STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345423	A. BUILDING _____ B. WING _____	07/01/2021

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WILSON REHABILITATION AND NURSING CENTER	1705 SOUTH TARBORO STREET WILSON, NC 27893

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E 000	Initial Comments An unannounced recertification survey was conducted on 6/28/21 through 7/1/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # UNUV11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 06/28/21 through 07/01/21. Event ID# UNUV11	F 000		
F 563 SS=E	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when	F 563		7/30/21

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

Electronically Signed | 07/23/2021

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F 563	Continued From page 1 such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, resident interview and staff interviews, the facility imposed a restricted visitation schedule that limited indoor visitations of family and friends for 1 of 1 resident sampled for visitation. (Resident # 19). This facility practice had the potential to affect all residents. Findings included: Resident #19 was admitted to the facility on 4/14/2021, and his diagnoses included diabetes mellitus. On 6/28/2021 at 12:51 p.m. in an interview with family member #1 for Resident #19, he stated visitations were limited to Monday through Friday from 10:00a.m. to 6:00p.m., and there were no visitations on the weekend. He stated he lived out of town, and the reason he was able to visit Resident #19 that day was because he happen to be off work. On 6/30/2021 during an interview with Nurse #3, she stated visitation consisted of two visitors at a time from 10:00 a.m. to 6:00 p.m. Monday through Friday. She stated there was no visitation on the weekends due to less staff in the facility to monitor the visitations. On 7/1/2021 at 10:49 a.m. in an interview with the Director of Nursing, she stated there was no time limits on the resident visitations, and residents	F 563	As of 7/28/2021 all visitation restrictions will be lifted. Residents and resident/representatives will be notified of the new visitation guidelines, including instruction for COVID screening for each visit. All residents may be potentially impacted. Residents and resident representatives will be notified of the new visitation guidelines, including instruction for COVID screening for each visit. A digital screening device was ordered 7/21/2021. Residents and Families will be notified via the COVID-19 Informational Line and a letter on 7/28/2021. Visual cues on the screening process and required COVID 19 precautions will be posted in the lobby for visitors use prior to visiting with residents. The DON/ICP/designee will monitor self-screening process for compliance. Will monitor 5 visitors Q week for 6 weeks to ensure compliance. If noncompliance is observed, the visitor will be re-educated as appropriate. A summary of compliance will be reported to the QAPI Committee for additional oversight.	

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F 563	Continued From page 2 and family members were aware visitations occurred on Monday through Friday from 10:00 a.m to 6:00 p.m. She further stated the restricted visitation hours were due to accountability for screening and safety reasons like when children were left unattended outside the facility. She stated the facility did not have a screener at the door at all times, and visitors were unable to conduct the COVID-19 screening themselves. She further stated the facility door was locked at 6:00 p.m. and visitations were not allowed except for compassionate care visits or scheduled off hour visits. On 7/1/2021 at 1:29 p.m. during an interview with alert and oriented Resident #1, she stated her family members were visiting a little, but a lot of people did not visit because they were working during the set visitation hours 10:00a.m. to 6:00p.m. on Monday to Friday. On 7/1/2021 at 1:39 p.m. during an interview, the administrator stated visitations were restricted to 10:00 a.m. to 6:00 p.m. Monday through Friday. He further stated the facility misinterpreted the use of time frames in the Centers of Medicare and Medicaid Services guidance for visitations.	F 563		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the	F 641	Resident #57 The resident□s MDS was corrected and submitted on 6/30/2021.	7/30/21

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F 641	Continued From page 3 area of special treatments for 1 of 16 sampled residents reviewed for MDS accuracy. (Resident #57) Findings included: Resident #57 was admitted to the facility on 5/14/2021. Her diagnoses included heart failure, asthma, respiratory failure and obstructive sleep apnea. A review of the physician progress notes dated 5/18/2021 revealed the following diagnoses for Resident #57: acute respiratory failure, diastolic heart failure and obstructive sleep apnea. The progress note further revealed Resident #57 used a Continuous Positive Airway Pressure (C-PAP), a mechanical device that sends a steady flow of oxygen into the nose and mouth while one sleeps, for obstructive sleep apnea prior to hospitalization, and a Bilevel Positive Airway Pressure (Bi-Pap), a non-invasive ventilator that pushes air into the lungs to improve oxygen levels and decreased carbon dioxide in the blood, was used to treat pleural effusion while Resident #57 was in the hospital. The physician progress notes further revealed the pulmonologist recommended the use of a Trilogy machine (a non-invasive ventilator, also known as a Bi-Pap, used to treat sleep apnea and lung disease.) The care plan dated 5/17/2021 documented Resident #57 rejected care and revealed she did not like to wear the Trilogy device due feeling like she was suffocating. Interventions included assisting her with placement of the Trilogy mask and reminding her of the importance of wear the trilogy mask and the adverse outcomes if the Trilogy mask was not worn. Resident #57 was	F 641	Other resident□s using Trilogy devices may have potentially been affected by this practice. A 100% review was conducted and no other MDS were found to be miscoded in Section O100[F]. The MDS coordinator was educated on accurate coding of MDS Section O100F and confirmed understanding of invasive ventilator versus non-invasive ventilators such as BiPap/CPap. The DON/designee will review each MDS assessment coded for use of ventilators in Section O100[F] and [G] weekly x6 weeks prior to submission of the MDS to CMS. Any variances will be immediately corrected. A summary of the weekly audits will be provided to the QAPI Committee for additional oversight and recommendation.	

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F 641	Continued From page 4	F 641		

also care planned for chronic respiratory failure with hypoxia, and interventions included the use of a Trilogy device with 2 liters of oxygen at bedtime and removing in the morning. It also could be used as needed for shortness of breath.

Nursing documentation revealed Resident #57 used a Trilogy device at night, and a representative from the Trilogy company explained to Resident #57 how the Trilogy device worked in a phone conversation on 5/17/2021.

A review of the physician orders dated 6/1/2021 revealed an order for Trilogy with two liters of oxygen to be placed at bedtime and removed in the morning daily and may be used as needed for shortness of breath for acute respiratory failure with hypercapnia and obstructive sleep apnea.

The comprehensive admission Minimum Data Set (MDS) assessment dated 6/7/2021 revealed Resident #57 was cognitively intact and rejected care. The MDS further documented Resident #57 received oxygen and an invasive mechanical ventilator as special treatments.

A Social Services note dated 6/7/2021 revealed a trilogy machine was at the bedside and applied at night. The Social Services note further revealed Resident #57 stated she felt like she was suffocating when wearing the Trilogy device, and the nursing staff were increasing the time she wore the Trilogy device at night to help her get more comfortable using the Trilogy device.

A review of the facility assessment revealed respiratory treatments included no residents used ventilators or required tracheostomy care, and ten residents used a Bi-Pap or C-Pap device.

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F 641	Continued From page 5	F 641		

A review of the Resident Matrix dated 6/28/2021 revealed Resident #57 used a ventilator.

Resident #57 on 6/28/2021 at 3:47p.m. was observed sitting up in a wheelchair with no tracheostomy or the use of an invasive mechanical ventilator. She answered interview questions verbally with no respiratory difficulty observed.

On 6/29/2021 at 3:05 p.m. in an interview with the MDS Nurse #1 and MDS Nurse #2, MDS Nurse #1 stated the Trilogy machine was not a Bi-Pap or C-Pap device but a more mechanical device that forced air in the lungs and pulled air out of the lungs. She further stated the Trilogy ventilator device was not an invasive device. MDS Nurse #2 stated the Trilogy device was an external device and often referred to as a Bi-Pap. She stated Resident #57 was unable to support her own ventilations and used the mechanical device to fill the lungs with air. She further stated the facility did not accept residents on invasive mechanical ventilators, and the use of a Bi-Pap and C-Pap devices should not be coded as an invasive mechanical ventilator.

On 7/1/2021 at 7:35 a.m. in an interview with Nurse #2, she stated the Trilogy device was like a Bi-Pap, and the nursing staff applied the Trilogy device at night and removed in the morning for Resident #57. She further stated Resident #57 was more cooperative in wearing the Trilogy device when asleep.

On 7/1/2021 at 10:25 a.m. in an interview with the Director of Nursing, she stated the use of the trilogy machine was not an invasive procedure.

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F 641	Continued From page 6 She stated the respiratory services department at the hospital educated the nursing staff on the Trilogy device as part of their competency training last month. On 7/1/2021 at 1:39 p.m. in an interview with the Administrator, he stated the MDS assessment needed to be completed accurately. He further stated the facility did not accept residents with invasive ventilators.	F 641		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the state mental health authority of a significant change in status for a resident diagnosed with Schizophrenia and Bipolar for 1 of 1 residents reviewed for Preadmission Screening and Resident Review (PASARR). (Resident #57) Findings Included: Resident #57 was admitted on 5/14/2021 and re-admitted on 6/1/2021. Her diagnoses included schizophrenia, bipolar, anxiety and depression. A review of the physician progress notes dated 5/18/2021 revealed Resident #57 had a past medical history of schizophrenia and depression.	F 646	A Level 1 PASRR was completed on 6/29/2021 for Resident #57. Notification of a Level II PASRR determination was received on 7/1/2021. The resident has continued to receive mental health services as ordered. A 100% audit was conducted for current residents to ensure that Level 1 and Level II PASRRs have been completed; if variances are identified, the PASARR will be completed and submitted to the state mental health authority. The DON, MDS Coordinator and the Social Worker have reviewed the state and federal guidelines for completing the	7/30/21

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F 646	Continued From page 7 The 5-day/admission Minimum Data Set (MDS) assessment dated 5/19/2021 revealed Resident #57 was cognitively intact and rejected care. The MDS revealed Resident #57 was diagnosed with an anxiety disorder, depression, bipolar, and schizophrenia and received antipsychotic and antidepressant medications. No information was recorded indicating Resident #57 was considered for a State Level II PASARR. The MDS further revealed an unplanned discharge on 5/19/2021. . A review of the psychiatric physician notes dated 5/19/2021 revealed Resident #57 reported she was a failure and would be better off dead and documented Resident #57 was experiencing auditory and visual hallucinations, feelings of hopelessness and worthlessness, depression, insomnia, energy deficit, no appetite and passive suicidal ideations. The psychiatric notes listed depression, severe anxiety, post traumatic stress disorder (PTSD) and borderline schizophrenia as diagnoses and listed Resident #57 on the following current antipsychotic medications: Trazadone 300 milligrams (mg), Aripiprazole 20mg, Bupropion Extended Release (XL) 150mg and Eszopiclone 3mg. Resident #57 refused to sign a verbal contract and reported to the psychiatric physician if she came up with a suicide plan, she would carry it out and not alert the nursing staff. The psychiatric progress notes further revealed the Director of Nursing and the nursing staff were alerted Resident #57 was experiencing passive suicidal ideations and was placed on suicidal ideation precautions prior to sending to an inpatient psychiatry facility for safety and stabilization. Nursing documentation dated 5/19/2021 revealed	F 646	pre-admission screenings. The Admissions Coordinator/designee will audit all new admissions weekly x6 weeks to ensure that PASRR Level 1 and Level II□s are completed and submitted to the state mental health authority per regulation/guidance. If variances are found, the screening will be completed and submitted as appropriate. A copy of the weekly audits will be provided to the Administrator and a summary will be reported to the QAPI Committee for additional oversight.	

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Resident #57 ' s did not want to live and felt comfortable with dying when visited by the psychiatric physician. Resident #57 was placed on suicidal precautions prior to sending to the hospital for an evaluation. When the responsible party was notified, she revealed Resident #57 was seen one to two times a week by psychiatric therapy.

On 5/19/2021, Resident #57 was discharged to the hospital for an evaluation.

On 6/1/2021, Resident #57 was re-admitted to the facility.

The physician orders dated 6/1/2021 revealed Resident #57 was ordered the following antipsychotics: Eszopiclone 3 milligrams (mg) daily for insomnia, Trazadone 300mg at bedtime daily for depression and Aripiprazole 20mg daily for depression. The physician orders further revealed the nursing staff were to observe for absence of behaviors to indicate effectiveness of psychotropic medications and absence of adverse side effects related to psychotropic medications. On 6/9/2021, the physician ordered Alprazolam 0.25mg at bedtime daily for anxiety and on 6/23/2021, Sertraline 25mg daily for PTSD.

The 5-day re-admission MDS dated 6/7/2021 revealed Resident #57 remained cognitively intact and rejected care. Her diagnoses were unchanged and continued to receive antipsychotic and antidepressant medications.

Resident #57's care plan dated 6/11/2021 revealed she had a history of mood problems (suicide ideations) related to the disease process

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of schizophrenia and bipolar initiated on 6/1/2021. Interventions included administering medications as ordered, monitoring and documenting side effects and effectiveness of medications, behavioral health consults as needed, encouraging her to express her feelings and monitoring, documenting and reporting to physician as needed any risk of harm to self or others. The care plan further revealed a focus for impaired cognitive function and impaired thought processes related to schizophrenia and depression, use of antidepressant and antipsychotic medications and hypnotic therapy initiated on 6/11/2021.

A review of the Medication Administration Record revealed virtual psychiatric appointments were conducted on June 9, 2021 and June 23, 2021 for Resident #57.

On 6/29/2021 at 10:33 a.m., no PASARR Level I or II determination letter was found in the medical record.

On 6/29/2021 at 2:13 p.m. in an interview with the Social Services Coordinator, she stated she did not have a PASARR Level II determination letter for Resident #57. She stated with the COVID-19 PASARR waiver PASARRs were due if the resident was in the facility longer than thirty days. She stated she had not submitted information on Resident #57 yet and anticipated her receiving a PASARR Level II due to her diagnoses of major depression, schizophrenia and bipolar. She stated Resident #57 was assessed by a psychiatric physician on 5/19/2021 for a mental episode that sent the resident to the hospital but was unaware of Resident #57 experiencing any mental issues since readmission on 6/1/2021.

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She stated she was using the thirty days in the facility as a guide as when to submit Resident #57's PASARR information to the state mental health authority.

On 6/30/2021 at 12:13 p.m. in an interview with MDS Nurse #1, she stated she generates a report on the electronic medical record that showed if Resident #57 had a PASARR Level II and stated Resident #57 was not on the list. She stated she needed a current PASARR to complete the MDS assessment and stated with the diagnoses of schizophrenia and bipolar Resident #57 should have a PASARR Level II.

On 7/1/2021 at 8:45 a.m. in an follow up interview with the Social Services Coordinator, she stated when submitting PASARR forms she did not know if a resident's diagnoses changed the prioritization of completing the PASARR forms, but mental health issues and diagnoses like depressive disorder, schizophrenia, anxiety and bipolar would indicate a Level II PASARR. She stated if Resident #57 had remained in the facility the whole time, it would had triggered her to reprioritized submission of her PASARR and would not have waited the thirty days.

On 7/1/2021 at 10:25 a.m. with the Director of Nursing, she stated psychiatric and significant changes in residents were discussed in the morning meetings, and an acute episode would trigger reprioritizing a resident to the top of the list to summit PASARR forms. She stated Resident #57 received a psychiatric consult due to appearing depressed and was not working with therapy. She stated Resident #57 was sent to the hospital and was out of the facility for more than a week before returning to the facility. She stated

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F 646	Continued From page 11 submission of PASARR forms to the mental health authority needed to be individualized completing first the residents with diagnoses and situations that triggered a PASARR Level II. On 7/1/2021 at 1:39 p.m. in an interview with the Administrator, he stated Resident #57 having suicidal ideations and receiving treatment outside the facility was considered a significant change in her mental health and required notification to the state agency mental health authority.	F 646		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		7/30/21

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WILSON REHABILITATION AND NURSING CENTER	1705 SOUTH TARBORO STREET WILSON, NC 27893

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F 657	Continued From page 12 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview and staff interviews, the facility failed to conduct an interdisciplinary care plan meeting with a newly admitted resident (Resident #57) for 1 of 1 resident reviewed for care plans. Findings included: Resident #57 was admitted to the facility on 5/14/2021 and was discharged on 5/19/2021. She was readmitted on 6/1/2021 and her diagnoses included Heart Failure, Diabetes Mellitus and Depression. The 5-day admission Minimum Data Set (MDS) assessment dated 6/7/2021 revealed Resident #57 was cognitively intact. On 6/28/2021 at 3:50 p.m. in an interview with Resident #57, she denied having a care plan meeting with any of the staff at the facility since admission. A review of Resident #57's medical record revealed no documentation of an interdisciplinary care plan meeting since admission. On 6/29/2021 at 3:27 p.m. in an interview with the Social Services Coordinator, she stated care plan meetings were held within the first week after a resident was admitted. She stated the care plan calendar showed a resident with the same first name of Resident #57 but a different last name was scheduled for a care plan meeting on May	F 657	A care plan meeting was held on 7/20/2021 for Resident #57 with the following team members present: Resident, Peggy Cale, RN/MDS, Sarah Wright, PTA/DOR and Jeanne Daniels, SW. A 100% audit was conducted for all current residents to identify any other residents who may not have had a care plan meeting within 7 days of the OBRA MDS assessments. If variances are found, the care plan meeting will be scheduled for the resident. The Social Worker/designee will schedule and invite the residents and their representatives to the care plan meeting. The Social Worker will ensure that scheduled care plan meetings are communicated to the interdisciplinary team. The MDS Coordinator, Social Worker and/or designee will make a note in the resident□s medical record of the care plan meeting including team member participation. The DON/designee will monitor the weekly care plan meeting schedule and conduct weekly audits x6 weeks to ensure documentation that meetings have been held as scheduled. Identified variances will be investigated and meetings will be scheduled as needed. A summary of the	

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F 657	Continued From page 13 21, 2021 and June 23, 2021 and stated it must be Resident #57 because there was no other resident with the other last name in the facility. She stated the MDS Nurse #1 had placed the care plan meeting signature sheet in medical records to be scanned into the electronic medical record. On 6/30/2021 at 9:30 a.m. in an interview with the Medical Records Specialist, she stated care plan meeting signature sheets waiting to be scanned into the electronic medical record were in alphabetical order located in a box. She stated she did not have a care plan meeting signature sheet for Resident #57. On 6/30/2021 at 12:07 p.m. in an interview with the MDS Nurse #1, she stated care plan meetings were conducted in the resident ' s room, and the social services coordinator, MDS nurse, therapy, dietary and nursing attended the care plan meetings. She stated the admission ' s coordinator or the social services coordinator scheduled the care plan meetings, and the MDS Nurse #1 was responsible for completing the care plan meeting signature sheet and placing it in a box in medical records to be scanned into the electronic medical record. She was unable to recall any specifics about a care plan meeting with Resident #57. On 7/1/2021 at 08:45 a.m. in a follow up interview with the social services coordinator, she stated she was unable to recall attending a care plan meeting with other team members in Resident #57's room. On 7/1/2021 at 10:25 a.m. in an interview with the Director of Nursing, she stated during the	F 657	weekly audits will be reported to the QAPI Committee for additional oversight and/or recommendation.	

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F 657	Continued From page 14 morning meetings scheduled interdisciplinary care plan meetings for that day were discussed. She stated she could not recall attending a care plan meeting for Resident #57 and stated she did not attend all care plan meetings. On 7/1/2021 at 1:39p.m. in an interview with the Administrator, he stated interdisciplinary care plan meetings with the resident or resident representative were to be held within seven days of admission.	F 657		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		7/30/21

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F 726	Continued From page 15 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to trained Nurse #1 to follow Centers for Disease Control and Prevention (CDC) recommendations for use of Personal Protective Equipment (PPE) when performing the COVID-19 nasopharyngeal swab test. This occurred during a COVID-19 pandemic. Findings included: Documentation on the Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Guidance For Collecting, Handling, and Testing Clinical Specimen for COVID-19" dated 2/26/21, stated healthcare providers collecting specimens or working within six feet of patients suspected to be infected with SARS-CoV-2 were to maintain proper infection control and use recommended PPE which included an N95 or higher lever respirator (or facemask is respirator not available), eye protection, gloves and a gown. On 6/28/2021 at 2:15 p.m., Nurse #1 was observed not wearing eye protection, a gown and a N-95 mask when performing a COVID-19 nasopharyngeal swab test for COVID-19 testing purposes. She was observed wearing a surgical face mask and gloves within six feet of distance swabbing the right and left nostril of a staff member, the Rehabilitation Director.	F 726	Nurse #1 was trained on proper PPE use when administering COVID 19 testing. All resident□s may have potentially been impacted by this practice. All nurses who may be administering COVID 19 testing will be trained in the appropriate PPE to wear when administering the test. The facility protocol on use of PPE when conducting COVID 19 testing for residents/staff has been reviewed. All nurses who may be administering COVID 19 testing will be trained in the appropriate PPE to wear when administering COVID 19 testing. The DON/designee will observe licensed nurse staff administering COVID 19 testing, monthly x 6 (currently testing 1x/month), to ensure that appropriate PPE is utilized. If variance is observed, the nurse will be immediately re-educated. A summary of the monthly audits will be submitted to the QAPI Committee.	

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F 726	Continued From page 16 On 7/1/2021 at 8:10 a.m. in an interview with Nurse #1, she stated she had not been trained at the facility on how to conduct COVID-19 testing. She stated she had watched other staff members perform the COVID-19 nasopharyngeal swab test wearing only the surgical mask and gloves and was following what she had observed when staff members were tested for COVID-19. On 7/1/2021 at 10:49 a.m. in an interview with the Director of Nursing (DON), she stated several nurses were trained to perform COVID-19 testing by the clinical lead nurse prior to her medical leave. The DON stated there was no documentation of the COVID-19 testing training. The DON further stated a surgical mask and gloves were required when performing the COVID-19 test since there were no positive COVID-19 cases in the facility.	F 726		
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		7/30/21

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F 880	Continued From page 17	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 18 §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 observation and staff interviews, the facility failed to follow Centers for Disease Control and Prevention (CDC) recommendations for use of Personal Protective Equipment (PPE) for collecting COVID-19 nasopharyngeal specimens for Point of Care testing when Nurse #1 was observed conducting the COVID-19 nasopharyngeal test within six feet of 1 of 1 staff member (Rehabilitation Director). The facility also failed to have a policy for collecting COVID-19 nasopharyngeal specimens for Point of Care testing. This occurred during a COVID-19 pandemic. Findings included: Documentation on the Centers for Disease Control and Prevention (CDC) guidance entitled, "Interim Guidance For Collecting, Handling, and Testing Clinical Specimen for COVID-19" dated 2/26/21, stated healthcare providers collecting specimens or working within six feet of patients suspected to be infected with SARS-CoV-2 were to maintain proper infection control and use recommended PPE which included an N95 or higher lever respirator (or facemask is respirator not available), eye protection, gloves and a gown.	F 880	Nurse #1 was trained on proper PPE use when administering COVID 19 testing. All resident□s may have potentially been impacted by this practice. All nurses who may be administering COVID 19 testing will be trained in the appropriate PPE to wear when administering the test per facility protocol and CDC guidelines. The facility protocol which follows CDC guidelines on use of PPE when conducting COVID 19 testing for residents/staff has been reviewed. All nurses who may be administering COVID 19 testing will be trained in the appropriate PPE to wear when administering COVID 19 testing. The DON/designee will observe licensed nurse staff administering COVID 19 testing, monthly x 6 (currently testing 1x/month), to ensure that appropriate PPE is utilized. If variance is observed, the nurse will be immediately re-educated. A summary of the monthly audits will be submitted to the QAPI Committee.	

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The CDC visual guidance titled, "Nasopharyngeal Specimen Collection Steps," recommended PPE was worn when collecting specimens. PPE included gloves, a gown, eye protection (face shield or goggles) and an N-95 or higher-level respirator (or surgical mask if a respirator is not available).

On 6/28/2021 at 2:15 p.m., Nurse #1 was observed not wearing eye protection, a gown and a N-95 mask when performing a COVID-19 nasopharyngeal swab test for COVID-19 testing purposes. She was observed wearing a surgical face mask and gloves within six feet of distance swabbing the right and left nostril of the staff member. She was observed placing the COVID-19 swab into the COVID-19 testing device and transporting the testing device to the collection area.

On 7/1/2021 at 8:10 a.m. in an interview with Nurse #1, she stated she was verbally trained while working at the hospital to conduct COVID-19 testing, and the PPE requirements included gown, gloves and a N-95 mask when performing COVID-19 testing. She stated she was not trained at the facility on how to conduct COVID-19 testing. She stated she had watched other staff members perform the COVID-19 testing wearing only the surgical mask and gloves and was following what she had observed when staff members were tested for COVID-19.

On 7/1/2021 at 10:49 a.m. in an interview with the Director of Nursing (DON), she stated several nurses were trained to perform COVID-19 testing by the clinical lead nurse prior to her medical leave. The DON stated there was no documentation of the COVID-19 testing training.

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F 880	Continued From page 20 The DON further stated if there were positive COVID-19 cases in the facility, PPE requirements of the staff performing the COVID-19 testing included a N-95 mask but was not required, gloves, gown and goggles. She stated when there were no positive COVID-19 cases in the facility, a surgical mask and gloves was required when performing COVID-19 testing. The DON stated she completed the Statewide Program for Infection Control and Epidemiology (SPICE) training in December 2020, and the facility did not have a policy on performing COVID-19 testing that listed the PPE requirements. On 7/1/2021 at 1:39 p.m. in an interview with the Administrator, he stated PPE requirements for staff conducting COVID-19 testing included gown, gloves, goggles and N-95 mask.	F 880		