STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345506	A. BUILDING ______ B. WING ______	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	**700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 08/01/2022 through 08/05/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #V2P111.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 08/01/22 through 08/05/22. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity (K) Immediate Jeopardy began on 08/02/22 and was removed on 08/06/22.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure a dependent resident's fingernails were clean for 1 of 2 residents reviewed for Activities of Daily Living (ADL). (Resident #3) The findings included: Resident #3 was admitted to the facility on 08/11/20 with diagnoses that included cerebral infarction (stroke), vascular dementia, and lack of coordination.	F 677	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The alleged deficient practice affected Resident #3. Resident #3 had nail care provided immediately upon findings to correct the alleged deficient practice. Address how the facility will identify other residents having the potential to be	8/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 08/25/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Continued From page 1

Review of Resident #3's quarterly Minimum Data Set (MDS) dated 07/26/22 revealed the resident's cognition was severely impaired. The resident required extensive assistance with dressing, eating, toilet use, and personal hygiene. The MDS did not indicate resident was resistant to care.

Review of Resident #3's care plan updated on 06/26/22 indicated the resident was care planned as having a self-care deficit for bathing, dressing, and feeding. The goal was for the resident to participate in self-care activities. Interventions included to evaluate resident's ability to perform ADL and provide assistance with ADL as needed.

An observation conducted on 08/01/22 at 2:00 PM revealed Resident #3's fingernails contained dark brown debris under 10 of 10 fingernails.

An observation conducted on 08/02/22 at 8:45 AM revealed Resident #3's fingernails contained dark brown debris under 10 of 10 fingernails.

An observation conducted on 08/02/22 at 3:05 PM revealed Resident #3's fingernails contained dark brown debris under 10 of 10 fingernails.

An observation conducted on 08/03/22 at 8:55 AM revealed Resident #3's fingernails contained dark brown debris under 10 of 10 fingernails.

An interview was conducted with Nursing Assistant #3 (NA) on 08/03/22 at 9:00 AM revealed Resident #3 was receiving hospice services and received showers from the hospice aide on Mondays and Fridays. She stated the facility did not provide showers to Resident #3 but

F 677

affected by the same deficient practice;

On 8/17/22, all residents had nail cleanliness audited by a licensed nurse to ensure proper care. Any residents identified for needing additional nail care were provided at that time.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The facility has added routine nail care to Nursing Aide point of care documentation to be done no less than weekly and as needed. The Assistant Director of Nursing will educate nursing aides of the new documentation requirement in the point-of-care documentation system. All new staff will be educated on this documentation requirement during new hire floor orientation moving forward. The Assistant Director of Nursing will educate hospice providers or other vendors performing ADL care, that the facility staff will be responsible for routine nail care as outlined above.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

Each Unit Nurse Manager will review compliance reports weekly for 4 weeks, and then monthly for 3 months. Compliance rates will be presented to the QAPI committee. The Director of Nursing

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F 677	Continued From page 2 provided bed baths. She further indicated third shift dressed and provided personal care to Resident #3 in the morning. She indicated she was a Restorative Aide but was working on the floor to provide additional assistance to the floor NAs. In an interview conducted with Nurse #1 on 08/05/22 at 12:01 PM indicated Resident #3 did not refuse care. He stated NA #3 typically performed nail care for residents because she was a Restorative Aide who was part of a team who preformed monthly nail care. He indicated floor NAs could perform nail care as well. On 08/05/22 at 12:04 PM an interview was conducted with the Clinical Care Coordinator which revealed residents have a monthly spa day and nail care was provided. She indicated NA #3 did nail care in between spa days. Residents could get their nail care done when requested and when nails were visibly soiled. An interview was conducted with the Staff Development Coordinator on 08/05/22 at 11:45 AM. She stated staff were educated in orientation regarding personal care via handouts. Staff were also educated during annual skills check offs. She indicated the restorative team did nail care as needed; however, floor NAs could perform nail care as well. She stated it was not acceptable for Resident #3 to have dark brown debris under his nails. She indicated that prior to eating, each residents' nails were cleaned and if a staff member cleaned Resident #3's hands, they would have noticed his nails having dark brown debris under them. On 08/05/22 at 12:28 PM an interview was	F 677	will be responsible for monitoring for compliance. Include dates when corrective action will be completed. Corrective action will be completed for all affected or potentially affected by 8/25/2022.	

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F 677	Continued From page 3 conducted with the Director of Nursing (DON) which revealed nail care was done with residents' weekly shower routine and as needed. She indicated residents' hands should be cleaned prior to eating. She further stated when a resident's hands and nails were visibly soiled, staff should clean them. Additionally, she stated cleaning under the nails was not considered nail care, but part of cleanliness.	F 677		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		8/25/22

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F 758	Continued From page 4	F 758		

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and Pharmacist interview, the facility failed to ensure physician's orders for as needed psychotropic medications had a 14 day stop date for 2 of 5 residents (Residents #240 and #9) reviewed for unnecessary medications.

The findings included:

1. Resident #240 was admitted on 7/5/22 with a diagnoses that included non-Alzheimer's dementia and dementia without behavioral disturbances.

A physician's order dated 7/5/22 indicated Haloperidol (antipsychotic medication) tablet 1 milligram (mg) every 4 hours as needed (prn) for

This directed plan of correction is to serve as Whitestone a Masonic & Eastern Star Community credible allegation of compliance.

Submission of this plan of correction does not constitute an admission by Whitestone a Masonic & Eastern Star Community or the management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.

Address how corrective action will be

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F 758	Continued From page 5 anxiety. There was no stop date. The admission Minimum Data Set (MDS) assessment dated 7/18/22 indicated Resident #240's cognition was severely impaired. Resident #240 was assessed to have no mood or behaviors and received antipsychotic medication 3 of 7 days and was in a hospice program. A care plan initiated on 7/19/22 revealed Resident #240 used psychotropic medications, and the goal was to reduce the use of the psychoactive medication. The interventions included administering medications as ordered and to discuss with the physician, family of ongoing need for use of medication. A review of Resident #240's Medication Administration Record (MAR) for July 2022 was reviewed and revealed that Resident #240 received haloperidol 1mg prn on 7/10/22, 7/13/22, 7/14/22, 7/15/22, 7/18/22, 7/21/22, 7/24/22, 7/25/22, 7/26/22, and 7/27/22. An interview was conducted with the Director of Nursing (DON) on 8/4/22 at 10:46 am. The DON indicated she did not realize that Resident #240 had received a prn antipsychotic. The DON indicated that the resident was on hospice and had these medication orders on admission to the facility and the orders should have been reviewed and a stop date provided. A telephone interview conducted with the Pharmacist on 8/4/22 at 10:57am revealed resident medications were reviewed monthly by the Consulting Pharmacist. The physician order for Haloperidol 1 mg prn for Resident #240 was reviewed with him and stated a PRN	F 758	accomplished for those residents found to have been affected by the deficient practice; The alleged deficient practice affected residents #240 and #9. The affected residents have been evaluated and MD orders and supporting documentation have been added to the resident's records. At the discretion of the resident's attending physician, the PRN psychotropic medications have been continued with supportive documentation for continued use. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Any resident receiving PRN psychotropic medication has the potential to be affected. The Director of Nursing (DON) reviewed all current PRN medications on 8/4/2022 to ensure no other psychotropic medications were being used without 14-day stop dates. No other residents were affected by the alleged deficient practice. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing will provide Unit Managers with education on the requirement for stop dates to review when validating orders. The DON or designee will run a weekly PRN psychotropic	

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F 758 Continued From page 6
antipsychotic required a stop date after 14 days. The Pharmacist indicated that the Consulting Pharmacist first review of these medications was due in August.

An interview was conducted with the Nurse Practitioner (NP) on 8/4/22 at 2:10pm revealed she had reviewed Resident #240's medication and this order did not have a stop date but when she does her orders, she was conscious of PRN stop dates and this must have been an oversight. She further revealed that she did attend the 7/20/22 risk meeting and haloperidol order was discussed but that she did not realize it was a PRN. She also stated that Resident # 240 received Hospice services and that she felt that the order was appropriate due to behaviors however the medication order should have had a stop date and been reviewed.
2. Resident #9 was admitted on 01/25/22 with diagnoses that included dementia without behavioral disturbance, major depressive disorder, and generalized anxiety disorder.

Review of the quarterly Minimum Data Set (MDS) dated 05/10/22 revealed Resident #9's cognition was severely impaired. The MDS further coded Resident #9 to receive antipsychotic and antidepressant medications 7 out of 7 days.

Review of physician's order dated 07/18/22 indicated Haloperidol (an antipsychotic medication) 1 mg tablet by mouth every 4 hours as needed for delusions related to major depressive disorder and generalized anxiety disorder. There was no stop date indicated for this PRN antipsychotic medication order.

An observation of Resident #9 on 08/03/22 at

F 758
medication report and ensure compliance with the 14-day stop date and review by the physician as needed.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

The Director of Nursing or designee will review compliance for PRN psychotropic medications weekly and report compliance to the QAPI committee monthly for 3 months.

Include dates when corrective action will be completed.

The facility will be back in compliance as of 8/17/2022

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F 758	Continued From page 7 8:45 AM revealed resident to be calm and did not indicate resident to be agitated, combative, or anxious. In a phone interview conducted on 08/04/22 at 10:57 AM with the Consulting Pharmacist indicated he was aware of the regulations for PRN antipsychotic medications. He confirmed he did not see a stop date on the physician order. He stated PRN antipsychotic orders would have a stop date of 14 days after they have been prescribed and then the resident would be reevaluated by the physician. An interview conducted with the Nurse Practitioner on 08/04/22 at 2:10 PM revealed Resident #9 was receiving hospice services and the hospice medical director ordered the PRN Haloperidol in which the facility staff put the order into the resident's chart. She stated that the order for the PRN Haloperidol should have a stop date. She stated when she writes orders for PRN antipsychotics, she is conscious of putting a stop date on the 14th day and the resident would have been reevaluated on the 14th day. She stated she typically reviews orders written by hospice but may have missed the stop date for this order. An interview conducted on 08/05/22 at 2:00 PM with the Director of Nursing (DON) revealed Resident #9 was receiving hospice services. She stated the hospice medical director did not recommend a stop date.	F 758		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		8/25/22

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F 880	Continued From page 8	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or
infections before they can spread to other persons in the facility;
(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

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F 880	Continued From page 9 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff, facility contracted Phlebotomist, and physician interviews, and record review, the facility failed to develop and implement facility policies for infection control as recommended by the Centers for Disease Control and Prevention (CDC) guidelines; the facility failed to implement current infection control measures as recommended by the CDC when a facility contracted Phlebotomist and 3 of 3 staff members (Treatment Nurse, Nursing Assistant #1 and Nursing Assistant #2) failed to wear the required Personal Protective Equipment (PPE) when they entered into COVID-19 enhanced droplet isolation rooms; a facility contracted	F 880	It is the practice of Whitestone: A Masonic & Eastern Star Community to 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. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;	

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F 880	Continued From page 10 Phlebotomist and 3 of 3 staff members (Treatment Nurse, Nursing Assistant #1 and Nursing Assistant #2) failed to remove PPE when they exited COVID-19 enhanced droplet isolation rooms; 2 of 2 staff members (Nursing Assistant #1 and Nursing Assistant #2) failed to disinfect face shields when they exited COVID-19 rooms and provided care to residents who were not up to date on the COVID-19 vaccinations for the duration of their shift (Resident #189 and Resident #190). The COVID-19 outbreak began on 08/01/22 when a second resident tested positive for COVID-19 (Resident #34). There were 4 residents who were not up to date on the COVID-19 vaccination series residing at the facility. Two of the 4 residents (Resident #189 and Resident #190) resided on the hall as the residents with COVID-19. These system failures occurred during the COVID-19 pandemic, which caused a high likelihood of affecting all residents by placing them at an increased risk for developing and transmitting COVID-19. Immediate jeopardy began on 8/02/22 when facility staff and a facility contracted Phlebotomist were observed to be out of compliance with CDC recommendations regarding PPE use, removal of PPE, and disinfection of PPE when caring for residents with COVID-19 and facility administrative staff were unaware of the noncompliance with CDC recommendations regarding required PPE required for COVID-19 enhanced droplet isolation rooms. Immediate jeopardy was removed on 08/06/22 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" (no actual harm with the potential for more than minimal harm that is not immediate	F 880	Residents #189 and #190 were identified as affected by the alleged deficient practice. The two residents were assessed by the licensed nurse on 8/1/2022 and evaluated by the physician on 8/1/2022. The two residents identified have had no adverse effects by the alleged deficient practice. Nursing assistants #1 and #2 and the treatment nurse have been re-educated on the personal protective equipment (PPE) to be worn in transmission-based precautions. This included re-education on when and how to don and doff the PPE. The contracted phlebotomist also received re-education. In addition, the Infection Preventionist and the Director of Nursing received re-education from the LCS Clinical Specialist on the CDC Guidelines as it relates to source control and the use of N95 masks and eye protection during outbreaks and for those individuals who are not up to date with all recommended doses of the COVID-19 vaccine. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Residents who reside in the 600 hall have been identified of having the potential to be affected by the alleged deficient practice. Residents who reside on the 600 hall were immediately assessed and placed on symptom monitoring for every shift for 72 hours.	

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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

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jeopardy) to ensure the facility complete all staff training and ensure monitoring systems put into place are effective.

The findings included:

1a. The CDC guidelines entitled "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," updated 02/02/22 indicated the following statements: Health Care Professionals (HCP) caring for residents with suspected or confirmed COVID-19 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator). Symptomatic residents, regardless of vaccination status, should be cared for by HCP using a NIOSH-approved N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face) gloves, and a gown.

Review of the facility policy entitled "COVID 19 Surgical and N95 Respirator Masks Guidelines" (undated) revealed "A surgical mask when worn with shield, can be used to care for COVID positive residents."

Review of the facility policy entitled "Isolation - Initiating Transmission-Based Precautions" revised August 2019 revealed "When Transmission-Based Precautions are implemented, the Infection Preventionist clearly identifies the type of precaution, the anticipated duration, and the personal protective equipment (PPE) that must be used." The policy further indicated the Infection Preventionist "Determines the appropriate notification on the room entrance door. The signage informs the staff of the type of

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Two residents who were identified as not up-to-date with COVID19 vaccinations were placed on transmission-based precautions related to potential exposure. These two residents remain free from COVID-19 infection.

During outbreak testing, two additional residents who reside on the 600 hall tested positive for COVID-19 on 8/7/2022 and 8/9/2022. These residents were assessed and evaluated by the medical provider. A physician order was obtained for transmission-based precautions. The residents are free from complications at this time.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

The Administrator, Director of Nursing, and Medical Director have reviewed and revised the policy for Transmission Based Precautions on 8/5/2022 to include special droplet precautions including the use of N95 masks.

The Infection Preventionist updated signage at the entryway to the community to prompt visitor, vendors, and guests to see nursing personnel for training on 600 hall on 8/5/2022.

On 8/5/2022 the Infection Preventionist has updated signage to resident rooms to include special droplet precautions, instructions for donning and doffing

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CDC precautions(s), instruction for use of PPE, and/or instructions to see a nurse before entering the room."

1b. Resident #34 tested positive for COVID-19 on 08/01/22 and was placed on enhanced droplet isolation precautions in a private room.

An observation on 08/02/22 at 9:49 AM of the sign posted on the door (no date available) of Resident #34 revealed staff were to wear "N95 (if available), eye protection, and gown and gloves when entering the room." The sign did not indicate how to remove PPE when exiting an enhanced droplet isolation room.

During a continuous observation on 08/02/22 from 2:13 PM to 2:15 PM, the facility's Treatment Nurse was observed to enter and exit Resident #34's room wearing gown, gloves, surgical mask, and reading glasses. When she exited, she did not remove or change her surgical mask. She then proceeded to walk down the hall in which other residents were walking.

An interview with the Treatment Nurse on 08/02/22 at 2:16 PM revealed she was preforming a skin assessment on Resident #34. She stated she was told by the Director of Nursing (DON) she could wear a surgical mask as well as her personal glasses when she cared for a resident with COVID-19.

1c. Resident #35 tested positive for COVID-19 on 07/30/22 and was placed on enhanced droplet isolation precautions in a private room.

An observation on 08/02/22 at 2:12 PM of the sign posted on the door (no date available) of

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personal protective equipment, and for visitors to see nurse before entering resident isolation rooms. On 8/5/2022 staff education was provided to licensed nurses to inform staff of their role and responsibilities to ensure proper entryway set up for future residents requiring isolation.

The Infection Preventionist added additional supply storage for personal protective equipment at the entryway of resident rooms on 8/5/2022. The Infection Preventionist provided education to licensed staff on 8/5/2022 to monitor supply levels throughout the shift and ensure supply is readily available.

The Infection Preventionist initiated education on 8/16/22 to staff and vendors who provide direct patient care on topics including donning and doffing PPE; N95 use when working with residents with COVID-19, wearing required PPE (gown, gloves, N95, eye protection) when working with residents requiring special droplet precautions, and disinfecting PPE (face shield) after existing isolation rooms.

Education as listed above was initiated on 8/16/22 and will be ongoing until all staff have been educated. Education will be completed by 8/26/2022. Staff that do not attend training will be prohibited from working until the required training has been completed.

On 8/17/2022, the community welcomed a member of the Regional Infection

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Resident #35 revealed staff were to wear "N95 (if available), eye protection, and gown and gloves when entering the room." The sign did not indicate how to remove PPE when exiting an enhanced droplet isolation room.

During a continuous observation on 08/02/22 from 9:50 AM to 10:03 AM, Resident #35 was observed to be getting blood drawn by a facility contracted Phlebotomist. The Phlebotomist was wearing a N95 mask, gloves, and gown. She was not wearing eye protection. The resident was observed to not be wearing a mask and could be heard actively coughing and speaking. During the continuous observation, the Phlebotomist walked 3 feet out of the room twice wearing a gown and N95 mask and retrieved items in her bag which were located on the floor. After she finished, she exited the room with the gown, gloves, and N95 still on. She proceeded to remove the PPE and entered back into the room to discard the PPE, then she performed hand hygiene.

The Phlebotomist stated in an interview on 08/02/22 at 10:04 AM she was not wearing eye protection because her glasses fell off while in Resident #35's room. She stated she wore eye protection when working with residents who were COVID-19 positive and removed the PPE before she exited the resident's room. She further stated she had 3 additional residents (Resident #27, Resident #29 and Resident #188) to visit after Resident #35. She stated these residents were not in COVID-19 isolation rooms.

During a continuous observation 08/02/22 from 2:18 PM to 2:25 PM, Nursing Assistants (NA) #1 and NA #2, were observed to enter Resident #35's room wearing gloves, gown, surgical

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Prevention Support (RIPS) Team Region 5 for a review of our infection control policies and to perform an audit of current practices. The Infection Preventionist had no findings at the time of their review.

On 8/19/2022 the community contracted a certified Infection Preventionist through APIC Consulting Services. The contracted consultant will assist the infection preventionist, QAPI committee, and governing body in conducting an RCA to identify the problem(s) that resulted in this deficiency and develop an intervention or corrective action plan to prevent a recurrence, as a part of the Quality Assurance and Performance Improvement (QAPI) program.

On 8/25/2022 the interdisciplinary team completed a root cause analysis (RCA)to further clarify issues related to the alleged deficiency. The RCA revealed the need for additional training and education for the infection control team. The leadership team will seek continued education from the hired infection control consultant and additional training from a third-party vendor. The contracted IP consultant will assist the community in updating policies and procedures based on the RCA and conduct audits for adherence to recommended infection prevention and control practices. Lastly, the consultant will assist the community infection preventionist in completing the CMS infection control self-assessment.

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masks, and face shields. They proceeded to reposition Resident #35 in the bed. They were not wearing N95 masks when they entered the room. When they exited the room, they removed their gown and gloves and preformed hand hygiene. They then walked down the hall with the same surgical mask and face shield.

Resident #189 was not up to date on the COVID-19 vaccination series.

Resident #190 was not up to date on the COVDI-19 vaccination series.

Resident #27, Resident #29, and Resident #188 were not in enhanced droplet precaution isolation rooms.

Interview with NA #1 on 08/02/22 at 2:26 PM revealed she had just started working at the facility. She stated she had asked for a N95 mask but was told by the Infection Preventionist none were available. She stated she was educated on how to put on and take off PPE. She further stated she wanted to keep the face shield for the duration of the shift but did not indicate why she did not sanitize the face shield.

An additional interview with NA #1 on 08/04/22 at 3:38 PM revealed her assignment included caring for Resident #34, Resident #35, Resident #189, Resident #190 on 08/02/22. She stated she provided direct personal care to these residents and indicated Resident #189, and Resident #190 were not in COVID-19 enhanced droplet precautions isolation rooms.

An interview with NA #2 on 08/02/22 at 2:28 PM revealed she was educated on how to put on and

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Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and

The Infection Preventionist or designee is conducting quality improvement (QI) audits of adherence to transmission-based precautions and PPE compliance within the facility. All shifts will be observed. Compliance audits will be complete daily for30 days. Additional QI audits will be completed based on the level of compliance.

In addition, the Infection Preventionist or designee is conducting daily visual rounds to ensure staff are demonstrating compliance with transmission-based precautions and PPE following the strategies established during root cause analysis. These rounds are being conducted five times weekly for 8 weeks, then ongoing weekly for a total duration of 12 months. Additional QI audits will be completed based upon the level of compliance.

The results of all QI audits are being reported to the Quality Assurance Committee monthly for additional recommendations as necessary.

Include dates when corrective action will be completed.

The corrective action will be completed on 8/26/2022. The Infection Preventionist will be ultimately responsible for ensuring

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F 880	Continued From page 15 take off PPE as well as to use a surgical mask when she worked with a resident with COVID-19. She stated she wanted to keep the face shield for the duration of the shift but did not indicate why she did not sanitize the face shield. An additional interview with NA #2 on 08/04/22 at 3:38 PM revealed she was assigned to another hall on 08/02/22 in which there were no COVID-19 enhanced droplet isolation rooms; however, assisted NA #1 with repositioning Resident #35 on 08/02/22. She further stated she provided direct personal care to Resident #35, Resident #189, Resident #190 on 08/03/22. During an interview with the Infection Preventionist on 08/04/22 at 12:22 PM revealed the facility used enhanced droplet precautions for resident diagnosed with COVID-19. She stated it was their policy for staff to wear surgical masks, face shields, gloves, and gowns when they provided care to residents with COVID-19. She stated it was acceptable to wear a surgical mask when staff cared for residents who were COVID-19 positive. She further stated only a few staff members had N95 masks because staff members must sign a medical release form and be fit tested for a N95 mask. She stated staff members could choose whether or not to wear a N95 mask, and N95 masks were available. She stated all PPE must be discarded before the staff exited a resident's room and face shields needed to be cleaned in between caring for residents with COVD-19. She further stated the Director of Nursing (DON) was responsible for the vaccination efforts in the facility. An additional interview with the Infection Preventionist on 08/04/22 at 3:49 PM revealed	F 880	compliance.	

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she was unaware of the CDC guidelines which stated a N95 mask were required when staff provided care to residents with COVID-19. Another interview with the DON on 08/05/22 at 10:07 revealed she did get updates from the CDC regarding COVID-19 but could not find the updated guidelines for N95 use.

The DON stated in an interview on 08/04/22 at 4:16 PM the facility was following CDC guidelines when staff wore a surgical mask, face shield, gown and gloves when providing care to residents with COVID-19. She stated N95 masks were not required during the pandemic and did not know why N95 masks were being required now. She further stated their policy allowed staff members to wear a surgical mask while they performed care for residents with COVID-19. Additionally, all vendors must follow their policy regarding PPE use when they provided care to residents with COVID-19, which included wearing a surgical mask, face shield, gown, and gloves. She stated signs were posted on the door which informed staff of the type of PPE required before staff entered the room. She stated the current sign used were sent to the facility a few months ago and could not remember who sent the signs.

An interview with the Medical Director on 08/05/22 at 5:11 PM revealed he believed the facility was using N95 masks for staff providing care for residents with COVID-19. He further stated he would wear a N95 mask when he cared for with residents who were COVID-19 positive.

The Administrator was notified an immediate jeopardy existed on August 4, 2022, at 6:00 PM.

The facility provided the following credible

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F 880	Continued From page 17 allegation for immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and The alleged deficient practice indicates that staff members and a vendor did not have proper PPE to enter COVID-19 positive resident rooms and proper donning and doffing of PPE was not conducted. Residents who reside in the 600 hall have been identified of having the potential to be affected by the alleged deficient practice. All identified residents on the 600 hall were immediately assessed by the licensed nurse for signs and symptoms of COVID-19 on 8/4/2022. All identified residents are free from signs or symptoms of COVID-19. Under the direction of the Infection Preventionist and Medical Director, physicians orders were obtained and entered for signs and symptoms monitoring every shift for 72 hours. The Director of Nursing notified the licensed nurse of their responsibility to monitor symptoms and report irregularities to the physician immediately for further intervention on 8/4/22. MD orders are effective on 8/5/22. The Infection Preventionist will be responsible for the completion of this task. Residents identified as exposed and not up to date on vaccination were placed on transmission-based precautions on 8/4/2022 for potential exposure under the direction of the medical director. These residents will be on precautions for 10 days or 7 days if asymptomatic and have a negative test per CDC guidelines. The Infection Preventionist was notified of these	F 880		

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F 880	Continued From page 18 precautions on 8/4/22 and will be responsible for overseeing the completion of this task. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete On 8/4/2022, the Director of Nursing and Medical Director reviewed CDC guidance for mask usage and updated the community policy regarding the use of N95 masks, including staff members to wear N95 masks when caring for residents who have a confirmed diagnosis of COVID-19. On 8/4/2022, the Infection Preventionist provided education to all staff and vendors present on the revised policy and practices. Education provided includes updated signage for transmission based precautions, placement of isolation storage devices, appropriate selection of personal protective equipment including use of N95 mask and face shields, and discontinuing use of surgical masks for resident COVID-19. Education has been provided on donning and doffing personal protective equipment and placing doffed equipment in trash receptacle before exiting room. Education reinforced sanitization of equipment including face shields. All staff and vendors who were not present for education will be educated on the updated practices on arrival to the community prior to the start of their shift and before providing resident care. The person responsible for overseeing the education and compliance of this plan is the Infection Preventionist. The facility has placed signage directing all vendors that they must see Infection Preventionist or 600 hall charge nurse for education prior to entering the COVID-19 positive	F 880		

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F 880	Continued From page 19 rooms. The Infection Preventionist placed additional isolation bins outside COVID-19 positive rooms on 8/4/22. Bins contain disinfecting products, N95 masks, and face shields for staff and vendor use. The Infection Preventionist or other licensed nurse will replicate this practice for all new cases of COVID-19. All licensed nurses were educated of this responsibility beginning on 8/4/22 and prior to next shift. The noted items have been completed on August 6th, 2022. On 08/05/22, the facility's credible allegation for immediate jeopardy removal was validated by observations of updated signage placed on COVID-19 isolation rooms; observations of the COVID-19 isolation rooms verified staff wore the required PPE for enhanced droplet precautions; multiple interviews with facility staff revealed they received training and were able to describe the facility's policy on the use of required PPE for enhanced droplet precautions; and review of the updated facility policy regarding required PPE use verified staff were to use N95 masks when caring for residents who have a confirmed diagnosis of COVID-19. Immediate jeopardy was removed on 08/06/22.	F 880		