STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345567	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN CARE OF CORNELIUS	19530 MOUNT ZION PARKWAY CORNELIUS, NC 28031

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 observation, staff interview, record review, review of the facility's staff education logs, review of posted signage for Advanced Droplet Contact Precautions, and review of the facility document entitled, General Infection Control Policy, the facility failed to ensure staff performed hand hygiene after contact with a resident or objects in the residents room for 3 of 3 residents (Resident #1, #2, and #3), failed to ensure proper Personal Protective Equipment (PPE) were donned and doffed when entering and exiting a resident room with signage indicating Advance Droplet Contact Precautions for 3 of 3 residents (Resident #1, #2,and #3), failed to perform proper decontamination and removal of items removed from a room with signage indicating Advanced Droplet Contact Precautions (Resident #3), the facility failed to develop and implement policies on wearing face coverings (Staff 1 of 1), the facility failed to develop and implement policies for wearing PPE and performing hand hygiene when entering and exiting resident care rooms for residents on Advanced Droplet Contact Precautions (Staff 5 of 5), and ensure proper usage of face coverings by reception staff when screening employees and visitors. (Staff 1 of 1). These failures in proper infection control practices occurred during a COVID-19 pandemic and had the potential to affect all residents and staff in the facility through the transmission of COVID-19. Findings included: According to the facility protocol document titled General Infection Control Policy revised 07/19/19, all staff shall be knowledgeable of Standard and Transmission based precautions and hand washing procedures shall be followed. According to the facility protocol document titled Hand Hygiene/Handwashing Policy revised [DATE], hand hygiene should be performed before and after contact with residents, after removing gloves, and be should performed after contact with inanimate objects including medical equipment in the immediate vicinity of the resident. According to the facility protocol titled Transmission-Based Precautions Policy revised 06/29/20, Contact Precautions, Droplet Precautions, and Airborne Precautions were listed as transmission-based precaution categories, but there were no policies specifically addressing Advanced Droplet Contact Precautions for COVID-19 pandemic. The facility did not have a policy addressing the use of face covering for all staff during the COVID-19 pandemic. 1. A physician's orders [REDACTED].#1's door indicating Advance Droplet Contact Precautions which included the use of a gown, gloves, mask, eyewear, as well as performing hand hygiene before and after entry. After entering the room, Nurse #1 touched Resident #1's call light, overbed table, and Resident #1's right arm before exiting the room. Nurse #1 was not observed to don personal protective equipment (PPE) when entering the room nor wash his hands following contact with Resident #1 before returning to the nurses' station to begin documentation. An interview with Nurse #1 on 07/15/20 at 12:52 PM revealed Nurse #1 had entered Resident #1's room to answer the call light. Nurse #1 indicated all staff had received education on signs/symptoms (s/sx) of COVID-19, proper hand hygiene, transmission-based precautions, and donning/doffing of PPE. He stated the signage on the door of Resident #1's room indicated Advance Droplet Precautions and full PPE including gown, gloves, mask, and eye wear should be worn by all staff when entering the room and proper hand hygiene should be performed after exit. Nurse #1 stated he went in to answer the call light and didn't think about Resident #1 being on precautions at the time. An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene, transmission-based precautions and donning and doffing of PPE including gowns, gloves, mask, and face shields/goggles. The Infection Control Nurse stated Nurse #1 should have donned a gown, gloves, facemask, and eyewear (face shield/goggles) when entering the room with signage indicating Advanced Droplet Contract Precautions, doffed PPE when exiting and followed by hand hygiene. An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed the facility had not had any shortage of PPE since the start of the pandemic in March 2020 and all staff had received multiple in-services trainings related to COVID-19 including hand hygiene, transmission-based precautions, and donning and doffing of PPE. Nurse #1 should have worn full PPE to include gown, gloves, face mask, and eyewear and performed hand hygiene before exiting Resident#1's room. An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene, transmission-based precautions, and proper use of PPE and he expected them to be followed by all staff. He stated all staff have received training in infection control and Nurse #1 should not have entered Resident #1's room without wearing full PPE and should have performed hand hygiene when exiting Resident #1's room. 2. An observation on 07/15/20 at 12:55 PM revealed Nurse Aide #1 was pushing a cart used for meal tray bussing wearing gloves and a surgical mask. Resident #2 was ambulating in the hallway without a mask and had stopped outside the closed door of another resident. Nurse Aide #1 approached Resident #2 in the hallway then removed her gloves and placed them in her hand. Nurse Aide #1 then locked arms with Resident #2's right arm and escorted her into her room which displayed signage that indicated Advance Droplet Contact Precautions. Nurse Aide #1 disposed of her gloves in the trash, then, transferred Resident #2 to her chair, placed her overbed table with her lunch tray in front of her, and begun encouraging her to eat. Then, Nurse Aide #1 exited the room. Nurse Aide #1 did not perform hand hygiene when exiting the room and returning to collecting other resident trays in rooms that were not on any transmission-based precautions. An interview on 07/15/20 at 12:59 with Nurse Aide #1 revealed Nurse Aide #1 voiced she should have washed her hands when leaving the room to decrease the risk of spreading infections. Nurse Aide #1 stated she should have washed her hands and re-applied gloves before collecting meal trays in other resident rooms on her unit that were not on transmission-based precautions. An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene. She also stated she should have applied clean gloves before returning to collect meal trays for other residents on the hall. An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed Nurse Aide #1 should have performed hand hygiene before exiting Resident #2's room before continuing to collect trays from other resident rooms. An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene and Nurse Aide #1 should have performed hand hygiene when exiting Resident #2's room. 3. A physician's orders [REDACTED]. An observation on 07/15/20 beginning at 1:05 PM revealed Resident #3 to be suspended in a total lift with nursing personnel providing supervision for safety. Three male staff members identified as maintenance/ EVS workers (Maintenance #1, #2, and #3) approached Resident #3's room with a metal cart containing an air mattress and an air mattress motor. The signage on the door of Resident #3's room indicated Advanced Droplet Contact Precautions. Maintenance Worker #1 spoke to staff inside the room and was directed about which PPE to apply and where it was located. Maintenance Worker #1, Maintenance Worker #2, and Maintenance Worker #3 began applying the PPE from the cart outside of the room. Once Maintenance Worker #1 had donned a mask, gown, and face shield, a staff member from inside the room reached out of the door of Resident #3 and handed off the contaminated air mattress motor to Maintenance Worker #1 who placed the motor in the floor in the hallway with his bare hands. He then applied gloves and all three maintenance workers took the metal cart in the room and began exchanging the air mattress for the new one. After the contaminated air mattress was removed from the bed, Maintenance Worker #1 exited the room wearing full PPE that included gown, gloves, mask, and a face shield and placed the contaminated air mattress in the floor in the hallway outside Resident #3's room. The facility Administrator approached Maintenance Worker #1 and provided instruction to re-enter the room and dispose of Maintenance Worker #1's contaminated

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) PPE. Maintenance Worker #1 re-entered Resident #3's room and disposed of his gown in the trash can provided and exited the room. When he exited the room, he laid his face shield on the isolation cart without sanitizing it, then the Administrator and Maintenance Worker #1 picked up the contaminated air mattress from outside of Resident #3's room and took it outside. Maintenance Worker #2 and #3 placed the new air mattress on the bed, disposed of their gown and gloves in Resident #3's bathroom, but exited the door pushing the metal cart from the room and placing their contaminated face shields in a plastic bag with their bare hands. Maintenance Worker #2 and Maintenance Worker #3 was not observed to perform hand hygiene after PPE was removed. An interview with Maintenance Worker #1 on 07/15/20 at 2:23 PM revealed he was asked to change out the air mattress for Resident #3 along with Maintenance Worker #2 and Maintenance Worker #3. He stated he recalled the staff member handed him the air mattress motor while he was trying to don his PPE and acknowledged he had not yet applied his gloves when he touched the motor with his bare hands and placed it on the floor in the hallway without sanitizing it. He also revealed he removed the air mattress from the bed of Resident #3 and placed it in the hallway before re-entering the room to dispose of his PPE. He acknowledged Resident #3 had signage that indicated Advanced Droplet Contact Precautions and he should have worn gloves before touching the air mattress pump and should not have placed neither the contaminated mattress nor pump in the floor in the hallway. Maintenance Worker #1 stated the contaminated items should have been placed on a cart for removal and his contaminated face shield should have been placed in a plastic bag and disinfected. He divulged he observed Maintenance Worker #2 and Maintenance Worker #3 placing their face shields in plastic bags with their bare hands and stated the cart should have been taken outside to be sanitized wearing clean gloves. An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene, transmission-based precautions and donning and doffing of PPE including gowns, gloves, mask, and face shields/goggles. The Infection Control Nurse stated Maintenance Workers #1, #2, and #3 should have donned a gown, gloves, facemask, and eyewear (face shield/goggles) when before entering the room of Resident #3 with signage indicating Advanced Droplet Contract Precautions or contacting contaminated objects from the room and correctly doffed and disposed of PPE when exiting Resident #3's room and should have performed hand hygiene after removal. The Infection Control Nurse also revealed contaminated items should not be placed in the floor in the hallway. An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed the facility has not had any shortage of PPE since the start of the pandemic in March 2020 and all staff had received multiple in-services trainings related to COVID-19 including hand hygiene, transmission-based precautions, and donning and doffing of PPE. Maintenance Workers #1, #2, and #3 should have worn full PPE to include gown, gloves, face mask, and eyewear and performed hand hygiene before exiting Resident #3's room. The Regional Nurse Consultant further revealed contaminated objects from Resident #3's room should not have been touched without gloves and should not have been placed on the floor in the common areas. An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene, transmission-based precautions, and proper use of PPE and he expected them to be followed by all staff. He stated all staff have received training in infection control and all three-maintenance staff should not have touched contaminated objects without proper PPE. They should not have exited Resident #3's room properly removing and disposing of the PPE worn in Resident #3's room and should have performed hand hygiene when exiting. An interview with the Maintenance Director on 07/17/20 at 7:00 PM revealed the facility protocol for exchange of an air mattress in an Advanced Droplet Contact Precaution room included taking the new air mattress and motor to the room on a cart. Maintenance workers should don PPE including gown, gloves, mask and face shield before entering the room and should not touch any contaminated surfaces without gloves. The Maintenance Director stated staff should remove the old air mattress and motor from the bed and it can be sat in the floor in the room while the new air mattress and motor are removed from the cart and installed. The contaminated air mattress and pump should be sanitized and be brought back out of the room and placed on the cart for removal. He stated the cart should not be taken into the room and the contaminated objects should not be placed on the floor in the hallway nor handled without gloves. The Maintenance Director further revealed all worn PPE should be discarded in the appropriate receptacles in Resident #3's room, face shields should be bagged before gloves are removed, and staff should perform hand hygiene following the removal of PPE. Gowns should not be worn in the hallways and face shields should never be laid on the isolation carts after usage without being sanitized. 4. Observations on 07/15/20 at 10:15 AM, 10:20 AM,10:25 AM, 1:10 PM, 1:15 PM, 1:20 PM, and 1:25 PM revealed Receptionist #1 near the front door of the facility. She was screening and/or interacting with employees and visitors who entered the facility by taking their temperature and asking regulatory screening questions and those who stopped by the business office. Receptionist #1 was initially observed to be wearing a cloth face covering around her mouth. The observations further revealed Receptionist #1 touched her face and pulled the face covering down around her chin each time she spoke to an individual she was screening at the front desk. She was not positioned in a socially distancing environment and there were no visible screens between Receptionist #1 and anyone who entered the front door of the facility. An interview with Receptionist #1 on 07/15/20 at 2:10 PM revealed she acknowledged she pulled down her cloth face covering to speak, and she had been trained the face covering should always cover both her nose and mouth when on duty. An interview with the Infection Control Nurse on 07/15/20 at 1:18 PM revealed all staff had received in-service training on hand hygiene, transmission-based precautions and donning and doffing of PPE including gowns, gloves, mask, and face shields/goggles. The Infection Control Nurse stated all staff are always to wear a face covering/mask when on duty. The face covering should be securely covering the nose and mouth to decrease potential spread of infections. An interview with the Director of Nursing and Regional Nurse Consultant on 07/15/20 at 1:30 PM revealed the facility had not had any shortage of PPE since the start of the pandemic in March 2020 that included surgical face masks which were made available and distributed. The Infection Control Nurse stated all staff had received multiple in-services trainings related to COVID-19 including proper donning and doffing of face coverings. Receptionist #1 should always wear a face covering over her nose and mouth and the face covering should not have been pulled down to converse with individuals at the front desk. An interview with the Business Office Manager on 07/15/20 at 2:15 PM revealed she was the supervisor for the front office staff which include Receptionist #1. She stated Receptionist #1 had been trained on how to properly wear a face covering and was always to wear it over her nose and mouth during her shift. She further revealed it was not acceptable practice and placed each person that entered at risk for the spread of infection when Receptionist #1 removed her face covering to speak. An interview with the Administrator on 07/15/20 at 2:30 PM revealed the facility had policies and procedures for hand hygiene, transmission-based precautions, and proper use of PPE and he expected them to be followed by all staff. He stated all staff have received training in infection control and Receptionist #1 should have a properly fitting face covering that always covered the nose and mouth when on duty.