STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345307	A. BUILDING _____ B. WING _____	06/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff interviews and review of the facility's Infection Control policies and procedures, the facility failed to implement their policy for COVID-19 screening when 17 of 30 staff failed to complete the screening process. Staff failed to complete the COVID-19 Employee Sign In/Out Log which included answering screening questions and self-monitoring their body temperature prior to reporting for work to provide direct resident care. In addition, 1 of 1 housekeeper who cleaned a resident's room that was on contact precautions, failed to remove his gloves and perform hand hygiene before he exited the room. These failures occurred during a COVID-19 pandemic. The findings included: 1. A review of the Exposure Control Plan for the facility dated 04/30/2020, revealed under 2. Risk Assessment (Early Detection) at 2.2 The facility has implemented a screening process in accordance with the Centers for Disease Control and Prevention (CDC), Center for Medicare and Medicaid Services (CMS), and County Health Department to decrease the risk for transmission of COVID-19 in our resident population, direct healthcare personnel, indirect healthcare personnel, volunteers and visitors. 2.8 The facility has implemented a COVID-19 Attestation form to monitor for travel outside of the USA to level 3 countries in the last 30 days, contact with anyone testing positive for COVID-19 in the last 30 days, cough in the last 30 days, and abnormal sneezing symptoms in the last 14 days. This Attestation will be reviewed and revised based on the determined risk level for the facility. 2.9 The facility will review and revise the screening (COVID-19 Attestation) of visitors, vendors, employees and residents related to the determined level of risk for the facility. Observation on 06/04/2020 at 9:00 AM of the facility's screening process for visitors, vendors, and staff revealed an unattended table in the front lobby which had a thermometer and screening forms on it. The screening forms titled, COVID-19 Employee Sign In/Out Log, contained date, time, department, 4 screening questions on entry and a place to document the body temperature with name. The form also contained time out, question about signs and symptoms during shift and a place to document the body temperature upon exit from the building. Review of the staff monitoring/screening sheets titled COVID-19 Employee Sign In/Out Log in comparison to the staffing sheets from 05/24/2020 to 06/03/2020 revealed the following: 05/24/2020 - 4 of 11 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. Nursing Assistant (NA) #1, NA#2, NA #3, and Nurse #2 failed to complete the form. 05/25/2020 1 of 12 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #7 failed to complete the form. 05/26/2020 3 of 13 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. Nurse #2, Nurse #1, and NA #4 failed to complete the form. 05/27/2020 4 of 12 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #4, NA #5, NA #7 and NA #10 failed to complete the form. 05/28/2020 4 of 13 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #5, NA #7, NA #9 and Nurse #4 failed to complete the form. 05/29/2020 2 of 10 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #5 and Nurse #4 failed to complete the form. 05/30/2020 8 of 11 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #3, NA #4, NA #8, NA #9, NA #10, Nurse #1, Nurse #3 and Nurse #4 failed to complete the form. 05/31/2020 6 of 11 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. Central Supply Clerk, NA #4, NA #8, Nurse #1, Nurse #3 and Nurse #6 failed to complete the form. 06/01/2020 5 of 12 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #4, NA #5, NA #6, Nurse #3 and Nurse #4 failed to complete the form. 06/02/2020 3 of 8 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #4, NA #5, and NA #6 failed to complete the form. 06/03/2020 4 of 13 staff did not complete the screening form and did not monitor their body temperature prior to beginning work. NA #4, NA #5, Nurse #4 and Nurse #6 failed to complete the form. A phone interview on 06/05/2020 was conducted with Nurse Aide (NA) #1 at 11:48 AM revealed she did not remember why she had not monitored her temperature and complete the screening process on 05/24/2020. NA #1 stated she was aware she was supposed to complete the screening process prior to reporting to work. She also stated she did not recall anyone asking her why she had not completed the process on 05/24/2020. A phone interview was conducted with NA #2 on 06/05/2020 at 11:49 AM. NA #2 stated she failed to sign the screening sheet that she self-monitored her body temperature on 05/24/2020. She explained she had probably just forgot to monitor her temperature and complete the process on 05/24/2020. She stated she had been educated to complete the screening process before reporting for work. NA #2 stated she did not recall anyone asking her why she had not completed the process on 05/24/2020. A phone interview was conducted with the Central Supply Clerk who also works as an NA on 06/05/2020 at 11:51 AM. The Central Supply Clerk failed to complete the screening form and she had not monitored her body temperature on 05/31/2020. She stated she did not complete the screening process on 05/31/2020 because there was a resident emergency that morning and was told to assist with the emergency. The Clerk stated she was educated on the screening process and did not recall if anyone had asked her why she had not completed the process on 05/31/2020. A phone interview was conducted with Nurse #1 on 06/05/2020 at 11:57 AM. Nurse #1 failed to complete the screening process on 05/26/2020, 05/30,2020 and 05/31/2020. She stated she did not recall why she did not complete the screening process on these 3 dates, but said it was probably because it was busy when she came in to work. She stated she did not recall anyone asking her why she had not completed the process on those dates. Nurse #1 stated she had been educated to screen prior to reporting for work. A phone interview was conducted with Nurse #2 on 06/05/2020 at 12:37 PM. Nurse #2 failed to complete the screening process on 05/24/2020 and 05/26/2020. Nurse #2 stated sometimes she was unable to monitor her body temperature prior to work because the thermometer did not work. She stated she no longer worked at the facility but did not recall anyone asking her why she had not completed the screening process on 05/24/2020 and 05/26/2020. A phone interview was conducted with NA #3 on 06/05/2020 at 12:40 PM. NA #3 failed to complete the screening process on 05/24/2020 and 5/26/2020. She stated on one of the days she was the only NA in the building, so she just went straight on the floor and started working without screening and on the other day she probably just forgot. NA #3 stated she was educated to complete the screening process before reporting to work. A phone interview was conducted with NA #4 on 06/05/2020 at 1:28 PM. NA #4 failed to complete the screening process on 05/26/2020, 05/27/2020. 05/30/2020, 05/31/2020, 06/01/2020, 06/02/2020 and 06/03/2020. She stated on some of the days she came in the back door and checked her temperature but did not write it down and on the other days she just reported to the floor, without checking her temperature or completing the screening process, because she was called in to work. NA #4 stated she had been educated to complete the screening process prior to reporting for work. A phone interview was conducted with NA #5 on 06/05/2020 at 1:41 PM. NA #5 failed to complete the screening process on 05/27/2020, 05/28/2020, 05/29/2020, 06/01/2020, 06/02/2020 and 06/03/2020. She stated on some of the days she completed the screening process but had not written it down and on the other days she did not complete the process. NA #5 stated she had been educated to complete the screening process prior to reporting for work. A phone interview was conducted with NA #6 on 06/05/2020 at 3:12 PM. NA #6 failed to complete the screening process on 06/01/2020 and 06/02/2020. She stated she could not recall why she had not completed the process on 6/01/20 and 6/2/20. NA #6 stated she had been educated to complete the screening process prior to reporting for

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 -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) work. A phone interview was conducted with Nurse #3 on 06/05/2020 at 4:53 PM. Nurse #3 failed to complete the screening process on 05/ 0 and 05/31/2020. She stated she could not remember why she had not completed the process on 05/30/20 and 5/31/20. Nurse #3 stated she had been educated to complete the screening process prior to reporting for work. A phone interview was conducted with NA #7 on 06/05/2020 at 5:09 PM. NA #7 failed to complete the screening process on 05/27/2020 and 05/28/2020. She stated she thought she completed the screening process and someone (she could not remember who) that was standing at the time clock told her they would sign her in, but and she guessed they had not signed her in to work. NA #7 stated she had been educated to complete the screening process prior to reporting for work. A phone interview was conducted with NA #8 on 06/05/2020 at 6:51 PM. NA #8 failed to complete the screening process on 05/24/2020, 05/30/2020 and 05/31/2020. She stated she could not recall any days she worked that she had not completed the process. NA #8 stated she had been educated about [MEDICAL CONDITION] and the need to complete the screening process prior to reporting for work. During the survey attempts were unsuccessful to conduct phone interviews with NA #9, NA #10, Nurse #4, Nurse #5 and Nurse #6. A phone interview was conducted on 06/08/2020 with the Administrator (the Director of Nursing was off on 06/08/2020) at 3:32 PM. He stated he was not sure why the staff were not completing the screening process but stated they had all been educated to complete the process prior to reporting for work. According to the Administrator it was his expectation that every staff member completed the screening process prior to reporting for work. The Administrator also stated that no one had been assigned to monitor the sheets, but he and the DON would be responsible for monitoring the sheets daily to ensure all staff are completing the screening process prior to reporting for work. 2. A review of the facility's Infection Control Policies and Procedures revised on August 2019 indicated the following statements: a. Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. b. After gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments. c. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water before and after entering isolation precaution settings. A continuous observation was made on 6/4/20 from 10:05 AM to 10:15 AM of Housekeeper #1. Housekeeper #1 was observed coming out of the Housekeeping/Laundry Supply room and putting on gloves. He rolled his cart towards the 100 hall and stopped in front of room [ROOM NUMBER]. A contact precautions sign was posted at the door of room [ROOM NUMBER]. Housekeeper #1 entered room [ROOM NUMBER] with spray bottle in hand and started disinfecting surfaces inside the room. Housekeeper #1 went out of the room and proceeded to lock the disinfectant spray bottle in his cart. He went back inside the room to remove the trash from the trash can. After replacing the trash liner in the trash can, Housekeeper #1 swept the floor inside the room. When he was finished with the floor, he exited the room without removing his gloves or doing any hand hygiene. He started rolling his cart off the hall towards the 300 hall. He stopped in front of the Therapy room. Without changing his gloves, Housekeeper #1 proceeded to re-fill the paper towels in a paper towel dispenser inside the Therapy room. On 6/4/20 at 10:15 AM, an interview with Housekeeper #1 revealed he had received education on COVID-19 precautions and was told to change his gloves and wash his hands after working in each room. Housekeeper #1 admitted that he failed to change his gloves and wash his hands after cleaning room [ROOM NUMBER] because he got distracted and forgot to do so. On 6/4/20 at 1:20 PM, an interview with the Environmental Services Manager (ESM) revealed Housekeeper #1 had been educated to remove his gloves and put in trash bag prior to leaving each room and to wash his hands after removing his gloves. The ESM stated Housekeeper #1 had been called in to work on his day-off and was asked to help clean the rooms which might have explained why he was distracted. The ESM added Housekeeper #1 received re-education immediately after the concern had been brought up. On 6/4/20 at 10:25 AM, an interview with the Director of Nursing (DON) revealed Housekeeper #1 should have removed his gloves and washed his hands after cleaning room [ROOM NUMBER]. The DON stated room [ROOM NUMBER] was on contact precautions because Resident #1 had just come back from the hospital, tested negative for COVID-19 prior to coming back to the facility and currently did not any active infection. The DON recognized that the paper towels in the Therapy room were potentially contaminated and would direct staff to sanitize the dispenser and replace the paper towels immediately. On 6/4/20 at 2:15 PM, an interview with the Administrator revealed he expected Housekeeper #1 to follow the facility's infection control protocol and stated staff members would require frequent monitoring and constant reinforcing of infection control guidelines.