SDC on 04/14/2021 and will not be permitted to work until education has been completed. Completion: 04/20/2021	

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F 684	Continued From page 2 record) as one of the medications that were due to be given. Nurse #2 stated she was not sure if it was on hold and was going to check with the unit manager about the order. An interview on 4/14/21 at 1:12 PM with the Unit Manager (UM) revealed she had looked into Resident #76's Senna S order and found out that it had been transcribed incorrectly by Nurse #2 on 3/31/21 when she received the order. The UM stated that Nurse #2 might have inadvertently clicked on the unsupervised self-administration button when she was entering the order into the EMR and this led to the order for Senna S to not show up for the nurses to administer on the times it was scheduled to be given. The UM disclosed that Resident #76 had not been receiving the Senna S as it had been prescribed on 3/31/21. She added that she was responsible for checking behind Nurse #2 after transcribing orders into the EMR but she admitted that she did not catch the error because the EMR normally defaulted to the clinician button whenever orders were entered and the nurses never had to pick the button for unsupervised self-administration so she did not usually pay attention to this area. A follow-up interview with Nurse #2 on 4/14/21 at 1:28 PM revealed she had mistakenly entered Resident #76's Senna S order as unsupervised self-administration on the EMR when she transcribed it on 3/31/21. Nurse #2 stated she did not know how it happened. She added that Resident #76 had not complained about feeling constipated in the past two weeks when she was not getting her Senna S. An interview with Resident #76 on 4/14/21 at 2:00 PM revealed that she last had a bowel movement	F 684	What measures will be put in place or systemic changes made to ensure that the deficient proactive will not occur: Director of Nursing and/or Unit Managers will audit all receiving orders and order transcription 5 times per week for 4 weeks, bi-weekly times 4 weeks, then monthly times 1 month, to ensure accuracy of receiving/transcribing orders. Results of the audits will be reviewed in QA. Any areas identified will be corrected immediately and licensed nursing staff will be in-serviced to changes in the current plan. Completion: 07/14/2021 How the facility plans to monitor its performance to make sure the solutions are sustained: All results of the receiving and transcription of orders audits will be reviewed in the Quality Assurance meeting monthly, and as needed. Date of Compliance: May 9, 2021	

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on 4/13/21. Resident #76 remembered not having had a bowel movement for at least five days in April but added that she had not been eating very much because she had been nauseated. Resident #76 remembered one day in April when she had difficulty having a bowel movement and was holding a hard stool in her rectum for at least three hours before she was finally able to move it. Resident #76 stated she did not usually ask for a laxative because she thought she was being given her Senna S as scheduled.

A phone interview with Nurse Aide (NA) #2 on 4/14/21 at 5:28 PM revealed she had cared for Resident #76 on 4/2/21, 4/3/21 and 4/4/21 but did not remember her having a bowel movement on those dates. NA #2 stated she did remember Resident #76 complaining about having difficulty trying to have a bowel movement on those dates. She also remembered one day but could not remember which date it was when she had to turn Resident #76 from side to side trying to help her move her bowels. While NA #2 was changing Resident #76's brief, a hard stool popped out of Resident #76's rectum when she turned her over to the side. NA #2 could not remember if she had notified the nurse of Resident #76's complaints about having difficulty with bowel movement.

A phone interview with Nurse #3 on 4/14/21 at 5:30 PM revealed she had cared for Resident #76 on 4/2/21, 4/3/21 and 4/4/21 but did not remember seeing an alert in the EMR about Resident #76 not having had a bowel movement for 3 days. Nurse #3 stated she had received no report of Resident #76 having difficulty moving her bowels and did not remember checking Resident #76 for signs of constipation.

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F 684	Continued From page 4	F 684		

An interview with Nurse #4 on 4/15/21 at 7:04 AM revealed she had worked with Resident #76 on the evening and night shifts and did not remember Resident #76 complaining of constipation. Nurse #4 also worked on 3/31/21 and remembered double-checking Resident #76's order for Senna S but did not pay attention to the clinician and unsupervised self-administration buttons because the EMR usually defaulted to the clinician button and she did not need catch that the order had been marked as unsupervised self-administration.

An interview with the Nurse Practitioner (NP) on 4/15/21 at 9:01 AM revealed she had decided to order Senna S twice a day for Resident #76 on 3/31/21 because she was complaining of being constipated, she was on chronic pain medications, had a large abdominal wound and a gastric sleeve. The NP shared that the previous order for Senna S was just once a day, so she decided to increase it to twice a day. The NP stated that bowel regimen was different for each resident and Resident #76 normally went five days without moving her bowels. The NP also stated that she knew the physician had examined Resident #76 on 4/5/21 because she was complaining of abdominal discomfort. From reading the physician's notes, she knew that the physician had palpated Resident #76's abdomen and checked her abdominal wound during the visit. The NP was not sure if the physician had ordered anything during Resident #76's 4/5/21 visit. The NP remembered checking on Resident #76 on 4/6/21 and being told by the resident that she just had a bowel movement and that she was feeling better. The NP did not know that her order for Senna S on 3/31/21 had not been

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carried out by the nursing staff but she did not believe that this contributed to Resident #76 not having had a bowel movement for at least five days. The NP shared this pattern of no bowel movement for five days might have been normal for Resident #76. The NP also stated that she expected the nurses to accurately transcribe her orders but felt the error in Resident #76's Senna S order was due to a computer issue. She added that it was very unusual for a medication order to be entered in the EMR as self-administration.

An interview with the physician on 4/15/21 at 11:50 AM revealed that he had examined Resident #76 on 4/5/21 because she was complaining of abdominal discomfort. The Physician stated he was not sure if the discomfort was coming from Resident #76's abdominal wound or from being constipated. The physician ended up not giving any orders after the visit because he wanted Resident #76 to go and have a bowel movement naturally which meant increasing fiber in her diet or giving her more water and prune juice. The Physician added that he typically did not like resorting to medications if they were not really needed. The Physician also stated that he was more concerned about Resident #76 not being able to empty her bowels fully whenever she had a bowel movement. The Physician emphasized that Resident #76's not getting the Senna S as ordered did not make a significant impact on her. He added that if Resident #76 had received her Senna S as ordered, it would have helped her to have more effective bowel movements. The Physician said that he expected all orders to be transcribed accurately and any error with transcription should have been caught when the orders were double-checked.

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F 684	Continued From page 6 An interview with the Director of Nursing (DON) on 4/15/21 at 1:50 PM revealed that she was not sure if Nurse #2 had made a mistake when she was entering Resident #76's order for Senna S in the EMR or if the unsupervised self-administration button was already set because the nurses did not usually deal with this area in the EMR as it automatically defaulted to the clinician button. The nurses who checked behind Nurse #2 missed the transcription error because they were not trained to click on view to look at the whole order as it was transcribed in the EMR. An interview with the Administrator on 4/15/21 at 1:50 PM revealed that she attributed the error in the transcription of Resident #76's order for Senna S to a computer glitch. The Administrator stated they had never encountered the same issue before and she was sure that Nurse #2 did not make an error because all the nurses knew not to check the self-administration button in the EMR as self-administration of medication by the residents in the facility was not allowed. The Administrator also stated that she expected all the nurses to transcribe orders accurately in the EMR.	F 684		
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.	F 880		5/9/21

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F 880	Continued From page 7 §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; (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	F 880		

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F 880	Continued From page 8 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 staff interviews, the facility failed to implement the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 2 of 2 staff members (Nurse #1 and Nurse Aide #1) failed to discard their masks after providing care to 11 of 11 residents on the quarantine hall and went to care for 5 of 5 residents on a non-quarantine hall, failed to wear an N95 or higher respirator and failed to prevent 1 of 11 quarantined residents (Resident #184) from leaving the quarantine hall, all reviewed for infection control practices. These observations occurred during a global pandemic. Findings included: The Centers for Disease Control and Prevention (CDC) guidance entitled, "Preparing for	F 880	F880 Infection Control How corrective action will be accomplished for those residents found to have been affected by the deficient practices. Nurse #1 and Nurse Aide #1 failed to wear appropriate mask when caring for residents on Enhanced Droplet Precaution. Nurse #1 and Nurse Aide #1 were under the assumption that the center was continuing to optimize mask quantity supplies and because the Enhanced Droplet Precaution sign on the door states the use of surgical mask and face shield or N95 if available, thus only using the surgical mask and not the N95. Both staff members were re-educated regarding Enhanced Droplet Precaution PPE when not in conservation mode.	

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F 880	Continued From page 9 COVID-19 in Nursing Homes," updated on 11/20/2020 indicated the following statement under the section "Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown:" " Healthcare Personnel (HCP) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves and gown when caring for these residents. The CDC guidance entitled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," updated on 02/23/2021 indicated the following statements under the section "Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection:" " Disposable respirators should be removed and discarded after exiting the patient's room or care area and closing the door unless implementing extended use or reuse. " Put on eye protection (i.e., goggles or face shield that covers the front and sides of the face upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply. " Remove eye protection after leaving the patient room or care area unless implementing extended use. " Reusable eye protection (i.e., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse.	F 880	Nurse #1 has received re-education regarding allowing the appropriate residents who may leave the quarantine area/14 day new admit area. All employees have been re-educated regarding: a) proper PPE for Enhanced Droplet Precaution Rooms (specially the type of mask required when not in conservation mode); b) to change out their mask when exiting the quarantine area/14 day new admit area; c) residents who are or are not allowed to come off the quarantine area/14 day admit area. Completion Date: May 9, 2021 How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice Nurse #1 and Nurse Aide #1 had been in-serviced on multiple occasions regarding proper PPE for Enhanced Droplet Precaution Rooms, last on 11/25/2020 and again on 5/4/2021. Nurse #1 had been previously educated regarding the process for residents who are and are not vaccinated (therefore who must be quarantined versus not quarantined to their designated room) on 3/29/2021. Both Nurse #1 and Nurse aide #2 have received documented education regarding the proper use of PPE for when caring for residents who are on Enhanced Droplet Precautions to include changing out their mask appropriately and what type of mask to use when not in conservation mode. Nurse #1 has received re-education regarding the centers process for	

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F 880	Continued From page 10 Review of the facility infection control manual revealed a Policy and Procedure entitled, "Infection Prevention and Control Policies and Procedures - COVID-19," under number 6. New Admissions/Readmissions/Return to Center from outside visits including hemodialysis patients: " Place new admissions/readmissions in a designated area of the Center. " Quarantine is not recommended for patients who are being admitted if they are fully vaccinated* and have not had prolonged close contact with someone with COVID-19 in the last 14 days. " Unvaccinated new admissions will be cared for using recommended personal protective equipment and placed on Enhanced Droplet-Contact Precautions. Monitor for signs and symptoms of COVID-19 every day for fourteen (14) days. If no symptoms appear, the patient may be moved out of this designated area and precautions discontinued on day fifteen (15). " *Fully vaccinated refers to a person who is greater than or equal to two weeks following receipt of the second dose in a two dose series or greater than or equal to two weeks following receipt of one dose of a single dose vaccination, per the CDC and Public Health Recommendations for vaccinated persons. During an observation on 04/13/2021 at 9:40AM of the quarantine hall, all resident doors had posted signage for enhanced droplet contact precautions requiring mask, gown, gloves, face shield or goggles. There were supplies of personal protective equipment (PPE) on the doors or in bins outside the doors including surgical masks, gowns, gloves and disinfectant wipes throughout the quarantine hall. At the time	F 880	residents who may or may not leave the quarantine area/14 day new admit area based on their vaccination status. All employees have been re-educated regarding: a) proper PPE for Enhanced Droplet Precaution Rooms (specially the type of mask required when not in conservation mode); b) to change out their mask when exiting the quarantine area/14 day new admit area; c) residents who are or are not allowed to come off the quarantine area/14 day admit area. Completion: May 9, 2021 What measures will be put in place or systemic changes made to ensure that the deficient practice will not occur Infection Preventionist and/or Unit Manager will make rounds twice daily Monday-Friday to ensure staff are adhering to Enhanced Droplet Precautions and ensuring that only the appropriate residents are leaving the new admit/14 day isolation area. This will be daily x 4 weeks then monthly x 1 month. All nursing staff who may enter the Enhanced Droplet Precaution Rooms work on 12/hour rotations, therefore will be monitored once on day shift and once on evening shift. Results of audits will be reviewed in QA. Any areas identified will be corrected immediately. Completion: June 30, 2021 How the facility plans to monitor its performance to make sure the solutions are sustained	

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(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 880	Continued From page 11 of the observation there were 11 residents on the quarantine hall. 1. On 04/14/2021 during a continuous observation from 1:10PM to 1:38PM Nurse Aide (NA) #1 and Nurse #1 were observed entering rooms on the quarantine hall wearing a surgical mask instead of an N-95 mask and face shield while delivering and setting up meals for residents on the quarantine hall, administering medications to residents in room and providing care for the residents on the quarantine hall. Nurse #1 and NA #1 were observed utilizing the face shields on the doors to the resident rooms on the quarantine hall but failed to change their mask when going room to room and out of the quarantine hall. NA #1 was observed delivering and setting up trays on the quarantine hall, exiting the quarantine hall and delivering trays on the non-quarantine hall at approximately 1:15PM with the same surgical mask on her face. Nurse #1 was observed from 1:10PM to approximately 1:20PM delivering trays on the quarantine hall with the same surgical mask on going room to room. After delivering the trays, at approximately 1:30PM Nurse #1 was observed to exit the quarantine hall with the same surgical mask on going through the non-quarantine hall and into the nurses station and medication room with the same surgical mask on as she had on the quarantine hall. An interview on 04/14/2021 at 2:44PM with Nurse #1 revealed she had changed her face shield for the residents on the quarantine hall but stated she had not changed her mask. Nurse #1 stated she had not been instructed to change her mask when leaving the quarantine hall and going onto the non-quarantine hall. She further stated she	F 880	All results of the Enhanced Droplet Precaution/PPE audits along with the monitoring of the appropriate residents who leave the new admit/14 day isolation area will be reviewed in the Quality Assurance meeting monthly and as needed. Date of Compliance: May 9,2021	

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	345526	A. BUILDING _____ B. WING _____	C 04/15/2021

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had not been instructed she had to wear an N95 mask on the quarantine hall.

An interview on 04/14/2021 at 4:20PM with NA #1 revealed she was assigned to take care of residents on the quarantine hall and the non-quarantine hall. She stated she had changed her face shield and used the ones on the doors of the residents on the quarantine hall but had not changed her mask between the residents on the quarantine hall, nor had she changed it before exiting the quarantine hall. NA #1 further stated she had not changed her mask when going from the quarantine hall to the non-quarantine hall because she was not aware, she was required to do so. She indicated she had not been instructed to wear an N95 and was told a surgical mask was sufficient.

An interview on 04/13/2021 at 2:30PM with the Central Supply Clerk (CSC) revealed the facility had plenty of Personal Protective Equipment (PPE). She stated they kept a 72-hour supply of equipment in the facility and had plenty of gloves, gowns, masks (surgical, KN95 and N95). goggles, and face shields. The CSC further stated she ordered some supplies once a month because they ordered in bulk and some, like gloves were ordered by corporate once a month and distributed. She indicated they were not having to use any equipment with extended use and were not re-using anything except face shields which staff clean between uses. She further indicated the Infection Control Preventionist (ICP) or Unit Managers were responsible for placing the PPE bins or PPE pockets on the doors of the isolation rooms.

An interview on 04/15/2021 at 1:39PM with the

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Staff Development Coordinator (SDC) and Infection Control Preventionist (ICP) revealed the staff had been educated on the principles of infection control and caring for residents on quarantine for COVID-19. She stated they had done numerous educations sessions on infection control including the use of appropriate Personal Protective Equipment (PPE) when caring for residents suspected of or having COVID-19. The ICP further stated the staff knew they were supposed to wear an N95 or KN95 mask on the quarantine hall; however referenced the SPICE signage that stated if an N95 was not available, a surgical mask covering the face, nose and mouth could be worn. The ICP stated the staff had been fit tested and there were N95 masks available for them to use.

An interview on 04/15/21 at 1:49PM with the Director of Nursing revealed all staff had been educated and trained to change their masks when going room to room on the quarantine hall and should be wearing an N95 or KN95 mask on the quarantine hall. She further stated they had been educated to change from their N95 or KN95 into a clean surgical mask each time they leave the quarantine hall to go to other non-quarantine hallways.

An interview on 04/15/21 at 2:30PM with the Administrator revealed the staff should be changing their masks when going in and out of resident rooms on enhanced droplet contact precautions and stated they should change into a clean surgical mask when leaving the quarantine hall to go onto non-quarantine hallways. The Administrator stated the staff should be wearing an N95 or KN95 mask while caring for residents on the quarantine hall and had been educated on

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infection control principles and should know to change their masks

2. Resident #184 was admitted to the facility on 03/30/2021 for short term rehab and there was no documented Minimum Data Set (MDS) available; however according to the initial nursing assessment the resident was alert and oriented to person, place and situation, and able to make her needs known.

On 04/14/2021 at approximately 1:30PM, Resident #184 came out of her room in the quarantine hall without a mask and Nurse #1 placed a mask on the resident's face. The resident propelled in her wheelchair to the double doors where Nurse #1 was observed opening the door for the resident to exit the quarantine unit. The resident was observed propelling up the 300 hallway, which was a non-quarantine hall and NA #1 stopped and talked with the resident and the resident then propelled on through the 300 hallway out to the nurse's station and onto the hallway between the 200 hall and the other hallways. Resident #184 then was propelling up the main lobby hallway and reached the bathrooms before she was stopped by a housekeeper and instructed to return to her room. Resident #184 propelled back through the 300 hallway and was going outside until a therapist stopped her and brought her back into the quarantine hall and into her room. The resident was observed with her mask down below her nose the entire time while propelling through the building.

An interview on 04/14/2021 at 2:44PM with Nurse #1 revealed residents on the quarantine hall could come out of their room provided they had a mask

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on their face and stated they could leave the unit if they so desired.

An interview on 04/14/2021 at 4:20PM with NA #1 revealed she was assigned to take care of residents on the quarantine hall and the non-quarantine hall. She stated she was under the impression that residents on the quarantine hall could come out of their room provided they had a mask on their face and stated they could leave the unit if they wanted to do so.

An interview on 04/15/2021 at 1:39PM with the Staff Development Coordinator (SDC) and Infection Control Preventionist (ICP) revealed the staff had been educated on the principles of infection control and caring for residents on quarantine for COVID-19. She stated they were aware residents should remain in their rooms if at all possible and should not leave the unit unless they have an appointment or there is an emergency with the resident.

An interview on 04/15/21 at 1:49PM with the Director of Nursing revealed all staff had been educated and trained on infection control principles. She stated residents on quarantine should remain in their rooms if at all possible and if out of their rooms they should be wearing a face mask. The DON further stated the residents should not be leaving the quarantine unit.

An interview on 04/15/21 at 2:30PM with the Administrator revealed the staff had been educated on enhanced droplet contact precautions numerous times. She stated it was difficult to keep residents confined to their rooms on the quarantine hall and keep them on the unit; however, the Administrator stated the staff should

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F 880	Continued From page 16 not be assisting them to leave the unit and if aware should redirect them back to their room on the quarantine hall.	F 880		