STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345503	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIBERTY COMMONS NSG & REHAB CTR OF ROWAN COUNTY	4412 SOUTH MAIN STREET SALISBURY, NC 28147

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 -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations and staff interviews, the facility failed to clean a vital sign machine between 2 of 2 residents (Residents #1 and #2), failed to discard soiled gowns worn by staff for 1 of 8 residents on droplet precautions (Resident #3) and failed to document screening results for staff entering the building 7 of 7 days (week of 4/20/2020). Additionally, staff entered the building from 2 different entrances, the front door and the back door through the breakroom and through hall 300 to receive screening at the nurse ' s station. These failures occurred during the COVID-19 pandemic and had the potential to affect all residents in the facility. Findings included: 1. The facility policy COVID-19 Preparation and Response dated 3/10/2020 and updated 4/19/2020 was reviewed. The policy read, in part, wipe external surfaces of portable equipment for performing .procedures in the patient ' s room with an EPA-approved (Environmental Protection Agency) hospital disinfectant upon removal from the patient ' s room. An observation of the 100 hall was conducted on 5/28/2020 from 12:16 PM until 12:27 PM. Nursing assistant (NA) #1 was observed checking the VS of Resident #1 with a VS machine (all-in-one unit to check blood pressure, pulse, oxygen saturation and temperature). NA #1 was observed removing the blood pressure cuff from Resident #1 ' s arm and observed exiting Resident #1 ' s room. NA #1 was observed performing hand hygiene in the hallway and then NA #1 took the VS machine into Resident #2 ' s room. NA #1 did not clean the VS machine between Resident #1 and Resident #2. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1 ' s medical record revealed a full set of vital signs (VS) had been documented on 5/28/2020 at 1:10 PM by Nurse #1. The VS included documented temperature, pulse, blood pressure and respirations. Resident #2 was admitted to the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED].#2 ' s medical record revealed a temperature had been documented on 5/28/2020 at 1:08 PM by Nurse #1. NA #1 was interviewed on 5/28/2020 at 12:25 PM. She reported she had not cleaned the VS machine between Resident #1 and Resident #2 because there were no disinfecting wipes available. Nurse #1 was interviewed on 5/28/2020 at 1:49 PM. Nurse #1 reported that NA #1 had requested disinfecting wipes for the VS machine after she had completed VS for Resident #1 and Resident #2. Nurse #2 reported the Director of Nursing (DON) had restocked the disinfectant wipes at the nursing station. The DON was interviewed on 5/29/2020 at 3:04 PM by phone call and she reported the facility had disinfecting wipes and when NA #1 requested the wipes, she had restocked the nursing station. The DON was interviewed again on 6/1/2020 at 8:57 AM by phone. The DON reported she was uncertain why NA #1 would not have wiped down the VS machine, but she felt that because NA #1 was only checking temperatures, she did not need to clean the machine between residents. 2. The facility policy COVID-19 Preparation and Response dated 3/10/2020 and updated 4/19/2020 was reviewed. The policy read, in part, employees that work with symptomatic and asymptomatic patients should be issued two masks, one for use in symptomatic areas and one in asymptomatic areas and gowns should be worn by the same employee for the same type of isolation .gowns should be provided for each type of isolation and utilize enhanced precautions for all residents that exhibit signs and symptoms of respiratory infection. The facility policy Supply conservation in disasters dated 9/2017 and updated 3/2020 was reviewed and read, in part, .a new gown should be used for each encounter with asymptomatic individual and . a new disposable surgical/procedure mask . should be worn for each encounter with an infected individual or entrance into the isolation area within the facility. Resident #3 was admitted to the facility on [DATE] and readmitted [DATE]. A review of Resident #3 ' s medical record revealed she had been placed on enhanced droplet precautions on 5/12/2020. Signage on the door for Resident #3 indicated a mask, gown, gloves and eye shield were to be used for resident care. Test results for COVID-19 were available in her chart and she tested negative on 4/24/2020 and 5/12/2020. The physician order [REDACTED]. Resident #3 ' s room was observed on 5/28/2020 at 12:32 PM. The door to the room was closed and a sign was posted on the closed door that indicated enhanced droplet precautions were in place for the room. A cart with personal protective equipment (PPE) was observed on the door and blue gowns, gloves and masks were stocked on the cart. NA #2 and #3 were observed wearing face masks, eye shields, blue fabric gowns as they passed trays on the hall. NA #2 and NA #3 were observed applying gloves before they entered Resident #3 ' s room with lunch trays. The NAs had not applied clean gowns or changed their face masks prior to entering Resident #3 ' s room. NA # 2 and NA #3 exited Resident #3 ' s room and walked up the 200-hallway removing their gowns and gloves as they walked. NA #2 and #3 did not remove their facial masks after exiting Resident #3 ' s room. NA #2 and #3 were observed to enter the shower room and discard their gowns and gloves into the trash receptacle. An interview was conducted with NA #2 and #3 at 12:40 PM. NA #3 reported they had delivered trays to both Resident #3 and her roommate and had assisted to adjust both resident ' s position for their meal. NA #2 reported they had not discarded their gowns in Resident #3 ' s room because there was not a red bag for biohazard trash within Resident #3 ' s room. NA #2 reported she was not certain who was responsible for putting a biohazard trash can or bag in the isolation room. The NAs further reported that they did not change their mask or gowns at Resident #3 ' s room because the gowns in the cart that was on the door were a different kind of gown and they wanted to wear the more breathable material that was available at the nurse ' s station. An in-service dated 4/20/2020 that reviewed the two above documents was signed by NA #2. NA #3 ' s signature on the in-services was not found. The Director of Nursing (DON) was interviewed by phone on 5/29/2020 at 3:04 PM. The DON reported NA #2 and #3 should have changed gowns before entering Resident #3 ' s room. The NAs should have taken those gowns off when they finished with care for Resident #3 and discarded the gowns in Resident #3 ' s room into the red biohazard trash. The DON further reported that all isolation rooms had a red biohazard trash container with a red biohazard trash bag for trash disposal and she did not know why they did not dispose of their gowns in the room. The DON reported both NA #2 and #3 had participated in in-services regarding isolation procedures. The DON reported it was her expectation that staff followed the policy and discarded PPE in the resident ' s room under droplet precautions. The DON reported she and the infection control nurse had observed staff entering and exiting isolation rooms and had not see issues with PPE disposal or use. The infection control (IC) nurse was interviewed by phone on 6/2/2020 at 10:43 AM. The IC nurse reported the red biohazard bags for trash disposal were in every isolation room and NA #2 and NA #3 should have disposed of the used gowns in Resident #3 ' s room. The IC nurse reported she and the DON had observed staff entering and exiting isolation rooms and no concerns were identified. 3. The facility policy COVID-19 Preparation and Response dated 3/10/2020 and updated 4/19/2020 was reviewed. The policy read, in part, all employees are screened as they arrive at the beginning of the shift and upon returning after leaving the facility. Employee screens are conducted by a nurse and consist of temperature, sign and symptom review and screening questions. Access to the building by staff was not addressed by the policy. The screening sheet used for screening employees was reviewed and the sheet included statements that the signing employee confirmed, including, no fever, cough or shortness of breath, chills, shaking with chills, muscle pain, headache, sore throat or new loss of taste to smell; in the past 14 days no contact with a confirmed or presumptive [DIAGNOSES REDACTED]. at work. The screening sheets included the date, a space for the employee name, the temperature, whether the employee passed the screening or was sent home, the employee initials, and the screener ' s initials. The screening sheets from the week 4/20-26/2020 were reviewed and compared to the schedule of nurses and nursing assistants (NA) for each day. The review revealed the following: April 20, 2020: seven (7) staff on the nursing

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) schedule did not have evidence of screening upon entrance to the building; Medication Tech (MT)#1, Nurse #6, Nurse #7, NA #7, NA #8, NA #9, and NA #19. April 21, 2020: eight (8) staff on the nursing schedule did not have evidence of screening upon entrance to the building: MT #1, Nurse #4, Nurse #8, Nurse #11, NA #6, NA #9, NA #10, and NA #12. April 22, 2020: nine (9) staff did not have evidence of screening upon entrance to the building: Nursing supervisor #1, MT #1, MT#2, Nurse #9, NA #10, NA #12, NA #13, NA #14 and NA #21. April 23, 2020: nine (9) staff did not have evidence of screening upon entrance to the building; Nursing supervisor #1, MT #2, Nurse #3, Nurse #10, Nurse #11, NA #6, NA #8, NA #14, and NA #16. April 24, 2020: nine (9) staff did not have evidence of screening upon entrance to the building: MT #1, Nurse #3, Nurse #12, Nurse #13, Nurse #14, NA #6, NA #14, NA #17, and NA #18. April 25, 2020: eleven (11) staff did not have evidence of screening upon entrance to the building: MT #1, Nurse #6, Nurse #9, Nurse #12, NA #9, NA #10, NA #12, NA #16, NA #17, NA #18, and NA #19. April 26, 2020: ten (10) staff did not have evidence of screening upon entrance to the building: MT #1, Nurse #7, Nurse #10, Nurse #12, NA #2, NA #10, NA #12, NA #13, NA #19, and NA #22. The screening process was observed at 5/28/2020 at 1:44 PM for a staff member and no issues were identified. The screener checked the temperature of the staff member, provided alcohol hand sanitizer for hand hygiene and a mask. The Screener was interviewed by phone on 6/1/2020 at 3:54 PM. The Screener reported that she was in the building Monday through Friday from 8:00 AM until 5:00 PM and when she was not in the building a nurse was assigned to screen staff. The Screener reported the front door was kept locked for the most part, but that she had found the front door unlocked and was not certain who was unlocking the door. The Screener reported that staff entered the building from the front door and some were skipping the screening process at the front and getting screened at the nursing station. Some employees were using the back door and walked through the 300 hall to the nurse ' s station to screen. The Screener reported screening form was kept at the nursing station and the facility had two active screening forms at both the nursing station and the front door. Nurse #2 was interviewed by phone on 6/1/2020. Nurse #2 reported he was the weekend day shift supervisor, and he also worked on the floor. Nurse #2 reported that he screened staff as they entered into the building from the front door. Nurse #2 reported some staff entered the building at the back door which entered into the staff breakroom, and then staff walked through 300 hall to the nurse ' s station to be screened into the building. The screening sheets were reviewed, and it was noted that MT #1 was scheduled to work 4/20/2020, 4/21/2020, 4/22/2020, 4/24/2020, 4/25/2020 and 4/26/2020. NA#5 did not have screening documented for any of those dates. A phone interview was conducted with MT #1 on 6/1/2020 at 3:59 PM. MT #1 reported that she entered the building in the front and was screened, or she entered the building at the rear and was screened at the nursing station. MT #1 reported she had not observed the screening person write down her name or temperature results and she was not certain why her screening results were not documented. The screening sheets were reviewed, and Nurse #3 was scheduled to work on 4/23/2020, and 4/24/2020. Nurse #3 did not have screening documented for those dates. Nurse #3 was interviewed by phone on 6/1/2020 at 11:10 PM. Nurse #3 reported that she used the back door to enter the facility and walked through the 300 hall to the nursing station to be screened. Nurse #3 reported she checked her temperature and reported the temperature to the person assigned to screen, but she had not waited to watch her name written down. Nurse #3 reported that screening during shift change and the assigned nurse is usually busy and Nurse #3 thought that some screening results were missed. The screening sheets were reviewed, and Nurse #4 was scheduled to work 4/21/2020. Nurse #4 did not have screening documented for that date. A phone interview was conducted with Nurse #4 on 6/1/2020 at 11:29 PM. Nurse #4 reported she entered the building from the rear and walked up the 300 hall to the nursing station to be screened. Nurse #4 reported that sometimes during the screening process, she had been pulled from the nursing station to the floor and she was not certain why her screening process had not been documented. The nurse reported that the screening process was very busy with a lot of staff at the nursing station and she had observed staff leaving before their screening results were documented. The Infection Control (IC) nurse was interviewed by phone on 6/2/2020 at 10:43 AM. The IC nurse reported she and the Director of Nursing (DON) were checking the sheets against the schedule to make certain all screenings were documented. The IC nurse reported staff were using the front door and screened in the front lobby and they were also entering the building by the back door, entering the breakroom and walking through the 300 hall to the nursing station for screening. The IC nurse reported that she had discovered one nurse had not completed the screening process and she had educated the nurse about the screening process but was unaware there were so many staff who did not have screening results for that week in April. IC nurse reported that nursing staff were also supposed to check the screening sheets against the schedule. The DON was interviewed by phone on 6/2/2020 at 10:54 AM. The DON reported that staff had been instructed to self-monitor their temperature at home and to not come into work if they had a temperature. The DON reported that she felt because the staff were self-monitoring at home and they were screening themselves before work, the lack of screening documentation should not be an issue. The DON reported she and the Administrator had discussed setting up a screening point at the back entrance in the break room to prevent staff from entering the building prior to screening. The Administrator was interviewed by phone on 6/2/2020 at 10:54 AM with the DON and he reported all staff were screened prior to working and the facility was following their COVID-19 policies.