STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015424	A. BUILDING _____ B. WING _____	07/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROANOKE REHABILITATION & HEALTHCARE CENTER	680 SEYMOUR DRIVE ROANOKE, AL 36274

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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, record review, staff interview, review of the facility document entitled, Novel Coronavirus Prevention and Response, the facility COVID-19 Resident Monitoring Log and Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to 1) ensure transmission based precautions were implemented and full personal protective equipment (PPE) was used when caring for one (1) of one (1) residents under investigation for COVID-19, who ultimately tested positive (Resident #4); 2) failed to ensure staff wore all recommended COVID-19 personal protective equipment (PPE) when transferring a resident who was COVID-19 positive (Resident #6); 3) failed to ensure staff did not wear the same personal protective (PPE) equipment when entering rooms of resident's who were COVID-19 positive (non-sampled Residents A, B, C, D, E and F) then the room of a resident who was COVID-19 negative (Resident #1) while collecting meal trays; 4) failed to ensure residents who were COVID-19 negative or who were readmitted and on a 14 day quarantine were not housed on or admitted to the COVID-19 positive isolation unit (Resident #1, #2 and #3); and 5) failed to ensure staff wore all recommended COVID-19 PPE when providing care to a readmitted resident with unknown COVID-19 status (Resident #5). These failures in infection control practices occurred during a COVID-19 pandemic and had the potential to affect other residents in the facility through the development and transmission of COVID-19 and other communicable diseases. 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 Director of Nursing, Administrator (via telephone) and Restorative Nurse were made aware the Immediate Jeopardy existed on July 16, 2020 at 7:49 p.m. Immediate Jeopardy was removed on July 17, 2020 at 12:15 p.m., after an acceptable removal action plan was received and after further observations, staff interview, 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. The findings include: 1) Resident #4 was admitted [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Resident #4 also had a [MEDICAL CONDITION]. Review of the residents Vital Signs Record revealed the following temperatures over 99.9 degrees F (Fahrenheit) since 6/27/20: 100.9 Axillary on 6/27/20 12:55 a.m. 101.8 Generic on 7/9/20 at 5:54 p.m. 102.4 Oral on 7/11/20 at 11:19 p.m. 102.5 Generic on 7/12/20 at 7:05 a.m. 103.1 Generic on 7/13/20 at 3:24 p.m. 102.3 Generic on 7/14/20 at 7:18 p.m. Review of the Nursing Note dated 7/15/20 at 3:31 p.m. revealed that at 2:00 p.m. the resident's temperature was 101.1 degrees Fahrenheit. Review of the Nursing Note dated 7/16/20 at 2:49 a.m. revealed the resident's temperature at 6:00 p.m. was 99.5 and the resident refuses to take Tylenol as ordered for fever. At 10:00 p.m. the resident's temperature was 99.6 but the resident continued to refuse Tylenol for fever. Review of the Physician Orders revealed an order dated 7/13/20 for a COVID-19 swab. Further review revealed there were no orders for transmission based precautions from 6/27/20 through 7/16/20. Review of the Nursing Notes from 6/27/20 through 7/16/20 revealed Resident #4 frequently refused his nebulizer treatments. The resident did receive [MEDICAL CONDITION] care daily and good cough effort was routinely documented in regards to the resident's ability to remove secretions. Review of the undated facility COVID-19 Resident Monitoring Log revealed Resident #4's COVID-19 swab was completed on 7/13/20. During an interview with the Director of Nursing on 7/16/20 at 2:00 p.m., she said that there was one resident in the facility who had COVID-19 test results still pending (Resident #4). An observation on 7/16/20 at 5:49 p.m. revealed Resident #4 was in a private room. The door to the room was open and the resident was observed in bed. An isolation kit containing PPE was not present by his door or near his room. During an interview with Nurse #1 on 7/16/20 at 5:51p.m., she stated Resident #4 was not on transmission based precautions. During an interview with Nurse #2 on 7/16/20 at 5:53 p.m., she stated the facility did not place residents on transmission based precautions for a fever or when COVID-19 test results were pending. She said the practice was to wait for a positive test result before initiating transmission based precautions. Nurse #2 said Resident #4 was not on transmission based precautions and staff just wore their mask when entering the resident's room. Nurse #2 was aware Resident #4 had been tested for COVID-19 but she unaware of the test results. During an interview with the Director of Nursing, Administrator (on the telephone) and Restorative Nurse #1 on 7/16/20 at 7:05 p.m., the Administrator stated that the facility practice for when a resident had a fever was to increase the frequency of vital signs monitoring from every 8 (eight) hours to every 4 (four) hours and test for COVID-19. If the test was positive transmission based precautions with full PPE (cloth gowns, gloves, face shield and N95 mask) would be initiated. The facility had N95 and KN-95 masks available for staff and had implemented mask reuse procedures to extend the supply. The facility did not have a respiratory program in place for fit testing. Resident #4 had been having fevers over 100 degrees Fahrenheit (a symptom of COVID-19) and had a COVID-19 swab test completed on 7/13/20. The test results were still pending at the time of the survey. A telephone interview with the Director of Nursing on 7/28/20 at 11:25 a.m. revealed the test result was COVID-19 positive. Resident #4 also had a [MEDICAL CONDITION] and orders for aerosol generating procedures. Review of the undated facility COVID-19 Resident Monitoring Log revealed the facility had 26 in-house residents that were COVID-19 positive. There were also 32 staff that tested positive for COVID-19. Review of the facility policy entitled, Novel Coronavirus Prevention and Response dated 3/29/20 revealed, Staff will 'Think COVID-19' when a resident or employee exhibits the following symptoms and epidemiologic risk: fever or cough/shortness of breath AND has had close contact with a laboratory confirmed COVID-19 patient within 14 days of symptom onset. Further review of this policy revealed the following procedure when COVID-19 is suspected: a. Notify physician, Director of Nursing, Infection Preventionist, and family. b. Place resident in a private room if possible, with the door closed. Residents with similar symptoms can be cohorted. e. Implement standard, contact, and airborne precautions (droplet precautions if no airborne isolation room available). Wear gloves, gowns, goggles/face shields, and masks (respirators, including N95 masks) upon entering room and when caring for the resident. f. Avoid aerosol-generating procedures (i.e. nebulizer treatments) as possible. 2) Resident #6 was admitted [DATE] with [DIAGNOSES REDACTED]. On 6/26/20 she tested positive for COVID-19. On 7/17/20 at 11:15 a.m. cloth isolation gowns were observed in bins in the hallway of the COVID-19 isolation unit. There were also laundry bins observed in the hall with a sign that read, Attention CNA's the isolation gowns need to be put in a water soluble bag inside of a red bag to be washed daily . On 7/17/20 at 3:00 p.m. Certified Nursing Assistant #1 (CNA #1) and CNA #2 were observed exiting Resident #6's room. Neither CNA was observed wearing or carrying a gown. CNA #1's face shield was pushed back on her head and not covering her face or N95 mask. During an interview with CNA #1 on 7/17/20 at 3:01 p.m., she stated she had helped CNA #2 transfer Resident #6 using the stand-up lift. She confirmed both she and CNA #2 did not wear a gown while providing this care to Resident #6. CNA #1 indicated she was aware Resident #6 was COVID-19 positive and cloth gowns should be worn along with the N95 mask, face shield and gloves when providing care to residents with COVID-19. She said she did not wear the gown because it was close to change of shift when CNA #2 had asked for help and they were trying to transfer the resident quickly, prior to leaving. CNA #1 stated that while she was in the room close to the resident she did have her face shield pulled down over her face and mask. During an interview with the Director of Nursing, Administrator (on the telephone) and Restorative Nurse #1 on 7/16/20 at 7:05 p.m., the Administrator indicated she expected staff to wear a cloth gown in addition to a mask, face shield and gloves when providing care to COVID-19 positive

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) residents. She also said she expected CNA #1 and #2 to wearing a gown when transferring Resident #6. A facility policy and procedure regarding the use of cloth gowns when caring for residents with COVID-19 was requested but not provided during the survey. A facility policy and procedure regarding the Personal Protective Equipment staff were to use for COVID-19 positive residents on the COVID-19 isolation unit was requested but not provided during the survey. 3) On 7/16/20 at 5:29 p.m. CNA #3 was observed wearing a yellow cloth isolation gown. She was also wearing an N95 mask and face shield. CNA #3 entered room [ROOM NUMBER] and picked up a meal tray which she then placed on the meal cart. CNA #3 then entered room [ROOM NUMBER] and picked up a meal tray which she placed on the meal cart. Next she entered Resident #1's room to pick up his meal tray and brought it out to the hall and placed it on the meal cart. While in Resident #1's room CNA #3 was wearing the same personal protective equipment that she wore in the previous two rooms. Review of the undated facility COVID-19 Resident Monitoring Log revealed the residents in room [ROOM NUMBER] were COVID-19 positive (unsampled Residents A, B and C) as were the residents in room [ROOM NUMBER] (unsampled Residents D, E and F). Resident #1 was listed as COVID-19 negative. During an interview on 7/16/20 with CNA #3 she stated that she was aware Resident #1 was COVID-19 negative and the residents in room [ROOM NUMBER] and #5 were COVID-19 positive. She stated this was her first time working on the COVID-19 isolation unit but she had been educated prior to her shift and was told that the cloth gowns were only to be used in rooms of residents who were COVID-19 positive. CNA #3 said she should not have worn the same gown, or face shield that she used for COVID-19 positive residents, in Resident #1's room because he was not COVID-19 positive. During an interview with the Director of Nursing, Administrator (on the telephone) and Restorative Nurse #1 on 7/16/20 at 7:05 p.m., the Administrator indicated they had already identified a concern on the COVID-19 Isolation Unit with staff wearing the cloth isolation gowns that they wore in the rooms of COVID-19 positive residents in the rooms of residents who were not COVID-19 positive. To resolve this she said they had made the room signage more clear; provided disposable gowns in an isolation kit outside the door of a readmitted resident whose COVID-19 status was unknown (Resident #3) on 7/15/20; and were planning to create a COVID-19 isolation unit exclusively for residents who were COVID-19 positive instead of having the mixed unit they had at the time of the survey. The Administrator acknowledged that at the time of the survey there were two residents who were COVID-19 negative (Resident #1 and #2) and one readmitted resident (Resident #3) who was on a 14 day quarantine, housed within the defined plastic barriers of the COVID-19 Isolation unit. All 26 of the facilities residents who were COVID-19 positive were housed on this unit as well. 4) Resident #1 was readmitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1 tested negative for COVID-19 on 6/26/20 but his room was located behind the plastic barrier that defined the COVID-19 isolation unit and separated it from the rest of the facility. A 7/16/20 Nursing Note (Late Entry for 7/13/20) revealed will ambulate in hall. On 7/16/20 at 11:45 a.m. Resident #1 was observed outside his room. He was not wearing a mask. He was redirected to return to his room by the Director of Nursing (DON). During an interview with the Therapy Director on 7/16/20 at 1:53 p.m., she stated that Resident #1 was known to wander and it was an ongoing challenge to ensure he stayed in his room. On 7/16/20 at 3:10 p.m. Resident #1 was observed outside his room in the hall on the COVID-19 isolation unit. He was wearing a mask that was covering his mouth but not his nose. After a few minutes the resident returned to his room. Resident #2 was admitted [DATE] with [DIAGNOSES REDACTED]. Resident #2 tested negative for COVID-19 on 6/26/20 but her room was located behind the plastic barrier that defined the COVID-19 isolation unit and separated it from the rest of the facility. Resident #3 was admitted [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Resident #3 tested negative for COVID-19 prior to being readmitted to the facility on [DATE] and was on a 14 day quarantine. His room was located behind the plastic barrier that defined the COVID-19 isolation unit and separated it from the rest of the facility. During an interview with the Director of Nursing (DON) on 7/16/20 at 2:00 p.m., she stated they (the facility) were in the process of moving the plastic barriers on the COVID-19 isolation unit to create a separate area for readmitted residents. The DON said some room changes had been initiated recently to get ready to make the unit smaller. She added that plans had been in place to move the plastic barriers that week to ensure the rooms of the two residents who did not have COVID-19 (Resident #1 and #2) and the readmitted resident on the unit (Resident #3) were no longer on the COVID-19 isolation unit. She did not know why this had not been done yet as she had been out of the facility for two weeks and just returned. During an interview with the Infection Preventionist (IP) on 7/16/20 at approximatley 3:00 p.m., she stated she had not been involved in the decision making regarding putting the COVID-19 positive residents on the same hall as two residents who were not COVID-19 positive. She indicated the decision had been Corporate driven. The IP stated both Resident #1 and #2 had a private room and a room change would be too disruptive for them, and not in their best interest. The IP was also the family member of Resident #2 and said she did not want Resident #2 moved despite the room being on the COVID-19 isolation unit. The IP revealed the original plan was to have the back hall (Rooms 8 - 22) designated as the COVID-19 care unit but she came back to work one day and the COVID-19 isolation unit was on the front hall (Rooms 1 - 7 and 101 - 112). The IP indicated she was aware the facility had a plan to move the plastic barriers defining the COVID-19 care unit so the readmitted residents would be in a separate area at the back of the hall but did not know why the barriers had not been moved yet. The IP also said that she had not been involved in developing or implementing any of the plans for responding to COVID-19 in the facility because she had been busy working on the medication cart to cover for staff who were out sick with COVID-19. Review of the CDC guidance entitled, Responding to Coronavirus (COVID-19) in Nursing Homes revealed, Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible . Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms. Assign dedicated HCP (Health Care Personnel) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. 5) Resident #5 was readmitted [DATE] with [DIAGNOSES REDACTED]. The resident was readmitted to room [ROOM NUMBER] which was not on the COVID-19 isolation unit, but was a private room. Review of the Physician Orders revealed there were no admission orders [REDACTED]. The resident also had an unproductive cough first documented on 7/8/20 which continued to be present through 7/16/20. On 7/16/20 at 11:00 a.m. an isolation kit containing PPE was observed outside the door of the resident's room. On 7/16/20 at 6:55 p.m., CNA #3 was observed donning a disposable gown and gloves. She was already wearing an N95 mask. During an interview at this time CNA #3 indicated she was planning to provide personal care for the resident. She entered the room without donning eye protection. Upon inquiry, she said she did have a face shield but she did not need to use it in Resident #5's room as it was only to be used for residents who were COVID-19 positive. Restorative Nurse #1 was present during this observation and interview. During an interview with Restorative Nurse #1 on 7/16/20 at 6:58 p.m., she confirmed that Resident #5 was on a 14 day quarantine due to being readmitted after a hospital admission. She also confirmed facility staff should wear full PPE (gown, gloves, mask and eye protection) when caring for residents on quarantine. A facility policy regarding the 14 day quarantine for readmitted residents and the PPE required when caring for these residents was requested but not provided during the survey. Review of the CDC guidance entitled, Responding to Coronavirus (COVID-19) in Nursing Homes revealed, Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. The recommended COVID-19 PPE . includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Removal Plan: The facility provided an acceptable removal action plan on July 17, 2020 at 11:30 a.m. that read: 1. On July 16, 2020 the barrier in the hallway was moved back to be across from room [ROOM NUMBER] to room [ROOM NUMBER] removing Rooms 4 (Resident #2), 6, and 7 (Resident #1) from the COVID unit. Residents in quarantine were moved to be located in rooms [ROOM NUMBER]. These rooms were labelled clearly as quarantine rooms. On July 17, 2020 another barrier was created separating rooms 110, 111 and 112 from the COVID Isolation Unit creating a divided Quarantine Unit. This barrier will ensure clear separation of residents with unknown COVID status (Quarantine Unit - Transmission Based Precautions) and COVID positive residents (COVID Isolation Unit). Residents will be removed from the Quarantine unit if they receive a positive COVID 19 PCR nasal swab and placed on the COVID Isolation Unit immediately upon notification of the results. If the resident is a new admission or readmission and has been at the building for 14 days and received a negative COVID swab collected no sooner than day 10 they will be transferred out of the Quarantine Unit. Resident #2 and Resident #1 will be immediately placed on 14 day transmission based precautions and quarantined due to possible exposure. 2. On July 16, 2020, education was provided to all staff on duty regarding the proper PPE that should be used in COVID Isolation Rooms versus the proper PPE that should be

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) used in Quarantine Rooms. Isolation Rooms will be clearly labeled along with a list of approved PPE for the room. Quarantine Rooms will be clearly labelled along with a list of approved PPE for the room. All off duty staff will be in serviced prior to the start of their next shift by DON/designee. Therapy staff, facility staff and all other staff, i.e., hospice, if applicable, will receive all training related to changes specified in the Removal Plan before being allowed to work their nest shift. 3. On July 16, 2020, licensed staff on duty were in serviced by DON/Designee that when a resident presents possible symptoms of COVID19 they will be placed on in quarantine on transmission based precautions immediately. The licensed nurse will write the order for the quarantine precautions immediately after symptoms identified. All licensed staff not on duty will be in service before the start of there next shift by the DON/Designee. 4. On July 16, 2020 all on duty staff were educated on the location of their 2 face shields and how to differentiate them. Face shields labeled with a Q are to be used only on residents located in Quarantine Rooms. Face shields labeled with a C are to be used only on residents located in Isolation Rooms. All off duty staff will be in serviced prior to start of their next shift by DON/Designee. On July 17, 2020 all staff on duty were educated that between different quarantine residents they are to sanitize the face shield utilizing bleach wipes located in the sitting room with the face shield bags. Bleach wipes are also located on medication carts and at the nurses station. 5. Resident #4 was relocated to room [ROOM NUMBER] in the Quarantine area due to pending COVID19 results. Resident #5 was relocated to room [ROOM NUMBER] in the Quarantine area due to recent new admission. Both rooms have the Quarantine Room signage which lists appropriate PPE to be worn. Each room on the Quarantine Unit and COVID 19 Isolation unit will have a box of surgical masks located in each room. 6. The two staff members who did not wear a gown when transferring Resident #6 will each receive one on one education in regards to appropriate PPE usage. 7. Quarantine Rooms are rooms of residents that are new or readmissions and residents that have displayed new COVID like symptoms. Quarantine Precautions include the use of disposable gowns for each resident, face shields, N95 masks with surgical masks over the N95 mask and gloves. 8. Isolation Rooms are rooms with laboratory confirmed COVID 19. The COVID-19 Isolation Precautions include the use of face shield, N95 mask with surgical mask to be changed between each resident in the room, washable gowns will be used and gloves. 9. On July 17, 2020 all housekeeping, laundry and therapy staff were educated on the difference between Quarantine Rooms and Isolation Rooms along with the appropriate PPE for each room and disinfection required of the PPE. Validation of the removal plan was completed on July 17, 2020 at 12:15 p.m., after the Federal Surveyor verified corrective actions taken by the facility had been implemented. This included observations, staff interviews, review of training logs and training materials to verify the immediate corrective actions were in place.