STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345473	A. BUILDING _____ B. WING _____	05/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILORA LAKE HEALTHCARE CENTER	6001 WILORA LAKE ROAD CHARLOTTE, NC 28212

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 observation, staff interview, record review and review of the facility COVID019 Pandemic Plan the facility 1) failed to implement the recommended transmission based precautions with the appropriate Personal Protective Equipment (PPE) for one (1) of one (1) residents with symptoms of COVID-19 (Resident #1) 2) failed to ensure a Housekeeper performed hand hygiene and wore the appropriate (PPE) when going in and out of resident rooms on an isolation unit for two (2) of two (2) random observations; 3) failed to consistently take or record resident temperatures, oxygen saturation and lung sounds according to facility policy and as ordered for two (2) of three (3) sample residents (Resident #1, and #4); and 4) failed to ensure two (2) residents maintained a social distance of (six) 6 feet during one (1) of one (1) random meal observations (Resident #5 and #6). The findings included: 1) Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of an Emergency Department Note dated 5/6/20 revealed Resident #1 was seen in the Emergency Department (ED) on 5/6/20 for evaluation following a fall. The ED note revealed her temperature was 99.4 degrees F (Fahrenheit) during the physical examination but had no respiratory symptoms and was not tested for COVID-19. Review of the Nursing Note dated 5/6/20 revealed, Returned from hospital transferred to room [ROOM NUMBER] from 403. Patient Stable. Temp (temperature) 100.3 (F). APAP 650 mg ([MEDICATION NAME] 650 milligrams). Awaiting results. Review of the Vital Signs Record revealed on 5/7/20 Resident #1's temperature was recorded as 102.9 (F). Review of the Physician order [REDACTED]. The indication and [DIAGNOSES REDACTED]. Review of a Nursing Note dated 5/9/20 revealed Resident #1 tested positive for COVID-19 after returning to the hospital. During an interview with the Director of Nursing on 5/14/20 at 10:45 a.m., she stated Resident #1 had been admitted to another facility, designated for COVID-19 residents, because it was difficult to get the resident to remain in a private room or wear a mask. She further indiated the resident was still COVID-19 positive. During a telephone interview with Licensed Practical Nurse #2 (LPN #2) on 5/15/20 at 4:45 p.m., she stated she worked with Resident #1 the night of 5/6/20 on the 11 p.m. - 7 a.m. shift. She recalled monitoring the resident for a fever and said she used a gown, gloves and mask when caring for the resident. She acknowledged eye protection was not available in the isolation kits on the unit and she had not used goggles or a facesheild. During a telephone interview with the Administrator and Director of Nursing (DON) on 5/15/20 at 6:10 p.m., the DON confirmed that Resident #1 was moved to the isolation hall when she was found to have a fever on 5/6/20 and it was the practice on that hall to implement Droplet Precautions for COVID-19 monitoring. She indicated that for Droplet Precautions staff wore a mask but did not wear eye protection unless the resident had symptoms like coughing or sneezing. The DON added that staff on the unit did have access to gowns and gloves. Review of the facility document entitled, COVID-19 Pandemic Plan revised 4/6/20 revealed, Residents exhibiting signs and symptoms of COVID-19 the Infection Preventionist or Designee will isolate resident in a private room with the door closed. Initiate transmission based precautions based on CDC (Centers for Disease Control and Prevention) guidance (Standard, Contact and Droplet and eye protection) . 2) On 5/14/20 at 11:40 a.m., Housekeeper #1 was observed in Room#110. There was a Droplet Precautions sign on the door that read, perform hand hygiene, and wear a mask when entering. Housekeeper #1 was wearing a cloth mask and a gown. She removed the gown and placed it in the trash bin on her housekeeping cart which was located immediately in front of the doorway to room [ROOM NUMBER]. Housekeeper #1 did not sanitize her hands after removing the gown. Housekeeper #1 then put on a gown and gloves before entering room [ROOM NUMBER], which had a Contact Precautions sign on the door. On 5/14/20 at 11:55 a.m., Housekeeper #1 was observed wearing a cloth mask and entering room [ROOM NUMBER], which had a droplet precautions sign on the door. After changing out the trash bag Housekeeper #1 exited room [ROOM NUMBER] and with out performing hand hygiene. She pushed the housekeeping cart away from the room and exited the unit. During an interview with Housekeeper #1 on 5/14/20 at 2:00 p.m. she confirmed that hand hygiene should be performed when exiting and entering resident rooms, but that she may have missed performing hand hygiene between resident rooms during the above observation. Upon inquiry she stated she had not been told cloth masks were not considered personal protective equipment and therefore not the appropriate mask to wear in an isolation room. During a telephone interview with the Director of Nursing (DON) on 5/15/20 at 3:30 p.m., she indicated all staff were supposed to be wearing surgical masks instead of cloth masks. She added the facility had used cloth masks previously, when they had limited Personal Protective Equipment (PPE). She further stated the cloth masks were not intended to be used as PPE in isolation rooms. She also stated staff were expected to sanitize their hands between each resident room and Housekeeper #1 had been reeducated. 3) Resident #1 was readmitted [DATE] with [DIAGNOSES REDACTED]. Review of the Physician order [REDACTED]. Further review of the April 2020 hand written Daily Vital Signs Sheets for Resident #1 revealed temperatures and lung sounds monitoring were completed only once daily, instead of per shift on 13 of 30 days in April. There was no evidence of pulse oximetry monitoring. Resident #4 was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the hand written Daily Vital Signs Sheets for Resident #4 from 3/20/20 - 5/14/20 revealed daily temperatures were missing for 3/26/20 through 5/14/20. Review of the Physician order [REDACTED]. Further review of the Medical Record revealed recorded vital signs for Resident #4 after 3/26/20 were not available. The missing sheets were requested but not provided during the survey. During a telephone interview with the Administrator and Director of Nursing on 5/15/20 at 6:10 p.m., the DON confirmed that the Vital Signs Sheets for Resident #1 and #4 had not been maintained within the medical record and some of the temperature and symptom screening was missing for both residents. She also indicated vital signs should have been taken and recorded each shift. Review of the facility document entitled, COVID-19 Pandemic Plan revised 4/6/20 revealed, Evaluate resident respiratory status daily and temperature and pulse oximetry every shift or as directed by physician. 4) Resident #5 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #6 was readmitted on [DATE] with [DIAGNOSES REDACTED]. On 5/14/20 at 12:45 p.m., Resident #5 and Resident #6 were observed sitting together at a table in the common area on 400 hall. They were sitting on joining sides of a small square. A staff member was observed walking past the table but did not intervene. On 5/14/20 at 12:48 p.m., Licensed Practical Nurse (LPN #1) was observed walking by the table where Resident #5 and Resident #6 were sitting. She took a lunch tray into room [ROOM NUMBER] and then walked back past the table again. During an interview at 12:50 p.m. with LPN #1, she stated that residents should be (six) 6 feet apart for social distancing. Upon inquiry she stated that she could see that Resident #5 and Resident #6 were sitting too close. She added that she would get the nurse to move them. On 12/14/20 at 12:52 p.m., the Director of Nursing (DON) arrived on the unit. She acknowledged that Resident #5 and Resident #6 were within six (6) feet of each other and should be repositioned further apart. The DON confirmed that even if they were sitting across from each other at that same table they would be within less than six (6) feet of each other. Review of the facility document entitled, COVID-19 Pandemic Plan revised 4/6/20 revealed, Eliminate communal dinning and group activities.

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.