STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345340	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE LEAF HEALTH CARE	1101 MAPLE CARE LANE STATESVILLE, NC 28625

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, staff interview, record review, and review of the facility's Infection Control and COVID-19 protocol documents, the facility failed to implement protocols when staff did not don and doff Personal Protective Equipment (PPE) when they entered and exited the rooms of residents who were on Droplet Precautions for 2 of 2 nursing staff observed working on the facility's quarantine hallway. The facility failed develop a policy that addressed when laundry staff were to perform hand hygiene and what Personal Protective Equipment (PPE) they were to wear. Additionally, a laundry aide was observed not wearing any PPE while handling clean and dirty laundry nor perform hand hygiene after touching soiled linen laundry for 1 of 1 staff observed processing laundry. Staff disposed of isolation gowns, that were used on the facility's quarantine unit, in a bag that was attached to a blood pressure machine. Staff failed to disinfect a mattress that was removed from a resident's room (Resident #4), who was on droplet precautions, and failed to wear PPE, to prevent contact with skin and clothing, when the mattress was removed from the quarantine unit. These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through the transmission of COVID-19. Findings included: 1. According to the facility protocol documents titled Tool Kit A-Section I and II: Center Preparedness Infection Prevention Strategies and Guidance for COVID-19 dated 07/15/20 read in part as of May 14, full PPE is recommended in admission units, observation units, and dedicated areas where residents with suspected and confirmed COVID-19 cases are located. Recommended PPE on these units include N-95 respirators, eye protection, gloves, and gowns. According to the facility protocol document titled Tool Kit B- Section I and II: Managing COVID-19 in your Center dated 07/01/19, all new admissions who are admitted with negative testing and asymptomatic shall be placed on droplet precautions for 14 days and re-tested on the 12th day of admission. It further indicated care considerations of residents in suspected care areas are positive until facility testing confirms otherwise and staff must be meticulous in hand hygiene and use of PPE. It reads in part that staff should ensure all needed supplies for the resident are available when entering the room. It further mentioned under frequently asked questions related to waste materials that surfaces should be wiped down with a disinfectant and that staff should follow OSHA (Occupational Safety & Health Administration) administrative controls, safe work practices, and PPE to prevent worker exposures. A continuous observation on 07/22/20 from 10:18 AM to 11:55 AM revealed Nurse Aide (NA) #1 was working on the facility's quarantine unit and the following observations were made: On 07/22/20 at 10:18 AM, NA #1 was observed to exit Resident #5's room wearing full PPE which included gown, gloves, N-95 mask, and a face shield. Signage posted on the resident's door indicated Resident #5 was on Droplet Precautions. NA #1 was carrying two plastic bags which revealed soiled linen and trash. She approached the community trash and soiled linen carts located in the hallway. NA #1 used her soiled gloved hands to open the lid instead of using the installed foot pedal. She then proceeded to remove the glove on her right hand followed by her isolation gown and her left glove. She then used her bare hand to compress the items in a downward fashion in the trash receptacle and touch the lid of the soiled linen and trash receptacles to close them then washed her hands. On 07/22/20 at 10:20 AM Nurse Aide #1 was observed to don full PPE which included a gown, gloves, mask, and face shield and entered the soiled utility room. Immediately following, Nurse Aide #1 exited the soiled utility room, walked across the hallway and retrieved linens from the clean linen cart and entered Resident #6's room and closed the door to the room. Signage posted indicated Resident #6 was on Droplet Precautions. Nurse Aide #1 then opened Resident #6's door and retrieved an item from the clean linen cart that was in the hallway outside of Resident #6's room and went back in the room wearing the same gloves she had on when she exited the room and closed the door to the room. On 07/22/20 at 10:28 AM, Nurse Aide #1 exited Resident #6's room carrying two plastic bags. One bag included linens and the other contained trash. She was wearing full PPE of gown, gloves, mask, and face shield when she approached the linen and trash receptacles located in the hallway. She opened the lid to both the trash and soiled linen cart with her gloved hands. After throwing the trash in the receptacle, she opened the bag of soiled linens and began removing the items from the bag and dropping them directly into the soiled linen receptacle before throwing the bag away in the trash receptacle and removing her PPE. She then closed the contaminated lids with her bare hands and was not observed to sanitize the receptacle after touching it with her gloved hands. NA #1 was observed to don a mask, gown, gloves, and a face shield out of the isolation cart located in the hallway. On 07/22/20 at 10:30 AM, NA #1 entered the soiled utility room using the door handle then exited and proceeded down the hall to answer Resident #7's call light. She entered Resident #7's room and turned off the resident's call light then exited the room and disposed of her PPE in the trash receptacle. She reapplied a gown, retrieved linen and gloves from the clean linen cart then re-entered Resident #7's room to perform care. She was not observed to perform hand hygiene before she applied the new gloves and returned to Resident #7's room. Signage indicated Resident #7 to be on Droplet Precautions. An interview was conducted with Nurse Aide #1 on 07/22/20 at 11:13 AM which revealed she was unaware there was a foot pedal for use in opening the trash and soiled linen cart she had used. She identified she had touched the lid with both her gloved and ungloved hands as well as compress the trash compartment with her bare hand followed by touching of the outside of the receptacle and did not use a disinfectant to clean it afterwards. She stated she should not have touched the outside of the cart with soiled gloves, the receptacle should have been emptied instead of compressing it with her hand, and the surface should have been disinfected if touched with a soiled glove. NA #1 also stated she should have removed her gloves and washed her hands before retrieving additional items from the clean linen cart. She acknowledged she should not exit the soiled utility room wearing PPE an enter Resident #6's room without washing her hands and changing PPE. She also revealed the reason she had been observed removing the laundry from the bags at the cart and placing the soiled linen directly in the soiled linen cart was because when carts were returned from laundry, they would include the bags linens had been in when sent to laundry and she must discard them in the trash. NA #1 stated she should have washed her face shield before she applied PPE and should not have worn the same PPE in Resident #7's room as she had worn in the soiled utility room. She also stated she should have washed her hands before applying clean PPE to return to Resident #7's room to provide care. On 07/22/20 at 11:55 AM, NA #1 was observed to don a gown and gloves from the isolation cart in the hallway and pick up a meal tray from the cart dietary had placed on the unit. She then noticed Resident #5's call light was on, so she sat the lunch tray back down on the cart and proceeded to the doorway of Resident #5's room to answer the call light. When she arrived at the door of Resident #5's room and placed her hand on the door frame, NA #1 spoke to Resident #5 and left and went into a room where Nurse #1's office was located to wash her hands. She removed one glove and discarded it, then turned on the faucet and washed the one ungloved hand, then reapplied a glove and exited the room. She returned to the meal cart and picked up another tray and entered another room that was on the quarantine unit. An interview with Nurse #1 was conducted on 07/22/20 at 12:20 PM revealed she was the nurse for the New Admission/Observation unit and was the supervisor for Nurse Aide #1. She stated NA #1 should not have touched the lids on the trash and soiled linen carts with gloves used in Resident #5 or 7's room. Nurse #1 revealed Resident #5, #6, and #7 were on Droplet Precautions. Nurse #1 further stated NA #1 should not have attempted to compress items in the trash receptacle with her hand. She indicated trash and linen receptacles

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) should be emptied frequently by nurse aides and should not be allowed to overflow. She further revealed all contaminated surfaces should be immediately disinfected. Nurse #1 indicated linen should not be emptied from plastic bags and emptied directly into the soiled linen receptacle and was unaware that NA #1 had. Nurse #1 stated NA #1 should prepare all needed supplies before entering the room of Resident # 6; however, if additional items were needed, all PPE should be removed, hand hygiene performed, and clean PPE should be donned before NA #1 returned to Resident #6's room. Nurse #1 revealed she was unaware laundry was returning bags previously used to hold soiled linen back in the carts. Nurse #1 acknowledged NA #1 should have removed both gloves and performed hand hygiene before delivering additional trays after touching the door frame of Resident #5's room. An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on 07/22/20 at 1:40 PM and revealed all staff had received in-service training on transmission-based precautions and donning and doffing of PPE including gowns. The IC Nurse/DON stated Nurse Aide #1 should not have touched the outside of the trash and soiled linen receptacles with her soiled gloves nor should she have attempted to compress the trash but should have instead emptied the trash receptacle before it became full. They said the outside of the receptacles should be sanitized if they become contaminated after contact with gloves used in Resident #5's or #7's room who was on Droplet transmission-based precautions. The IC Nurse and DON revealed NA #1 should have taken all supplies needed into the room, but PPE should have been removed when exiting the room. Hand hygiene should be performed, needed supplies gathered, and full PPE should be donned before re-entering Resident #6's room. They stated NA #1 should always remove gown and gloves and perform hand hygiene after touching the door frame of Resident #5's room and continued with meal delivery. An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions and proper use of PPE. She stated staff should properly remove PPE into waste receptacles without contacting the exterior of the container with soiled gloves nor attempt to compress the trash into the receptacle and should always remove contaminated PPE and perform hand hygiene before entering Resident's rooms housed on the New Admission/Observation quarantined unit. She acknowledged it was unsafe and posed an increased risk of infection through cross contamination. 2. According to the facility protocol document titled Tool Kit B- Section I and II: Managing COVID-19 in your Center dated 07/01/20 read in part under frequently asked questions to waste materials that staff should follow OSHA administrative controls, safe work place practices, and wear PPE to prevent worker exposures. The undated facility document titled The Laundry Process, it did not address processing laundry during the COVID-19 pandemic, laundry processing for residents on transmission-based precautions, nor did the document define appropriate PPE when the documented laundry workers must always wear proper PPE when handling soiled linens under the transferring and sorting headings. The document also did not address when hand hygiene should be performed at any point when staff processed laundry. A continuous observation of the laundry department on 07/22/20 beginning at 12:35 PM and ending at 12:45 PM revealed Laundry Worker #1 to be located on the dirty side of the laundry room. She was wearing a face mask at the time of the initial observation. Laundry Worker #1 was observed to open the washing machine door with her bare hand, then apply one standard surgical glove, retrieve a bag of soiled linen from the linen/trash receptacle and place the bag in the washing machine. The clothes placed in the washer contained both personal residential laundry and facility linens. She removed the bag from the washer using both her gloved and bare hand and placed the bag into the linen. Laundry Worker #1 then applied a second glove and continued retrieving linen from the soiled cart. When she was attempting to retrieve linen from the cart, Laundry Worker #1 was observed to have her entire uncovered arms in the soiled linen cart and her forehead and hair was touching the back portion of the cart and its lid. After Laundry Worker #1 had removed all linen from the cart, she closed the cart with her gloved hand, shut the washer door, and pushed the dirty cart into the adjacent room next to the sink. Laundry Worker #1 then removed her gloves and disposed of them in the trash. She then pushed a yellow flat cart of damp laundry to the dryer located on the clean side of the laundry room and began loading the damp linen into the dryer with her bare hands. Once all damp linen was loaded, she returned to the washer, applied one glove and repeated the above sequence of loading laundry in the dryer again. She was not observed to apply an apron, long thick gloves, or a face shield when emptying the linen carts nor perform hand hygiene during the continuous observation. An interview with Laundry Worker #1 on 07/22/20 at 12:45 PM revealed she had worked in the laundry department for the last 7 years and stated she had the apron, long gloves, and a face shield available, but never uses them to sort or load laundry into the washing machine. Laundry Worker #1 identified the apron, face shield, and long gloves were located on a shelf in the laundry department. Laundry Worker #1 acknowledged she should wear gloves on both hands to load the washer and agreed she should wash her hands after removing them. An interview with the Maintenance Director on 07/22/20 at 12:48 PM revealed Laundry Worker #1 should have gloves on both hands and washed her hands after removing PPE. He stated he was unaware Laundry Worker #1 was not wearing full PPE when sorting and loading laundry and was also unaware she was not washing her hands between performing tasks requiring her to move from the dirty to clean side of the laundry room. An interview with the Environmental Services (EVS) Supervisor on 07/22/20 at 1:00 PM revealed the EVS Supervisor was unaware Laundry Worker #1 was not wearing the appropriate PPE when sorting and loading laundry on the dirty side of the laundry room. He further revealed he was also unaware Laundry Worker #1 was putting dirty bags back into the cart to be returned to the units after emptying soiled linen. He stated Laundry Worker #1 should have worn gloves on both hands when sorting and loading the washing machine. He also stated full PPE that included apron, long gloves, and a face shield should be worn when emptying some soiled linen carts, but he did not require it on others. He provided the undated document titled The Laundry Process that did not specify when it was acceptable for Laundry Worker #1 to not wear full PPE when loading or sorting linens in the laundry department. The EVS Supervisor verified the document provided did not include when and what type of PPE the laundry workers should wear during sorting and processing linens in the laundry room nor when laundry workers were to perform hand hygiene while processing soiled and clean linens. An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on 07/22/20 at 1:40 PM. The IC nurse revealed all staff had received in-service training on hand hygiene, transmission-based precautions, and donning and doffing of PPE. The DON stated Laundry Worker #1 had been re-educated often about concerns in the laundry department without success of retention. The DON further stated since the pandemic began clothing had been returned to the inappropriate resident's room by Laundry Worker #1 and it require the item to be re-washed. The IC Nurse and DON indicated not wearing full PPE and not performing hand hygiene after removal posed risk of infection for Laundry Worker #1, all residents, and other laundry workers through cross-contamination. An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions, proper use of PPE, and hand hygiene. She stated Laundry Worker #1 should have worn full PPE and washed her hands after removal. She acknowledged Laundry Worker #1 not wearing full PPE and not washing her hands was unsafe practice and posed an increased risk of infection through cross contamination. The Administrator verified the laundry department is a contract company and had their own policies separate from the facility. 3. An observation was made on 07/22/20 at 12:02 PM, revealed Medication Aide (MA) #1 wearing a mask and a face shield and was working the quarantine hallway. She applied a gown, picked up a tray from the meal delivery cart, and entered Resident #6's room without wearing gloves. Signage on the outside of the door of Resident #6's indicated she was on Droplet Precautions. She placed the meal tray on Resident #6's overbed table and used her bare hands to set up the resident's meal tray. MA #1 was not observed to wear gloves when she was in the room of Resident #6. On 07/22/20 at 12:05 PM, MA #1 exited Resident #6's room and returned to the meal delivery cart in the hallway of the quarantined unit. MA #1 was then observed to use her bare hands to obtain a meal tray from the cart, carry it to Resident #8's room, enter the resident's room and serve the meal to the resident. Resident #8 had signage that indicated she was on Droplet Precautions. An interview with MA #1 on 07/22/20 at 12:15 PM revealed she did not wear gloves to setup the meal tray for Resident #6 who was on Droplet Precautions. She stated she was not sure why she did not have on gloves when delivering meal trays to residents, who were eating in their rooms, but had received training and should have worn full PPE including gloves when entering resident rooms to deliver and set up their meal trays. An interview with Nurse #1 was conducted on 07/22/20 at 12:20 PM and revealed she was the nurse for the New Admission/Observation unit and was the supervisor for MA #1. She stated full PPE including gown, gloves, mask, and a face shield are to be worn to deliver meal trays in Resident #6 and Resident #8's room who was on Droplet Precautions. An interview with the IC Nurse/DON was conducted on 07/22/20 at 1:40 PM revealed MA #1 should always wear gloves to deliver a meal tray in Resident #6 and #8's room who was on Droplet Precautions on the New Admission/ Observation quarantine unit followed by performing hand hygiene. An interview with the Administrator was conducted on 07/22/20 at 2:45 PM revealed MA #1 should have worn a gown, gloves, mask, and a face mask when delivering a meal tray for Resident #6 and Resident #8. 4. Observations was made of a blood pressure machine located on the New Admission/Observation quarantine unit on 07/22/20 at 10:00 AM, 11:00 AM, and 12:30 PM. The machine was observed to have a plastic bag attached to it that was overflowing with yellow gowns that appeared to be

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She stated she was unaware staff were disposing of isolation gowns in a bag attached to the blood pressure machine and immediately applied gloves and removed the bag from the cart and disposed of the bag. An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on 07/22/20 at 1:40 PM. The IC Nurse revealed all staff had received in-service training on transmission-based precautions and donning and doffing of PPE including gowns. The IC Nurse and the DON both stated no member of staff should attach a bag to the blood pressure machine and isolation gowns should be disposed of immediately and not placed in a bag on the cart which is used from room to room. An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions and proper use of PPE. She stated staff should properly remove PPE into waste receptacles and not placed in a bag on the blood pressure machine. She acknowledged it was unsafe practice and posed an increased risk of infection through cross contamination. 5. Review of facility policies revealed there was no policy available that addressed how a mattress that was used by a resident, who was on droplet precautions and resided on the in a on the quarantine unit, should be cleaned and disinfected and removed from the room and the unit. An observation on 07/22/20 at 10:15 AM revealed an uncovered resident bed mattress was leaned against the wall in the hallway of the New Admission/Observation quarantined unit. The mattress was in the hallways outside of Resident #4's room. Signage posted on the door to Resident #4's room indicated she was on Droplet Precautions on 7/22/20 at 11:05 AM revealed the mattress remained in the hallway floor outside of Resident #4's room. On 7/22/20 at 11:08 AM, the Environmental Services (EVS) Supervisor donned a pair of surgical gloves and picked up the contaminated mattress from the hallway and carried the mattress against his clothing out a side door on the unit. He was not observed to don a gown before placing the mattress against his skin and clothing nor disinfect the mattress or hallway surfaces before or after removing the mattress from the quarantined unit. An interview with Nurse Aide #1 was conducted on 07/22/20 at 11:13 AM. It revealed the mattress had been removed from the bed of Resident #4 and exchanged for a new mattress before her shift began at 7:00 AM. NA #1 was unsure why it was left in the hallway. She stated it should have been disinfected and taken outside. An interview with the Maintenance Director was conducted on 07/22/20 at 12:48 PM revealed items such as mattresses used in a Droplet transmission-based precaution room should be disinfected immediately, removed from the unit, and placed on the service hall for storage by appropriate Environmental Services (EVS) or Maintenance staff. He stated staff were trained to don PPE, when they removed a resident's mattress from the unit and to place the mattress on the service hall. An interview was conducted with the EVS Supervisor on 07/22/20 at 1:00 PM. The interview identified the mattress removed from the Admission/Observation quarantined unit during his shift had been removed from the bed of Resident #4 by second shift staff on 07/21/20 and was left in the hallway for housekeeping to disinfect and remove. The EVS Supervisor stated the mattress should have been immediately disinfected and removed from the unit after removal from Resident #4's room who was on transmission-based precautions. He stated it should not have been placed against a wall in the hallway. He stated he was trained, when removing a mattress from the quarantine unit he should have donned PPE to prevent the mattress from touching his uncovered skin and clothing. An interview with the Infection Control (IC) Nurse and Director of Nursing (DON) was conducted on 07/22/20 at 1:40 PM. The interview revealed all staff had received in-service training on transmission-based precautions and donning and doffing of PPE including gowns. The IC Nurse stated the EVS Supervisor should have worn PPE to remove resident objects that had been used in the Admission/Observation quarantined unit which included Resident #4's mattress. An interview with the Administrator on 07/22/20 at 2:45 PM revealed all staff had received in-service education on the policies and procedures for transmission-based precautions and proper use of PPE. She stated staff should wear full PPE when contacting and moving contaminated items like Resident #4's mattress.