STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	04/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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 interview, Nurse Practitioner interview, record review, review of staff screening logs and review of facility documents entitled, COVID-19 Policy/Plan for Facilities, FAQ COVID-19, and Respiratory Symptoms COVID-19 algorithm the facility failed to 1) ensure the appropriate transmission based precautions were ordered for suspected or confirmed COVID-19, precautions signage was posted, and the available eye protection for droplet precautions was being worn by staff when caring for one (1) of one (1) residents with suspected, and then confirmed, COVID-19 (Resident #1); 2) ensure the appropriate transmission based precautions were ordered for suspected COVID-19 and that criteria consistent with the Centers for Disease Control was used to identify suspected COVID-19, for (1) of one (1) residents with suspected COVID-19 (Resident #2); 3) ensure staff were consistently screened when coming to the facility and that their temperature was taken and recorded; 4) ensure staff properly donned and doffed surgical face masks and had guidance on how to appropriately store full day use surgical masks during breaks; 5) ensure housekeeping staff performed hand hygiene between dirty and clean tasks, and when changing gloves, and that sanitizing of high touch surfaces was monitored; 6) ensure nursing staff assisted or encouraged residents to wash their hands before meals and as needed; and 7) have a system in place for conveying updates on COVID-19 to all facility and contract staff . These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents in the facility through the development and transmission of COVID-19 and other communicable diseases. The facility census was 90. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm impairment or death to residents. The Immediate Jeopardy was related to 480.80 Infection Control. The Director of Nursing and the Administrator were made aware the Immediate Jeopardy existed on April 9, 2020 at 11:40 a.m. Immediate Jeopardy was removed on April 11, 2020 at 3:30 p.m., after an acceptable removal action plan was received and after further observations, staff interview, medical record review and review of training and logs were conducted to verify the immediate correction. The facility remained out of compliance at a lower scope and severity of E, for deficiencies at F880. In addition, the facility failed to 8) ensure residents remained 6 feet apart by not sitting more than one resident at a table for one (1) of two (2) meal observations on one (1) of three (3) floors; 9), have a surveillance tool for tracking all residents and/or staff with respiratory symptoms to identify the actions taken and outcomes and also to allow for an overall accurate review of respiratory cases in the facility at any point in time; and 10) ensure the facility's Quality Improvement Committee, or other multidisciplinary facility committee, and the Medical Director were involved in developing and implementing strategies for COVID-19 preparedness with in the facility. The findings include: 1. Resident #1 was admitted [DATE] with [DIAGNOSES REDACTED]. Resident #1 also had suspected Coronavirus Disease (COVID-19) as of 3/19/20. On 4/4/20 Resident #1 was diagnosed with [REDACTED]. Review of the Nurse Practitioner Late Note dated 3/19/20 at 2:47 p.m. revealed Resident #1 had fever that morning of 101.3 degrees Fahrenheit (F). He reports that he is having a cough and some nasal drainage. Patient denies having allergies [REDACTED]. The physical examination revealed the residents lungs were clear with no respiratory distress and no nasal drainage noted. The plan included completing diagnostic tests including a [MEDICAL CONDITION] culture and COVID-19 testing and to place the resident on contact precautions. Review of the Progress Notes and Vital Signs from 3/20/20 through 4/1/20 indicated Resident #1 remained on isolation. The type of isolation was not documented. There were no further reports of the resident coughing and one elevated temperature of 100 degrees F documented on 3/21/20. The Progress Note dated 4/2/20 at 1:41 p.m. read, Resident was transferred from this floor back to 3rd floor after his isolation period ended. Review of an Infection Progress Note dated 4/4/20 at 11:27 p.m. revealed . COVID-19 test completed on 3/19 due to complaints of a runny nose, new onset cough and low-grade fever. It was also ordered for him to go on contact precautions upon receipt of results. His chest x-ray showed no negative findings. Both the CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) were within normal range. The pending results for the COVID-19 testing was received today presenting with positive findings. (Name of Resident #1) remains on isolation that will not be lifted until April 26th which is based on 28 days from what is considered his 'recovery date' should he remain asymptomatic per (name) from (name of Local Health Department). No further testing or new orders have been instructed or implemented. Review of the Progress Notes from 4/4/20 through 4/7/20 revealed daily documentation that Resident #1 was on contact isolation precautions related to being positive for COVID-19. Review of the Physician's Orders revealed an order for [REDACTED].#1's room. There was no isolation precautions signage indicating the personal protective equipment (PPE) that should be worn in the room. During an interview with the Administrator on 4/7/20 at 10:30 a.m. he stated that there was one resident with COVID-19 in the facility (Resident #1) on droplet precautions (using gown, gloves, mask and eye protection). He said that they were not using airborne precautions as the facility did not have N95 masks and no one had been fit tested . He added that the Centers for Disease Control (CDC) guidance indicated that using a surgical mask and goggles instead was acceptable. During an interview with the Director of Nursing (DON) who was also the acting Infection Preventionist (IP) and the Administrator on 4/8/20 at 10 a.m., the DON said she did not know what happened to the isolation precautions signage that was supposed to by the resident's door. The DON indicated Resident #1 was on droplet precautions currently and also from 3/19/20 - 4/2/20. Upon inquiry, the DON did not comment regarding the documentation in the Medical Record which did not indicate droplet precautions. She did say that the following PPE was available and being worn when caring for Resident #1: gown, eye protection, gloves and masks. The Administrator stated that on 3/20/20 he had gone to the Hardware Store and purchased eye protection for the staff caring for Resident #1. Review of a hardware store receipt dated 3/20/20, provided by the Administrator, revealed 10 over the eye glasses were purchased. Review of the packaging for the over the eye glasses revealed they were safety glasses. During a telephone interview with Registered Nurse #1 (RN #1) on 4/7/20 on at 2:30 p.m., she said that there had not been an isolation precautions sign posted by Resident #1's room either the first time he was on precautions for suspected COVID-19 or after going back on precautions when the positive test result came back. During a telephone interview with CNA #3 on 4/7/20 at 3:00 p.m., she stated that she first worked with Resident #1 on 4/4/20 and today would be the third time she worked with him. She said there was no sign near the door indicating what PPE to wear. CNA #3 said she wore a gown, gloves and mask when caring for Resident #1 but did not wear eye protection and did not see any available to use. During a telephone interview with CNA #4 on 4/8/20 at 12:30 p.m. she stated she had seen a contact precautions sign at Resident #1's door at one point in time. CNA #4 stated that when caring for Resident #1 she wore a gown, gloves and mask but she did not wear eye protection or see any eye protection available between 3/19/20 and 4/2/20 or on 4/4/20. CNA #4 added that they now had eyeglass covers (safety glasses). During a telephone interview with LPN #2 on 4/8/20 at 3:30 p.m. she stated Resident #1 had been on contact precautions and then was taken off because he had finished the 14 days of isolation. She had not worked with Resident #1 since he was taken off isolation precautions and was not aware of a positive COVID-19 result. She stated a gown and gloves were required for contact precautions but she also wore a mask when caring for Resident #1, while he was on transmission based precautions, because he had a cough. LPN #1 said Resident #1 coughed once in a while. During a telephone interview with the Central Supply Clerk (CS Clerk) on 4/8/20 at

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) 3:45 p.m. she stated she had seen goggles in Resident #1's isolation kit when she restocked the PPE. The CS Clerk added that they were big enough that they could fit over eyeglasses. During a telephone interview with the Nurse Practitioner (NP) on 4/8/20 at 5:11 p.m. she stated that she conducted a telemedicine assessment of the Resident #1 with the aid of a Nurse. The NP said that with the fever that was reported to her and the resident indicating he had a cough and felt bad she thought he may have COVID-19. She said that she discussed the case with the physician and asked him what to do and he told her to place the resident on normal precautions, like she would for the flu, as there had not been a positive COVID-19 result yet. The NP said that as a result she ordered contact precautions but thought the staff would also wear a mask. After the resident had been on transmission based precautions the facility called and requested contact precautions be discontinued, as the resident had been asymptomatic since having a fever early on and his chest x-ray and labs were normal. She added that the COVID-19 test result had not come back yet and was still pending at that time. She didn't think they were ever going to get the test result as there was information indicating one of the samples spilled in transit. After contact precautions were discontinued the COVID-19 test result did come back as positive and he was placed back on contact precautions. The NP said on 4/6/20 she updated the isolation precautions order to contact and respiratory precautions to clarify the need to use a mask. the NP stated that she was unaware residents with suspected or confirmed COVID-19 should ideally be on airborne precautions (using gown, gloves, eye protection and N95 respirator). She stated she would be unable to order airborne precautions if the facility could not implement them due to not having the needed PPE. She was also unaware that droplet precautions (using gown, gloves, mask and eye protection) were an acceptable alternative and should be used if the facility had the available PPE. On 4/8/20 at 10:50 a.m. CNA #2 was observed exiting room Resident #1's room and carrying a bag of linens. CNA #2 was wearing safety glasses, an N95 respirator and carrying a bag of linens. She put on a pair of gloves and then took the linens to a soiled utility room. She then went to the Nurses Station sink where she washed her hands and sanitized the safety glasses. During an interview 4/8/20 at 10:52 a.m. CNA #2 stated that she did not wear a gown when she went into Resident #1's room. She said that she knew she should have worn a gown but only wore gloves and goggles (safety glasses) and her N95 respirator, which she had gotten from a friend. Upon inquiry she said that she did not wear eye protection while caring for the resident until after he his COVID-19 test result came back positive. During an interview with the Administrator on 4/7/20 at 1:15 p.m., he confirmed that the facility did not have any face shields in the inventory but added he had purchased eye protection for staff on 3/20/20 from a Hardware Store. He provided a receipt for 10 over the eye glasses (safety glasses) dated 3/20/20. The Administrator indicated the safety glasses had been put in the isolation kit for Resident #1 and had been available for the staff to wear. During an interview with the Administrator and DON on 4/11/20 at 3:20 p.m. the Administrator indicated that the facility was trying to order N95 respirators, for airborne precautions, through their corporate ordering system. In the meantime the facility would be using droplet precautions with the expectation that staff would wear, gown, gloves, surgical mask and eye protection. The eye protection currently available to staff was safety glasses but he indicated the facility was trying to get face shields. Neither the DON nor Administrator had been aware that previously multiple staff were not wearing eye protection while providing care to Resident #1 which increased the risk of COVID-19 transmission throughout the facility. Review of the facility policy updated 3/28/20 entitled, COVID-19 Policy/Plan for Facilities revealed, The IP will assist in determining the correct use of PPE by staff, determine the need for and the type of isolation required and assure staff has received appropriate training and guidance in caring for any resident who has the potential to infect others. The IP will establish and monitor any isolation required including proper PPE and required posting of the type of isolation to serve as notice to others. Review of the facility document dated March 29, 2020 entitled, FAQ COVID-19 revealed the facility protocol for residents with confirmed COVID-19 included Place sign on the door clearly indicating precautions for staff . Staff caring for test positive residents (confirmed COVID-19) should wear a gown, gloves, N95 mask and eye protection. If an N95 mask is not available, surgical mask with face shield is appropriate . Confine all residents with exposure to their room. 2. Resident # 2 was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set assessment dated [DATE] revealed Resident #2 was cognitively impaired but was usually understood and usually understands others. Review of a Nurse Practitioner note dated 4/6/20 at 1:14 p.m. revealed the resident had a fever of 100.5, chills, and complained of a sore throat and cough. Known case of COVID 19 positive in facility. Patient with hx (history) of dementia and is overall a relatively poor historian. He is not acutely distressed or short of breath. Staff are concerned that he is not getting OOB (out of bed) and is not himself and the resident was sleepy. The assessment read fever, cough, malaise - concern for acute respiratory infection. The orders included: a chest x-ray, blood work, respiratory panel, flu swab, COVID-19 testing, contact precautions and respiratory precautions. A Nurse Practitioner note dated 4/6/20 at 2:23 p.m. revealed the NP discussed the case and the orders with the Attending Physician and he was in agreement with the orders. Review of a Progress Note dated 4/6/20 at 3:19 p.m. Resident #2 had a temperature of 100.5 at 8:55 a.m. Respiratory Assessment was completed with no negative findings. The facility was not implementing the order to test the resident for COVID-19 as testing was not indicated by the facility algorithm. Tylenol 1000 mg (milligrams) was effective in reducing the resident's temperature. Review of the completed Respiratory assessment dated [DATE] revealed the Resident's complaint to the Nurse Practitioner about having a sore throat and cough was not included in the assessment. The sections pertaining to complaints of a sore throat and cough were checked No. Review of the facility document dated March 29, 2020 entitled, FAQ COVID-19 revealed if a resident was showing signs and symptoms of COVID-19 the testing protocol was to test for influenza and pneumonia then if negative for both test for COVID-19. Review of the facility algorithm, undated, entitled Respiratory Symptoms COVID-19 revealed residents would be put on droplet precautions if vital signs and completion of a full respiratory assessment revealed the following symptoms: Fever: 99.0 degrees Fahrenheit or 2 degrees higher than baseline; New Cough; Productive Cough; Shortness of Breath; Increased respiratory rate, Oxygen saturation less than 90%. If these symptoms were present the algorithm indicated Droplet Precautions Assess need for isolation. Resident #2 had a fever and new cough as noted in the Nurse Practitioner Progress Note, however droplet precautions (using gown, gloves, mask and eye protection) were not ordered. In addition, review of the symptom criteria listed on the algorithm was not consistent with the symptoms as identified by the Centers for Disease Control (CDC). According to the CDC document Preparing for COVID-19: Long-term Care Facilities, Nursing Homes last reviewed April 15, 2020, sore throat and fatigue can be symptoms of COVID-19. Resident #2's symptoms of a sore throat and fatigue were not included in the facility algorithm for identifying residents who should be on droplet precautions. On 4/7/20 at 10:09 a.m. and 4/8/20 at 1:00 p.m. an isolation kit was observed outside the door of Resident #2's room . There was a sign that read contact precautions on top of the isolation kit. During an interview with the Nurse Practitioner (NP) on 4/8/20 at 5:11 p.m. the NP stated that she was unaware residents with suspected or confirmed COVID-19 should ideally be on airborne precautions (using gown, gloves, eye protection and N95 respirator). She stated she would be unable to order airborne precautions if the facility could not implement them due to not having the needed PPE. She was also unaware that droplet precautions (using gown, gloves, mask and eye protection) were an acceptable alternative and should be used if the facility had the available PPE. The NP added that she ordered a COVID-19 swab for Resident #2 but the facility didn't do it because they said his symptoms didn't meet their criteria. The NP acknowledged Resident #2 hadn't had further symptoms but she thought his presentation could be similar to Resident #1 who was asymptomatic after the first couple of days but tested positive for COVID-19. During an interview with the DON and Administrator on 4/11/20 the DON confirmed droplet precautions were ordered for Resident #2 on 4/10/20. Upon inquiry about whether the Attending Physician had been consulted regarding whether a COVID-19 swab was indicated the DON said the COVID-19 swab had been completed and was being sent to the lab. Review of the facility policy updated 3/28/20 entitled, COVID-19 Policy/Plan for Facilities revealed The IP will assist in determining the correct use of PPE by staff, determine the need for and the type of isolation required and assure staff has received appropriate training and guidance in caring for any resident who has the potential to infect others. The IP will establish and monitor any isolation required including proper PPE and required posting of the type of isolation to serve as notice to others. 3. On 4/8/20 at 9:02 a.m. a staff member (Staff E) was observed going into the facility. At 9:05 review of the 9:02 entry on the COVID-19 Employee Sign In/Out Log Form revealed a staff member's first name but no screening questions were answered and a temperature wasn't recorded. Screener #1 said that Staff E had said something was wrong and she thought he had gone to the conference room. Review of the COVID-19 Employee Sign In/Out Log Form from 4/7/20 at 7:20 a.m. through 4/8/20 at 9:02 a.m. revealed 71 entries on the log for this time period. Of these 71 staff entries four (4) did not have either the temperature recorded or the entrance screening questions completed; one (1) did not have a temperature recorded but the entrance screening questions were completed and seven (7) were missing an answer to at least one of the entrance screening questions. In addition, there was a section for exit screening that was not completed for the screening question 58 out of 71 staff exits

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) and did not have a temperature recorded 60 out of 71 staff exits. During an Interview with the Director of Nursing (DON) on 4/8/20 at 1:00 p.m., she stated staff had been trained regarding the requirement to complete the screening questions and have their temperature taken every time they come to the facility. She stated she had been auditing the logs when the procedure was first implemented and indicated she expected the screening to be completed as required. Review of the facility policy updated 3/28/20 entitled, COVID-19 Policy/Plan for Facilities revealed, Temperatures of staff will be taken with no person permitted to work with a temperature greater than 100.4. All staff will complete the Staff Log and be screened for potential concerns prior to reporting to resident areas. Staff logs now include temperatures at exit as well. 4. On 4/7/20 at 10:00 a.m. Screener #1 was observed coming out of a room off the entry/exit area wearing a surgical mask under her chin. It was not covering her mouth or nose. She proceeded to put the mask in place over her mouth and nose while holding the front of the mask at the top and bottom of the mask. She did not sanitize her hands before donning the mask. On 4/7/20 at 10:05 a.m. Nurse #1 was observed in the first floor Nursing Station. She was using the telephone and not wearing a mask. On 4/7/10 at 10:07 a.m. Screener #1 was observed sitting at a table in a room off the facility entry/exit area with her back to the door. When she got up the surgical mask was observed under her chin and not covering her mouth and nose. On 4/7/20 at 12:00 p.m. a staff member (Staff B) sitting at a desk in the Information Office was observed wearing a surgical mask under her chin. The mask was not covering her mouth or nose. Staff B was observed in the same room using the copier. The surgical mask was hanging from his left ear. On 4/7/20 at 12:05 a.m. Screener #1 was observed at the facility entrance/exit area assisting a resident (Resident A) in a wheelchair who was coming back in the building. Screener #1 was wearing the surgical mask under her chin and it was not covering her face or nose. She was bent over to help hold the door open and was talking face to face with the resident, directly in front of him. Her face was within approximately two (2) feet of the resident's face. On 4/7/20 at 12:08 p.m. an observation with the Director of Nursing (DON), who was also the acting Infection Preventionist (IP) revealed Screener #1 was wearing her mask under her chin. The DON instructed Screener #1 to put pull her mask up at that time. Screener #1 placed the mask over her mouth and nose while holding the front of the mask at the top and bottom. She did not sanitize her hands before or after donning the mask. On 4/7/20 at 12:10 p.m. Housekeeper #1 was observed wearing a cloth mask. The mask covered her mouth but not her nose. She was observed pulling the cloth mask up over her nose however the mask was loose at her nose and did not fit snuggly. The Housekeeper's nose remained exposed. She was wearing a surgical mask under the cloth mask and she pulled it up from her chin to cover her mouth but not her nose. She did not sanitize her hands after touching her mask. During an interview with Housekeeper #1 on 4/7/20 at 12:10 p.m., she stated she had received education about needing to wear the mask but added that she thought she was probably wearing it wrong. On 4/7/20 at 12:13 p.m. Screener #1 was observed with her mask under her chin. During an interview with Certified Nursing Assistant (CNA) #1 on 4/7/20 at 12:20 p.m., he asked which side of the surgical mask was considered the outside of the mask. He stated that he had not received education on whether the yellow or the white side of the mask was the outside and wanted to know if he was wearing the surgical mask correctly. CNA #1 was wearing the mask correctly at the time of the interview. On 4/7/20 at 12:55 p.m. Licensed Practical Nurse #1 (LPN #1) was observed wearing a surgical mask under her chin. During an interview with LPN #1 on 7/7/20 at 12:55 p.m., she stated that it was hard to breathe with the mask on so she pulled it down off her face. She added that she pulls it back up over her face and nose before going in a resident's room. On 4/7/20 at 1:00 p.m. a staff member (Staff D) was observed wearing a respirator style mask or dust mask on her forehead while assisting a resident in room [ROOM NUMBER] with her lunch. Staff D did not have her mouth and nose covered with the mask and was within approximately two feet of the resident. On 4/7/20 at 1:02 p.m. two staff were observed in the first floor Nursing Station. Both staff members were wearing a surgical mask under their chin and were within approximately 4 feet of each other. On 4/7/20 at 1:05 p.m. a staff member (Staff E) was observed in the third floor dining area sitting with a resident at a table. The surgical mask she was wearing was under her chin and not covering her mouth or nose. Staff E then got up and walked another resident to his room. On 4/7/20 at 1:08 p.m. CNA #2 was observed wearing a respirator style mask on her forehead while assisting a resident in room [ROOM NUMBER] to eat. CNA #2 did not have her mouth and nose covered with the mask and was within approximately two (2) feet of the resident. During an observation with the Administrator on 4/7/20 at 1:09 p.m., CNA #2 was wearing a respirator style mask on her forehead while assisting a resident in room [ROOM NUMBER] to eat. The Administrator told CNA #2 that she had to wear the mask. CNA #2 stated that it made her feel claustrophobic and she had to take it off sometimes. She then grabbed the front middle part of her mask and put it over her mouth and nose. CNA #2 did not sanitize her hands and continued to assist the resident with eating. During an interview with the Director of Nursing, who was the acting Infection Preventionist (IP), and the Administrator on 4/7/20 at 1:15 p.m., the DON stated all staff had been provided education on wearing the surgical masks, including how to properly don and doff the masks on 4/4/20, either on-site or over the phone, although there were no sign in sheets. She added that on 4/5/20 she started educating nursing staff that were onsite during their shift regarding hand washing, infection control, PPE (Personal Protective Equipment) and vital signs. Sign-in sheets were provided by the DON. She stated she had not audited yet to see who had been missed and would need to be educated over the telephone. She indicated she expected staff to properly don and doff their mask and to keep it in place over their face and nose. During an interview with CNA #2 on 4/8/20 at 10:52 a.m., she used her hand to grasp the front middle area of her respirator and pull it away from her face three (3) times. She did not sanitize her hands afterwards. Upon inquiry CNA #2 stated she got the N95 respirator from a friend. During an interview with the DON and Administrator on 4/8/20 at 10:00 a.m. the Administrator indicated that since staff receive a new surgical mask daily, there were no policies or procedures for reusing the masks. This included during lunch periods even though staff were issued one mask per day. In addition, the facility did not have a policy or procedure regarding how staff should care for their own personal masks to prevent cross contamination from masks being brought to and from the facility and stored or used improperly. The Administrator acknowledged the facility had provided cloth masks to some staff but did not provide guidelines on how to properly handle the masks when not in use, or how frequently they should be washed. 5. On 4/8/20 at 11:15 a.m. Housekeeper #1 was observed cleaning room [ROOM NUMBER]. She was wearing gloves while emptying the two garbage cans from the room and also put her right gloved hand into the collected garbage to push it down. She was then observed straightening up belongings on the bedside table for bed 115 Bed B (window side of the room) without performing hand hygiene and applying new gloves. Housekeeper #1 then obtained a cloth, put sanitizer on it and cleaned the stripped mattress of Bed 115 A. The Housekeeper then removed her gloves and put on a new pair without sanitizing or washing her hands. A near-by resident needed help pulling up her right sock and the Housekeeper assisted. Housekeeper #1 then obtained a new cloth, sprayed it with sanitizer and started wiping down the over bed table for Bed 115 B During an interview with the Director of Nursing (DON) and the Administrator on 4/8/20 at 10:00 a.m. the Administrator indicated that Housekeeping staff were expected to sanitize high touch surfaces routinely however there were no logs to show that this was being done. During an interview with the Director of Nursing (DON) and the Administrator on 4/7/20 at 1:15 p.m. the DON stated that the previous Staff Development Nurse who had left employment at the facility on 3/20/20 had been checking staff competency regarding hand washing. The DON said she would try to find documentation of hand washing competency being completed with housekeeping staff. This documentation was not provided during the survey. Review of the facility policy updated 3/28/20 entitled, COVID-19 Policy/Plan for Facilities revealed, all staff to be competency evaluated for proper hand hygiene technique and strategy. Further review revealed, Housekeeping will clean high touch surfaces such as handrails, doorknobs, handles, every two hours using bactericidal solution. 6. On 4/8/20 from 12:15 - 12:55 p.m. observations on the second floor revealed staff were not assisting residents to wash their hands, or encouraging them to wash their hands if they were capable of doing it themselves. Observation was initiated prior to the trays being delivered. Three staff were observed delivering trays during 10 random observations within this time period. No assistance or encouragement was provided for hand washing during any of these observations. During an interview with the Director of Nursing (DON) and the Administrator on 4/8/20 at 10:00 a.m. she indicated nursing staff provided assistance to residents with personal are and she thought it may have been done before the trays were delivered. Review of the facility policy updated 3/28/20 entitled, COVID-19 Policy/Plan for Facilities revealed, Provide careful hand hygiene to residents before and after meals and snacks, before and after medication administration and before and after contact with other residents. 7. Review of the facility policy updated 3/28/20 entitled, COVID-19 Policy/Plan for Facilities revealed the document was created and sent to the facility from their corporate office on 3/4/20. Since then the policy was updated on 3/5/20, 3/11/20, 3/18/20 and 3/28/20. The Administrator also provided the following documents that contained information regarding COVID-19 preparedness and updates directed towards facility staff from the corporate office / COVID-19 Task Force: 1) a facility document dated 3/29/20 entitled, FAQ COVID-19; and 2) a facility Memorandum to all staff dated 4/4/20 regarding wearing masks at all times while in the facility, how to store the mask for reuse during the

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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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) next shift, social distancing and not working at other facilities. Review of education training material revealed 30 of 116 staff (not including Therapy/contract staff) had signed in for training related to infection control. During an interview with the Director of Nursing, who was also the acting Staff Development Coordinator, and the Administrator on 4/7/20 at 1:15 p.m., the DON stated all staff had been provided education on wearing the surgical masks, including how to properly don and doff the masks on 4/4/20, either on-site or over the phone, although there were no sign in sheets. She added that on 4/5/20 she started providing education to nursing staff regarding hand washing, infection control, PPE (Personal Protective Equipment) and vital signs. Sign in sheets were provided by the DON. She st