STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015120	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, ANNISTON	2300 COLEMAN RD ANNISTON, AL 36207

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, Centers for Disease Control and Preparedness (CDC) guidelines, review of the facility Infection Control Manual, and staff education materials the facility failed to ensure staff wore a gown, mask, gloves and eye protection, as required when caring for four (4) of four (4) residents (Resident #1, #2, #3 and #4). The facility also failed to ensure staff wore a gown, mask gloves and eye protection, as required when caring for residents with unknown COVID-19 status on one (1) of one (1) quarantine units; this failure had the potential to affect 43 unsampled residents on the unit. These failures occurred during a COVID-19 Pandemic. The findings include: 1) Resident #1 was admitted [DATE], discharged to acute care on 6/2720 and readmitted from acute care on 7/21/20 with [DIAGNOSES REDACTED]. Resident #2 was admitted [DATE], discharged to acute care on 7/11/20 and readmitted from acute care 7/16/20 with [DIAGNOSES REDACTED]. Resident #3 was admitted [DATE], discharged to acute care 7/15/20 and readmitted [DATE] with [DIAGNOSES REDACTED]. Resident #4 was admitted [DATE], discharged to acute care 7/2/20 and readmitted from acute care 7/22/20 with [DIAGNOSES REDACTED]. During an interview with the Administrator on 7/23/20 at 10:45 a.m., she stated the facility was not taking new admissions at the time due to having both staff and residents that had tested positive. She stated that all readmitted residents had to have a negative COVID-19 test within 72 hours of readmission. Once readmitted residents were on a 14 day quarantine and were monitored to ensure they remained symptom free before being moved off from the quarantine area on the 400 hall. The Administrator said that staff should wear masks, face shield and gloves when providing care to readmitted residents during the quarantine period. In addition, all staff throughout the facility were to wear universal masks and had face shields or other eye protection. Upon inquiry, the Administrator confirmed staff did not wear gowns when caring for readmitted residents during the 14 day quarantine period the resident developed symptoms of COVID-19. On 7/23/20 at 11:52 a.m. the rooms of Resident #1, #2, #3 and #4 were observed with the Administrator. Resident #1, #2 and #3 were in private rooms with the door closed and Resident #4 was in a semi-private room but did not have a roommate. The door to Resident #4's room was also closed. Staff working on the hall were observed to be wearing masks and face shields, or other eye protection. There were no isolation kits with gowns for donning observed in the hallways or near the resident room doors. There was no signage on the doors indicating these residents were on transmission based precautions. The infection control policies, procedures and plan related to COVID-19 Prevention, Preparedness and Response were requested during the survey. The facility did not provide a COVID-19 specific plan during the survey. They did provide excerpts from the facility Infection Control Manual revised 10/1/08. Review of these excerpts revealed they did not specifically address Transmission Based Precautions for readmitted residents who may have been exposed to an airborne communicable disease. Review of COVID-19 staff education power point presentations (undated) provided by the facility revealed staff were educated on the appropriate Personal Protective Equipment (PPE) to wear when caring for residents with confirmed or suspected COVID-19. However, the materials provided did not include any education regarding the appropriate PPE for readmitted residents during the 14 day quarantine period. Review of the CDC guidelines entitled, Responding to Coronavirus in Nursing Homes (COVID-19), dated April 30, 2020, revealed 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. . a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. 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. Further review revealed the required COVID-19 PPE for readmitted residents was 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. 2) Resident #5 was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the Nursing Notes Dated 7/4/20 - 7/6/20 revealed Resident #5 had a temperature of 99.6 degrees Fahrenheit (F) on 7/4/20 and was put on droplet precautions. On 7/5/20 the Resident's temperature was and 99.1 and she also had a productive cough and COVID-19 testing was ordered. On 7/6/20 she was noted to have a poor appetite the results of her COVID-19 test were positive. On 7/6/20 Resident #5 was discharged to a COVID-19 treatment unit at the hospital. Resident #5 had been located on 200 hall. Resident #6 was admitted [DATE] with [DIAGNOSES REDACTED]. Resident #6 had been the roommate of Resident #5. Review of the Nursing Notes dated 7/11/20 revealed Resident #6 tested positive for COVID-19 and was discharged to a COVID-19 treatment unit at the hospital. Resident #7 was admitted [DATE] with [DIAGNOSES REDACTED]. Review of the Nursing Notes dated 7/6 /20 - 7/21/20 revealed Resident #7 had been asymptomatic but tested positive on 7/23/20 and was placed on droplet precautions in the private room he was already residing in on 200 hall. Resident #8 was admitted [DATE] with [DIAGNOSES REDACTED].#8 was asymptomatic but tested positive for COVID-19 on 7/21/20. Resident #8 was put on droplet precautions and was transferred from a semi private room on 200 hall to a private room on 200 hall; across from Resident #7. During an interview with the Administrator on 7/23/20 at 10:43 a.m., she stated that the facility had four (4) residents who had tested positive for COVID-19. Two (2) of these residents remained in the facility and two (2) had been transferred out to the hospital. The two (2) residents who remained in the facility had been asymptomatic but were tested because they resided on the 200 Hall and 14 days had passed since the first resident (Resident #5) on 200 Hall tested positive. They were testing for surveillance purposes. She stated that the facility had also tested residents on other units but so far the only positive residents had been on 200 hall and all residents had been tested at least once. Eleven staff members had also tested positive and two (2) of these staff had worked on 200 hall. The Administrator said that after Resident #5 tested positive for COVID-19 the facility closed that unit off from the rest of the facility using plastic barriers. The facility had dedicated staff working on that unit and the only way to enter and exit was through the door leading to what used to be the facility's Rehabilitation Gym. This room had a door to the exterior of the building through which staff had to enter and exit. The Rehabilitation Gym had been converted into a large anteroom where staff were screened; donned and doffed masks, gloves and face shields; and performed hand hygiene as needed before entering and when exiting through a plastic barrier to the 200 hall. Upon inquiry she stated both residents who were COVID-19 positive resided on this unit in private rooms at the end of a hall and that staff donned gowns and gloves as needed to go in and out of the COVID-19 positive isolation rooms. Upon further inquiry she indicated that gowns were not worn when caring for the other residents on 200 hall who had potentially been exposed to COVID-19. On 7/23/20 at 12:15 p.m. the 200 Hall was observed with the Director of Rehabilitation, who was acting in a Unit Leadership Role for the 200 Hall (COVID-19 positive and COVID-19 quarantine unit). Isolation kits containing PPE were observed outside the rooms of Resident #7 and #8. No other isolation kits were observed on the unit. Upon inquiry the Director of Rehabilitation conformed that gowns were not worn when providing care to the residents on the unit whose COVID-19 status was unknown. While all the residents on 200 Hall had previously tested negative for COVID-19, it had only been two days since Resident #7 and Resident #8 tested positive for COVID-19. During an interview with the Administrator on 7/24/20 at 3:22 p.m., she indicated she was unaware of the requirement for staff to wear gowns during a quarantine period when caring for residents

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015120	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NHC HEALTHCARE, ANNISTON	**2300 COLEMAN RD ANNISTON, AL 36207**

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	(continued... from page 1) who resided on the same unit as other residents had tested positive for COVID-19. The Administrator added the facility's implemented droplet precautions with full PPE including gowns, gloves, face shield and N95 masks only for when residents had symptoms of COVID-19 or were COVID-19 positive. In addition she said that Resident #9 (the previous roommate of Resident #8) had been placed on droplet precautions (with full PPE) as a preventive measure. During an interview with the Administrator and Regional Nurse on 7/24/20 at 3:40 p.m., the Regional Nurse stated that the facility was only using gowns for residents who were COVID-19 symptomatic or positive due to a shortage of PPE. The Administrator indicated the facility supply of gowns was at contingency capacity. Upon inquiry the Administrator confirmed the facility had a supply of cloth gowns available. Review of the facility census dated 7/23/20 revealed that in addition to Resident #7 and Resident #8 there were 44 residents on 200 Hall. This included Resident #9 who was on droplet precautions as noted above. Therefore there were a total of 43 residents who had potentially been exposed to COVID-19 that staff were providing care to without wearing all recommended PPE (gown). The facility policy and procedure regarding optimizing the supply of PPE in response to contingency or crisis capacity supplies was requested but not provided during the survey. During an interview with the Administrator on 7/24/20 at 3:22 p.m., she indicated the facility did not have a written policy on this subject. The facility policy and procedure regarding transmission based precautions for residents potentially exposed to COVID-19 and/or the procedures specifically in place for the residents on 200 Hall who were not already known to be COVID-19 positive was requested but not provided during the survey. Review of the CDC guidance entitled Responding to Coronavirus (COVID-19) in Nursing Homes dated April 30, 2020 revealed, when a resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit. In addition HCP (health care providers) should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents. Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.