STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, physician interviews and review of the facility ' s Communicable Disease Outbreak Preparedness Plan, COVID19 Unit Best Practices policy and COVID19 Hand Hygiene and Donning and Doffing Personal Protective Equipment (PPE) policy the facility failed to prevent an infection control systems failure by 1. Failing to implement the facility ' s Communicable Disease Outbreak Preparedness plan and the facility ' s COVID19 Unit Best Practices policy by not providing housekeeping services to maintain a sanitary and clean environment to prevent the spread of the COVID19 virus in the facility ' s COVID positive unit which included; 30 of 30 resident rooms, 2 of 2 shower rooms, hallways, the unit ' s COVID screening station area and the unit ' s entrance and exit areas and 2. Failing to implement the facility ' s policies and procedures on hand hygiene and PPE when staff failed to perform hand hygiene and remove their PPE after they provided resident care and exited resident rooms for 2 of 2 staff members (Nursing Assistants #4 and #5), who worked on the facility ' s COVID positive unit. As of 08/26/20, 73 of 118 the facility ' s residents tested positive for the COVID19 virus. These failures occurred during a COVID-19 pandemic. Immediate Jeopardy began on 08/17/20 when the facility failed to provide housekeeping services to maintain a sanitary and clean environment to prevent the spread of the COVID 19 virus in the facility ' s COVID positive unit. Immediate Jeopardy was removed 8-28-20 when the facility implemented an acceptable creditable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of E that is not Immediate Jeopardy to ensure monitoring systems put in place are effective. The findings included: 1. The facility ' s Communicable Disease Outbreak Preparedness Plan dated March 2020 , read in part; Environmental Service: would ensure the availability of alcohol-based gels, tissues and waste receptables at the facility. Make sure every sink is well-stocked with soap and paper towels for hand washing. Increased environmental cleaning using disinfectants approved to kill the Communicable disease. Laundry services-community staff will bag the transport and wash clothes following the manufactures instructions to determine the appropriate method and amounts of chemicals to produce a hygienically clean linen. Community plan operations would increase environmental cleaning using disinfectants approved to kill Communicable Disease. Ensure a trash can is near the exit inside every resident room to make it easy for employees to discard PPE. The facility ' s COVID19 Units Best Practices Policy dated June 3, 2020, read in part: laundry within the COVID unit was to be put into water-soluble bag, when picking up laundry within the unit, all water-soluble bags will be placed in a larger receptacle and taken out of the end hall COVID unit door outside and then around to the back door to the laundry area. Trash pickup included all smaller bags of trash from resident rooms when being picked up are to be placed into a larger receptacle and taken out the end hall COVID outside door around back to the dumpsters. Any items that are in red bags are to be boxed and taken (like trash) out the end of the hall door to the designated area. Observations on 08/17/20 from 11:20 AM to 1:45 PM of the facility ' s COVID positive unit, which was located on the facility ' s 400 and 500 hallways, revealed the following: A. On 8/17/20 at 11:20 AM, of the entrance to the COVID positive unit on the 400 and 500 hallways, revealed the unit was sealed behind zipper enclosures. At the unit ' s entrance there were several boxes of supplies stacked against the wall, barrels filled with soiled linen and trash and soiled gloves and a mask on the floor. B. Observations on 08/17/20 near the COVID unit ' s exit door revealed there was a COVID screening station in this area. There were used gloves, tissues and paper on top of the screening station ' s table. Wheelchairs, clothing, boxes of supplies, opened briefs, used juice cups, food wrappers and leftover meal trays were observed around or under the screening station ' s table. The floor under the screening station ' s table was stained with red and brown colored substances, dried fluids and food. Two barrels filled with soiled linen and trash were at the unit ' s exit door. C. Observations on 08/17/20 of the unit ' s hallway, where rooms 401 to 501 were located, revealed there were multiple bags of soiled linen and trash in the hallway. Observations inside each of the six resident rooms on this hallway revealed there were used gloves, used masks, dried fluid spills, food and resident clothing on the floors. Also, the side tables in these rooms were not clean with dried substances. D. Observations on 08/17/20 of the unit ' s hallway, where rooms 502 to 512 were located revealed there were barrels filled with trash and soiled linens, old bedding, wheel chairs and boxes of unopened supplies and cleaning products in the hallway. Observation inside the eleven resident rooms on this hallway revealed the floors in these rooms were unclean with dried fluids, brown matter, used gloves, briefs and food. Observations of the shower room on this hallway, revealed there was black mold in the tiles, a heavy build of soap residue in the two shower stalls, and the bathtub was unclean with a large volume of a brown sand like substance and rust. There were used towels, washcloths, gloves and trash on the floor of the shower room. There were used gloves, wipes, brown matter and areas of rust in the shower room ' s sink. The floor under the sink had a heavy buildup of mold and soap residue. E. Observations on 08/17/20 of the unit ' s short hallway, where rooms 513 to 515 were located, revealed in the hallway there were used nursing supplies in bags, trash and beds stored along the walls. Observations of the three resident rooms on this hallway revealed gloves, dried fluid spills, paper products and food on the floors, tray tables with dried substances, and trash cans filled with trash. Observations of this hallway ' s nurse ' s station revealed used gloves, used masks, and opened nursing supplies on the desk and on the floor. F. Observations on 08/17/20 of the area near the COVID unit ' s exit door revealed five yellow barrels that were full of trash and two grey barrels that were full of used PPE and other used items. A total of eighteen plastic bags that contained soiled linen and resident laundry were piled up against the wall. Additionally, opened and uncovered packs of briefs and gloves were observed in the handrails and on tray tables in the hallway. G. Observations on 08/17/20 of the unit ' s hallway, where rooms 406 to 415 were located, revealed there were used gloves and a mask in the hallway ' s hand rails and barrels were overflowing with trash. Observations of the ten resident rooms on this hallway revealed the floors were unclean with soiled linen, used cups, dried fluids, food, and paper products. Used gauze and medication cups were on the floors near unemptied trash cans in resident rooms. Plastic bags that contained resident clothing were on the floor in resident rooms and in the hallway outside of resident rooms. H. Observations on 08/17/20 of a shower room on the hallway, where rooms 406 to 415 were located, revealed mold growth was on the wall tiles and floor tiles. Also, wheelchairs, bedding and resident equipment were stored in the shower stalls. On 08/17/20 at 11:55 AM an interview was conducted with NA #4, who was an agency NA and worked on the facility ' s COVID unit. NA #4 stated this was her first day working in the facility ' s COVID unit and she received brief training on the transmission of COVID 19 infection and unit requirements. NA#4 stated she had not received any direct training on the cleaning or disinfecting procedures for the facility ' s COVID19 positive unit. NA #4 stated, I just wipe things down with the wipes located in the resident ' s rooms. There was no specific place where the disinfectant was kept, as you can see everything is all over the unit and disorganized. I was asked to come to work at this facility and placed on the COVID19 positive unit, and I am trying to keep the residents clean, fed to the best of my ability. On 8/17/20 at 11:58 AM, an interview was conducted with NA #5, who was an agency NA and was working on the facility ' s COVID unit. NA #5 stated that he received a very brief training on the transmission of COVID19, infection control practices and handwashing and sanitizing. NA #5 stated he had worked several back to back shifts in the facility ' s COVID unit and it was getting very frustrating trying to keep residents clean and cared for and keeping the unit clean.

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

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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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) NA #5 further stated, it was too much to care for residents and clean an entire unit by the end of the shift. NA #5 specified the trash and linen barrels would get full because there was no housekeeping staff working on the unit and when you needed to clean things off you had to go through boxes on the hall to find things. NA #5 explained, that he did not receive any specific training on the cleaning or disinfecting procedures for the unit. He stated, that he was asked to come to the facility, and was placed on the COVID19 positive unit and did his best to clean in between caring for the residents. During an interview on 8/17/20 at 12:10 PM, Nurse #3 stated the facility ' s COVID positive unit had several call outs due to illness or not returning to the unit. Therefore, the current aides and nurses had to pitch in and do their best to clean the unit after all the resident care was provided. Nurse #3 stated, the cleaning can get difficult at times. During an interview on 8/17/20 at 12:30 PM, Nurse #4 stated prior to staff working on the facility ' s COVID19 positive unit they were educated and informed on the infection control policy and procedures for COVID 19 positive unit, which included; handwashing and sanitizing practices and disinfecting surfaces. Nurse #4 explained, the unit ' s nursing staff were required to maintain and clean the unit due to no housekeeping staff being assigned to work on the unit. She explained, the housekeeping staff provided the supplies and were expected to pick up trash and soiled linen at the unit ' s back door. But, at times the trash was not picked up for a few days, so things were stored at unit ' s back door and at other locations on the unit until the housekeeping staff came to pick them up. Nurse #4 stated, with the increase of COVID positive residents at one time it became very challenging for the unit ' s nursing staff to provide the medical care to the residents and to properly clean and disinfect the unit. An interview was conducted with the facility ' s contracted Housekeeping Supervisor (HKS) and Housekeeping District Manager (DM) on 08/17/20 at 1:45 PM. The HKS stated the facility ' s contracted housekeeping staff were only responsible for cleaning the non-COVID area and the nursing staff assigned to the COVID19 positive unit were responsible for cleaning the unit. The HKS added that he was responsible for providing the COVID positive unit with cleaning and disinfectant supplies and picking up trash and linen to prevent the spread of the infection. He added there was no housekeeping staff assigned to the COVID positive unit. The HKS further stated the nursing staff, who worked on the unit, were in-serviced on environmental cleaning checklist for isolation rooms for the COVID19 unit, but he was not sure if they were provided with other training on how to clean the unit. The Housekeeping District Manager stated he was informed by the corporate manager that the nursing staff working on the facility ' s COVID unit would be responsible for cleaning and disinfect the unit, therefore contracted housekeeping staff were not assigned to work on the COVID unit. The District Manager further stated that he was uncertain what kind of cleaning and disinfection training the nursing staff that worked on the COVID unit was provided. The DM explained the expectation was for the COVID unit nursing staff to place all trash and soiled linen in the designated barrels and to place the barrels at the designated door for housekeeping staff to pick up, to prevent the housekeeping staff from walking through the unit. The DM further explained, the housekeepers were expected to pick up these items daily in accordance to the facility best practice policy and procedures. During an interview on 8/17/20 at 12:15 PM, the facility ' s Regional Nurse Consultant (RNC) stated, all nursing staff were educated on the COVID19 policies and procedures and required to perform return demonstration of handwashing and sanitizing practices, infection control practices for cleaning and disinfecting rooms and surfaces, before they were assigned to the unit. The RNC did not specify what cleaning and disinfection training the nursing staff working on the unit was provided in the absence of housekeeping staff working on the unit. She indicated supplies for cleaning were available, but it had been difficult for unit ' s nursing staff to perform resident care and to clean and disinfect the unit thoroughly as required by the facility ' s infection control policies and procedures. During an interview on 8/17/20 at 2:15 PM, the Director of Nursing (DON) stated the facility ' s Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) were responsible for monitoring the COVID19 unit and checked the condition of the unit and the residents on the unit, but they both became sick and were unable to work. The DON explained the staff that worked on the unit should use bleach, which was the designated disinfect to clean frequently touched surfaces. The DON stated, there should be no soiled linen, resident clothing, trash, used supplies or leftover food on the floor in the COVID unit. The DON stated the COVID unit previously had a designated housekeeper, but she walked off the job a few weeks ago and no replacement was provided by the housekeeping department. The DON specified the unit ' s nursing staff struggled to keep the unit as clean as possible. The cleaning supplies were provided and available, but the nursing staff did not have much time to maintain the cleanliness of the unit. Several residents were moved to the unit at one time and things became dysfunctional when the ADON and SDC became sick and there was no management monitoring of the unit. The DON stated the administrator and housekeeping supervisor were aware of the situation. During an interview on 8/17/20 at 2:00 PM, the Administrator stated weekly discussions via Quality Assurance Meetings were held to determine the cause of the facility ' s COVID outbreak and the action plan. The continued source of the infection among staff had not been determined, but issues with the cleanliness of the environment became an issue as the facility did not have staff available to do the proper cleaning. The administrator explained the facility ' s current housekeeping contract was terminated at the end of July 2020, but they were working out their contract through the end of August 2020. The Administrator stated the expectation was for the housekeeping department to supply the COVID19 positive unit with designated cleaning supplies and follow the Best Practice Policy and Resident Placement Policy to pick up trash and laundry from the unit. The Administrator confirmed there were no housekeeping staff assigned to the COVID19 positive unit since the end of July 2020 and the expectation was for the unit ' s nursing staff to clean and maintain the environment of the facility ' s COVID positive unit. During a telephone interview on 8/24/20 at 3:49 PM, with a member of facility ' s Department of Operation (DO) and Director of Nursing (DON) reported the ADON/infection preventionist had been doing the monitoring and surveillance tracking of the COVID unit, but she was out sick. The housekeeping staff were affected, therefore, the responsibility for cleaning and maintaining the environment had been impacted. The DO stated the new housekeeping contract service would start at the end of the month (August 2020), and housekeeping staffing was now being covered by agency staff, staff from sister facilities, and the facility was offering staff overtime and bonus pay to ensure coverage was available. The agency staff were provided basic infection control training practices prior to accepting a position at the facility. During the survey, no in-service or orientation checklist for the agency staff was provided. Additionally, no infection control, cleaning/disinfection training documents were provided for the staff working on the COVID19 positive unit or new hires. During a telephone interview on 8/27/20 at 2:48 PM, the Chief of Nursing Officer for the facility ' s contracted staffing agency stated, the staffing contract with the facility was established on 7/16/20 with the agreement the facility was responsible onsite training of the facility requirements in infection control prior to placement and to determine the adequacy of each employees ' job performance. During a telephone interview on 8/25/20 at 9:44 AM, the Medical Director stated he was unable to pinpoint a specific cause for the outbreak of the COVID infection in the facility. However, the Medical Director speculated the outbreak was potentially due to lack of adequate housekeeping cleaning and disinfecting procedures, poor ventilation in the facility and limited staff. He further stated to control the rapid spread at a short period of time was difficult to manage when resources were limited and reporting of symptoms when staff were asymptomatic. The facility had enough PPE and cleaning supplies available, however, due to the contracted housekeeping service company ' s practice, the facility staff and residents were impacted by the poor cleaning practice of the company. The Medical Director stated, I had been informed by the administrator and the director of nursing that due to the housekeeping contract services, the quality of cleaning throughout the facility had a significant impact on the spread of [MEDICAL CONDITION]. The staff attempted to do their best to provide care and maintain a clean environment for the residents. The contracted housekeeping staff did not work in accordance to the professional standards. The Medical Director stated, I had been made aware the current housekeeping company had been terminated the end of July and the new company would start on end of August, therefore, unit staff had the extra burden of trying to clean and maintain the environment. The Medical Director indicated the contract cleaning standards were poor which may have had a direct impact on the spread of [MEDICAL CONDITION]. The Medical Director specified, the timeliness of the returned COVID19 test results revealed an increase of positive cases each week. He continued to review the cases each week and currently 51 residents who had been on the COVID 19 unit for the past 15 or more days have been moved to the step-down unit and there are only 23 current active cases. Review of the facility ' s weekly tracking information on the number of residents who tested positive for the COVID19 virus revealed the following: week of 7/15/20- 2 residents, week of 7/22/20- 4 residents, week of 07/29/20- 10 residents, week of 08/06/20- 12 residents, week of 08/12/20- 35 residents and the week of 08/19/20- 23 residents. 2. The facility ' s Communicable Disease Outbreak Preparedness plan dated March 2020, read in part; Prevention section read in part all staff should practice good hygiene and handwashing techniques and would be educated to conduct frequent washing of hands and to avoid touching the eyes/face area. Healthcare workers should wear appropriate Personal Protective Equipment (PPE) masks, gloves, and gowns while working

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) with suspected cases. Nursing would ensure on-going education and training of staff. Ensure employees clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE). The facility ' s revised COVID19 Hand Hygiene and Donning and Doffing PPE competency infection control checklist for nurse aide in training policy and procedure dated 8/7/20, revealed in part; put 3 to 5 milliliters of antiseptic soap in the palm of your hands. Rub your hands together to distribute it. After you complete your care for the individual and if your hands are chapped or dry, apply lotion or a barrier cream that is dispensed by an individual-use dispenser and approved by your organization. Wears and/or uses safety equipment and supplies when indicated and properly trained to use. The facility ' s COVID 19 unit special airborne/contact precaution signage revealed a reminder: HAND HYGIENE must be performed before entering the room and following removal of PPE and leaving the patient ' s room. Observation on the facility ' s COVID19 positive unit on 8/17/20 from 11:40 AM to 11:45 AM, revealed NA#4 entered and exited two different resident rooms on the unit ' s 400 hall to assist residents with water and snacks touching bed side trays and tables, and picked up soiled linen from the floor. NA#4 was observed to exit the first resident ' s room and did not remove her PPE, gloves or wash her hands or use sanitizer before entering the second resident ' s room. NA #4 entered the second resident ' s room wearing the same PPE, gloves in place and wiped off a resident with the provided wipes. NA#4 was observed exit the second resident ' s room wearing the same PPE and did not wash or sanitize her hands. NA #4 carried soiled linen from the resident ' s room and stacked it in already filled barrels at the end of hall. On 8/17/20 at 11:55 AM, an interview was conducted with NA #4, who was an agency NA and worked on the facility ' s COVID unit. NA #4 stated this was her first day working the unit and she was provided brief training on the transmission of COVID 19 infection and unit requirements for handwashing and sanitizing, donning and doffing PPE when entering and exiting resident rooms. NA#4 confirmed there were occasions she had not removed the PPE or washed her hands as required because she was trying to respond to resident call lights and clean up the unit. NA #4 stated, I got in a hurry trying to do everything and did not remove my PPE after entering or exiting every resident room where I had either provided care or touched surfaces. NA #4 explained, things have gotten so overwhelming on the unit with two aides and so many residents to look after. NA #4 stated, that she was asked to come to work at this facility and placed on the COVID19 positive unit, and that she was trying to keep the residents clean, fed to the best of her ability. Observation on 8/17/20 from 11:45 AM to 11:50 AM, revealed Agency NA #5 was observed in a resident ' s room cleaning up the soiled linen and trash and placed the items in plastic bags and placed the bags outside of the resident ' s room in the 500 hallway. NA #5 exited this resident ' s room, but did not remove the PPE, gloves or perform hand hygiene. NA #5 then entered a second resident ' s room wearing the same PPE and gloves and provided this resident with requested fluids. NA#5 was observed to exit the second resident ' s room without removing PPE, gloves or performing hand hygiene. NA #5 then entered a third resident ' s room wearing the same PPE and gloves. While in the third resident ' s room NA#5 was observed to touch unclean surfaces including tray tables and remote control without cleaning them. On 8/17/20 at 11:58 AM, an interview was conducted with NA #5, who was an agency NA and worked on the facility ' s COVID unit. NA #5 stated he had received very brief training on the transmission of COVID19, infection control practices, handwashing and sanitizing and donning and doffing PPE. NA#5 stated he had worked several shifts back to back and things were getting very frustrating trying to keep residents clean and cared for as well as keeping the unit clean. NA #5 stated that he knew if he was providing care and handling soiled linens, he should remove his PPE and wash his hands between each resident. NA #5 explained, Things have gotten so busy with so many residents and trying to keep up with care and cleaning and he may have walked in and out of resident rooms and not changed his PPE in between each resident. NA#5 further stated it was too much to care for residents and clean an entire unit by the end of shift. During an interview on 8/17/20 at 12:10 PM, Nurse #3 stated the expectation for the staff assigned to the facility ' s COVID19 positive unit was to provide care for each resident while wearing with full PPE, which included gloves, gown, K95 mask or surgical mask, and face shield or goggles. and proper handwashing when staff entered and exited resident rooms. Nurse #3 explained, all staff have been informed of the unit policy and procedures for donning and doffing PPE and washing and sanitizing hands to prevent the spread of [MEDICAL CONDITION]. During an interview on 8/17/20 at 12:15 PM, the facility ' s Regional Nurse Consultant (RNC) stated all staff were educated on the COVID19 policies and procedures, required to perform return demonstration of handwashing and sanitizing practices, infection control practices for the unit and donning and doffing PPE before they were assigned to work on the unit. The nurse explained there were signs posted throughout the unit and in front of resident rooms that specified hand hygiene must be performed before entering the resident ' s room and following the removal of PPE when exiting the resident ' s room. The RNC stated all staff assigned to the COVID19 positive unit were expected to follow and perform infection control practices of hand hygiene and proper use of PPE when they performed resident care and when they touched potentially infected surfaces. The RNC indicated staff should wash their hands in resident rooms when sinks were available and use the provided hand sanitizer in areas where direct handwashing was not available. During an interview on 8/17/20 at 12:30 PM, Nurse #4 stated prior to any staff working the COVID19 positive unit they would have been educated and informed of the infection control policy and procedures for COVID 19 positive unit, handwashing and sanitizing practices, donning and doffing PPE. Nurse #4 further stated there were infection control and contact precaution signs posted throughout the unit as a reminder to perform proper hand hygiene and about donning and doffing PPE when staff entered and exited resident rooms. During an interview on 8/17/20 at 2:15 PM, the Director of Nursing stated all staff assigned to the COVID19 positive unit were required to wear full PPE (gloves, gown, K95 mask or surgical mask, and face shield or goggles) when providing care or physical contact with the resident. The entire unit had signage posted to remind staff to perform hand hygiene, proper donning and doffing of PPE and discarding procedures of used PPE. The DON explained, staff should wash and sanitize hands prior to placement of full PPE and mask before entering resident rooms. When staff exited resident rooms they were expected to wash hands in room and/or sanitize hands before exiting and discarded items in the designated yellow barrels for trash and grey barrel for PPE. The DON stated, staff should wash and sanitize their hands when all PPE was removed. The DON explained staff should not enter any other resident room or common areas wearing the same PPE after they provided care or assistance to a resident. The DON stated every resident room on the facility ' s COVID unit had a full PPE cart in front of the room ' s doorway which included full covering PPE and hand sanitizer. During a telephone interview on 8/27/20 at 2:48 PM, the Chief of Nursing Officer for the facility ' s contracted staffing agency stated the staffing contract with the facility was established on 7/16/20 with the agreement the facility was responsible for onsite training of the facility requirements in infection control prior to the staff member ' s placement and to determine the adequacy of each employees ' job performance. The administrator was notified of immediate jeopardy on 08/28/20 at 11:39 AM. The facility provided the following credible allegation of immediate jeopardy removal: F 880 INFECTION PREVENTION AND CONTROL 1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: The Facility failed to follow its Infection Prevention and Control policies as evidence by a quarantined COVID-19 positive unit with (23) residents having soiled floors, uncontained/uncovered soiled linen and trash on floor in hallways and/or resident rooms, staff not performing hand hygiene between residents and a shower room with black substance noted on wall on quarantine unit. The facility failed to ensure infection control training for (2) two agency staff members (NA #4 and NA#5). These (2) agency staff did not have a [DIAGNOSES REDACTED]. The first positive staff member (Hospice CNA) reported to the facility that she was positive on 7/16/2020, the facility immediately excluded her from work. The facility resident placement policy was implemented and any resident who has exposure to this positive staff member was moved to a quarantined person under investigation (PUI) room and tested for COVID-19. The second positive staff (RN Supervisor) member was screened for signs and symptoms of COVID-19 upon reporting to work on 7/14/2020. Mid-shift, she stated she did not feel well. This employee was sent home after being tested by facility staff. Her COVID-19 results on 7/16/2020, was positive. Both employees were excluded from work and quarantined for 14 days. The facility implemented mass testing of all residents and staff on 7/14/2020 - 7/15/2020. The facility routinely monitored residents for signs and symptoms of COVID-19. The facility continued to utilize our resident placement policy and relocated all suspected residents with signs and symptoms of COVID-19 to a dedicated unit called persons under investigation (PUI) and immediately tested and quarantined a minimum of 14 days. These residents ' symptoms were monitored routinely by the Licensed Nurse. Despite these efforts, from 07/15/2020 to 7/29/2020 the facility increased COVID-19 positive residents from two (2) to sixteen (16) after mass testing was completed. From 08/06/2020 to 08/12/2020 after mass testing was completed, the facility increased COVID-19 residents from (16) sixteen to (47) forty-seven positive COVID-19 residents. From 08/19/2020 to 08/26/2020 the facility increased positive COVID-19 residents from (47) forty-seven to (73) positive COVID-19 residents. Total facility census on 8/26/2020 was 118 residents. The facility failed to follow its Infection Prevention and Control policies and training of the (2) two agency

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) staff in infection control which potentially lead to the increase in COVID-19 positive residents and staff in the facility. This is evident by observations of the quarantined /COVID-19 unit positive with 23 residents. This unit upon observations revealed soiled floors, uncontained/uncovered soiled linen and trash on floor in hallways and/or resident rooms and a shower room with black substance noted on wall on quarantine unit. Additionally, the (2) two agency staff were not performing hand hygiene between residents and inappropriately donning/doffing personal protective equipment. On 8/28/2020, the entire quarantine unit including resident rooms, hallways, shower room and the doors to enter and exit the quarantine unit were cleaned by Housekeeping and Nursing Staff. After cleaning completed, this area was inspected by the Assistant Director of Nursing and Housekeeping Supervisor to ensure a clean, sanitary orderly environment. No issues were identified. 2) 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 8/28/2020, the Director of Nursing/Regional Nurse Consultant/Ad