STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145999	A. BUILDING _____ B. WING _____	C 09/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROSSE POINTE MANOR	6601 WEST TOUHY AVENUE NILES, IL 60714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaints: 2095617/IL124905 F 686G & F689 G 2096618/IL126028 F880 F 2095109/IL124359 F880 F	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review , the facility failed implement turning and repositioning a resident to prevent the development and worsening of pressure sores for 1 (R3) resident of 3 residents reviewed for pressure ulcers. This failure resulted in R3 sustaining a facility-acquired pressure sore that became infected and necrotic (dead tissue). Findings include: R3 is an 83 year old resident with Alzheimer's Disease, hypertension, diabetes, and dysphasia. R3's physician orders include (but not limited to):	F 686	PLAN OF CORRECTION: GROSSE POINTE MANOR CMS -2567 Providor 145999/0045203 Cycle Date : 9/17/20 F686 PRESSURE ULCERS I. Corrective Actions: R3 was re - assessed by IDT and nursing and cna staff were re educated as to the updated care plan. R3 was placed to bed and repositioned and has shown improved wound status.	10/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/08/2020

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F 686	Continued From page 1 Physical therapy wound evaluation, treatment and debridement as needed; Reposition hourly from side to side only; Skin inspection every shift; Turn and reposition every 1-2 hours; Offload heels while in bed. MDS (Minimum Data Set) dated 6/3/20 show R3 requiring extensive assistance to move while in bed and is totally dependent on staff for transfers to be performed by two or more staff. MDS also shows R3 with no pressure sores upon admission to the facility and that current pressure sores were facility-acquired. R3's skin care plan dated 7/28/20 stated intervention shows, "I need my aides to help me reposition at least every 1 hour when I'm in a chair." On 9/14/20 at 10:55 AM, R3 was observed in a high back recliner seated on the left hand corner against the window. R3 was asleep and lying upright in a 45 degree angle with R3 looking up towards the ceiling. R3 was fully dressed and appeared to be on top of a blue netted sling bunched up under her buttocks. On 9/14/20 at 12:05 PM, R3 remained lying in a high back recliner on the left hand corner of the main dining room waiting to be assisted in eating her pureed diet meal that was on a tray. R3 appeared uncomfortable and the sling that was left under her, the sling was still visible and her reclining position remained unchanged. At 12:35, V4 (LPN) sat down next to R3 and started to feed R3 lunch. R3 appeared to be agitated and refusing to eat what V4 was spooning in R3's mouth. V4 stood up and walked away from R3 and returned to the nurse's station. V4 went back to sit and offer R3 more food but did not adjust or reposition R3 to address her discomfort.	F 686	II. Identify other Residents: Facility will audit all residents at risk of PU development as identified as high risk through MDS section G needing ADL assistance in turning and repositioning, and from dietary assessments as identified with compromised nutrition , and other risk factors, staff will examine skin assessments, and conduct staff observations and interviews.DON and designee will conduct daily rounds to assure all residents needing repositioning are provided as per their plan of care. III. Alter systems to assure that the problem will not recur: DON and or wound nurse will conduct rounds daily for all identified residents with existing and at risk for PU to assure they are repositioned as per plan of care necessary to prevent and treat pressure ulcers. IV. Quality Assurance plans to monitor: Facility staff have enrolled and actively participated in Telligen QII in PDSA process beginning 9/15/20 through 10/6/20. Facility will report findings weekly to QAPI committee, and plan, do , study, and act upon the findings. MDS coordinator, DON, Administrator, wound nurse are attending and monitoring performance to assure that corrections are achieved and permanent . V. Date when corrective Action will be completed: 10/09/20	

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On 9/14/20 at 1:50 PM, R3 was observed in her room on her recliner and placed next to her bed however was not placed back in bed. R3 remained in the same position on her backside with her head elevated at over 45 degrees. The same plastic nylon mechanical lift sling remained under her with no evidence of any repositioning devices such as wedges or pillows to relieve pressure from her buttocks.

On 9/15/20 at 9:50 AM, R3 was lying upright in a recliner in the same corner of the dining area. She was seated atop the same plastic nylon mechanical lift sling that was used to transfer her from her bed to the recliner. V6 (Wound Nurse) was present in the dining room and when asked about R3, V6 stated, "We usually get her up first thing in the morning and keep her in the recliner until after lunch when the staff put her back to bed." Surveyor asked about the plastic nylon mechanical lift sling observed under R3, V6 stated, "It's okay to have it under her because the staff use it to transfer her to her recliner." When asked if the sling affected R3's wound to her sacral area, V6 stated, "No It's okay, we keep the sling there because it is easier for the staff to transfer her back to bed." Asked if the sling should be removed from under R3 after each use, V6 stated,"No, I think it's fine."

R3's wound notes written on 9/10/20 by V6 (Wound nurse) state "Weekly assessment: Onset/discovery 8/16/2020. Source: Acquired. Location: Sacrum. Original wound type: Stage 2. Current wound type: Unstageable. 3.5 centimeters length x 1.5 centimeters width x undetermined depth. Treatment: Cleanse wound with 0.9% Normal saline solution.. Apply ointment then top with calcium alginate, cover with

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F 686	Continued From page 3	F 686		

bordered foam dressing/gauze daily until resolved. Comments: Wound became Worse. Wound consultation noted. Replaced mattress to low air loss mattress, cushion, repositioning every hour from side to side only."

On 9/15/20 at 1:10 PM. R3 was lying in bed fully dressed atop a flat sheet that was folded up in 4 layers. Under the layered sheet was a fitted sheet wrapped tightly around the specialty air mattress. R3's wound was observed with V6 and V7 (Nurse aide) assistance. Surveyor asked V6 to describe the wound while showing the surveyor, V6 (Wound nurse) stated, "The wound is on her sacrum. She got it here about a month ago. It's 90% slough and 10% necrotic (dead) tissue with redness in the surround skin area. Edges of the wound are attached and it measures approximately 3 centimeters by 1.5 centimeters and the depth is undetermined because it is not stageable. This is when I contacted V12 (wound consultant) because it worsened last week and got infected. V12 ordered a new ointment medication and we also added an air mattress." Surveyor asked V6 how long R3 would lie in bed, V6 stated, "Well after lunch she's placed back in bed and she's pretty much there until bedtime because we don't get her up again until breakfast." When asked about the linens R3 laid on, V6 stated, "They use this folded flat sheet to turn her and the fitted sheet is on the mattress but they should just be using the flat sheet and we shouldn't be layering the sheet under her so I see what you mean. I will ask the staff to put her in her gown when she is in bed."

Interview on 9/15/20 at 2:07 PM with V12 (Wound Consultant) stated, "I have not seen this patient yet but I will. I just advise them about not putting

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pressure on the area as much as possible and not to place her in bed as much as possible, because when you sit down there is sheer pressure that can arise. I am called upon to do wound debridements (surgical removal of dead tissue) but like I said I have not seen her yet but I was told she has necrotic tissue. When I see her I will schedule this. I do expect that the staff turn and reposition the patient frequently as much as possible and to keep pressure off that wound. (R3's) case is really tricky because she needs to be on a low air loss mattress, frequent repositioning and there should only be a flat sheet on her bed. I understand minimizing linens and I have read that but more important is keeping pressure off her pressure sore."

Interview on 9/16/20 at 1:45 PM with V13 (Advanced Practice Nurse) stated, "I do see (R3) and just saw her today in fact. I consult on wounds and I give doctors orders for patients R3 is not as mobile as she was before and we are trying to get her nutritional requirements up again. I have been telling the staff there to try to get her up from bed and to reposition her as much as possible to keep pressure off her pressure sore. When she is in her recliner they must keep her off her pressure sore by using pillows or wedges. When she is in bed she must be repositioned as much as possible. I don't know why they kept her up in the dining room for the amount of time you say. I just spoke to the nurse when I was there and told them that she must be placed back in the bed after meals and then to reposition her as often as possible when she is in bed. Surveyor asked if this was an avoidable pressure sore, V13 stated, "I don't know if I can answer that but I know that it is healing now" When asked if R3 is capable of her wound healing then if it's possible

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F 686	Continued From page 5 to avoid it, V13 stated, "Again, I know that we are doing our best to heal the wound and I have told the staff to not put her in her recliner for long periods and place her back in bed after meals so they are correcting this." Interview on 9/16/20 at 3:15 PM with V6 (Wound Care Nurse) stated, "We are supposed to reposition (R3) every hour from side to side when in bed and when she's on the multi-positional chair (recliner). Surveyor asked how staff reposition R3 while in the recliner, V6 stated, "Well we can increase or decrease the incline of the back and it changes her position." When asked how this takes pressure off R3's buttocks, V6 stated, "I guess it doesn't." When asked to provide any documentation that demonstrate repositioning is conducted for R3, V6 stated, "On the TAR Treatment Administration Record) the nurses sign off on each shift that R3 is turned on each shift." Surveyor asked V6 what the doctor's order, V6 stated, "The order says to reposition hourly from side to side." Surveyor asked who transcribed the doctor's order to the TAR, V6 stated, "I thought it was a recommendation only so I put it as every shift and not every hour." Surveyor asked if the wound was avoidable, V6 stated, "Yes if she was turned and repositioned like we're supposed to she would not have acquired that wound."	F 686		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/9/20

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F 689	Continued From page 6 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement planned monitoring intervention to prevent a fall for 1 of 4 residents (R1) with a history of falls from falling and sustaining injuries. This failure resulted in R1 being sent to an acute care hospital for surgical repair for a right hip fracture due to a fall. Findings include: R1 is a 91 year old resident with diagnoses of hypertension, dementia, heart failure and history of falls. MDS (Minimum Data Set) dated 7/2/20 shows R1 required one person physical assistance to ambulate as she was totally dependent on staff to perform this function. R1's Care plan dated 7/25/20 states, "Need/Preference: Because I sometimes get confused have a diagnoses of anemia and may feel weak, have the potential to fall down and hurt myself and I fell down 05/25/20. 5/31/20. Approach: Place resident close to monitoring staff in dining room, educate staff to closely monitor resident in dining room. Goal: Stay safe while I'm moving about." Records document previous unwitnessed and unsupervised falls prior to 5/31/20 occurred two previous times on 5/25/20 and 1/21/20. Prior to these unwitnessed and unsupervised falls R1 fell another 5 times on 12/4/2019, 10/15/2019, 6/25/2019, 4/28/2019, and 3/5/2019. Incident report dated 5/31/20 stated, "Time of	F 689	F689 Accidents/ Hazards/ Supervision: I. Corrective Actions: R1 was transferred to the hospital and received surgery. R1□s recovery continued at facility with therapy and restorative nursing care. II. Identify other residents: Safety and fall risk assessments will be examined, restorative assessments will be examined ; staff will be interviewed and residents will be observed for prodromal signs of potential falls, accidents and hazards. III. Measures to ensure that the problem will not recur: DON and Restorative coordinator will conduct weekly rounds to monitor compliance with fall prevention implementation. Staff studied the existing system and determined that the root cause of the fall occurred during shift change and adjusted the supervision responsibility so that change of shift staffing will be applying fall prevention measures such as monitoring residents for falls even during and especially during change of shift. IV. Quality Assurance Plans: Weekly reporting of compliance audits will be given to the QAPI committee, DON, and administrator .Monitor progress and adapt policy as needed.	

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F 689	Continued From page 7 Incident 3:10 PM. Type of Incident: Right Hip Closed Fracture. Description of occurrence: Alert and oriented x1-2. Ambulates with walker one staff assist. At 3:10 PM, found resident walking by herself, lost her balance and fell on the floor. Reported to nurse immediately. Head to toe assessment done. No visible injury. Complained of right hip pain. Immobilized affected area. Tylenol given for pain. MD (medical doctor) notified, order received to send resident to Lutheran General Hospital. Admitted with diagnoses of right hip closed fracture. Conclusion: After thorough investigation, it was determined that the root cause of the fracture was due to resident ambulated without staff assist, became weak and lost her balance." Interview with V6 (Wound Care Nurse) on 9/16/17 at 11:05 PM stated, "I do a lot of things here, not just wound care. I did the fall investigation for R1 and my director of nursing (V2) reviews it." When asked who was assigned to be the dining room monitor when R1 fell, V6 stated, "It was V15 (c.n.a. /certified nurses aide)." Surveyor asked about the conclusion of the investigation as it was written, V6 stated, "We concluded (R1) tried to ambulate without staff assist and that's why she fell." When asked V6 who R1 was supposed to ask for help when she's confused, she had no call light for her to use in the dining room, and there were no staff in the dining room to ask for that assistance, V6 stated, "I'm not sure." On 9/16/20 at 12:20 PM interview with V14 (RN) stated, "I remember (R1) and yes I took care of her. She is alert and oriented times 1-2 and she is confused and speaks mostly Russian. She is a frequent faller and I think she has fallen more than 3 or 4 times since I've been there. We try to	F 689	V. Date Certain : October 9th, 2020	

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prevent her from falling by reminding her to ask for help and we moved her to a room closer to the nursing station. She has a bed alarm but no she does not have a chair alarm but I guess we should have one on her. I was at the nursing station that day when she fell. I did not see her fall because she is usually placed around the left side of the dining room.Where the nurses sit and where I sit, we can't see around the corner but there is supposed to be a c.n.a sitting there to watch the residents. I was taking an endorsement from V3 (LPN) and around 3:15 PM or something like that, V15 came and said to come to the dining room because R1 on the floor. I went right away and I checked her. She complained of pain when we got her up so I called the doctor and got order to send her to the hospital." Surveyor asked what precautions she took to prevent R1 from falling, V14 stated, "I check on her frequently and we put an alarm on her when she's in bed. We always remind her to use the call light to ask for help and we constantly try to educate her to ask for help." When asked how R1 could use a call light in the dining room, V14 stated, "There wasn't one put on her in the dining room."
When asked if R1 could be reminded or taught to ask for help since she was confused, V14 stated, "No, I guess you can't so, we must watch her more closely."

On 9/16/20 at 12:30 PM interview with V15 stated, "Yes I remember R1. I was there the day she fell but I really didn't see her fall because she was already on the ground when I got to the dining room, so I ran to her right away to make sure she was okay." Surveyor asked if there were any other residents or staff in the dining room, V15 stated, "I think there were about a couple of residents in the dining room but I'm not sure. But

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F 689	Continued From page 9	F 689		

no, there wasn't any staff." When asked where she was when R1 fell, V15 stated, "I was doing my rounds first before I went to the dining room because I was assigned to sit there." When asked how she was supposed to sit in the dining room and do her other nursing aide duties, V15 stated, "Well we're supposed to get someone to sit there while I do my work or go on break. That doesn't always happen because we run short staffed a lot and especially on weekends, so it's not always like that there."

Attempts to reach R1's attending physician were met with referrals back to the physician extender (V14). On 9/16/2019 at 1:45 PM interview with V14 (Advanced Practice Nurse) stated, "I am familiar with R1's injury and fall with fracture but I don't recall getting a call for that so it could have been my partner since it was on a Sunday. I know I was not on duty on Sunday." Surveyor informed V14 that she was listed on the 5/31/20 fall incident report a being notified of the fall. V14 stated, "I remember being informed about previous falls but I just don't remember about this last one." When asked whether R1 was at risk for falls, V14 stated, "She is definitely at risk for falls because I recall she has fallen several times in the past from what the facility tells me."

R1's progress records show in part (but not limited to):

5/31/20: 6:23 pm transferred to: Emergency Department per MD order. TIME: 4:16 PM. Reason for transfer: Fall at 3:10 pm, C/O (complain of) moderate pain on right hip pain. Treatments prior to transfer: Medications: Tylenol 500 mg (2 tabs) at 3:20 pm authorized by: (V14).

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F 689	Continued From page 10 6/4/20 7:20 pm re-admitted from: Acute care hospital 6/4/20 8:34 pm muscle/skeletal findings: generalized weakness right hip FX (fracture), Right interchanetric hip fracture. muscle/skeletal pain: Moderate pain on right hip. Lower extremity range of motion: Right leg very limited movement due to surgery."	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		10/9/20

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F 880	Continued From page 11 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 880	Infection Control 483.80	

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	145999	A. BUILDING _____ B. WING _____	C 09/17/2020

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F 880	Continued From page 12 review, the facility nursing staff taking care of a resident suspected of having COVID-19 (R2) failed to wear PPE (Personal Protective Equipment) to prevent the spread of potential communicative diseases. This failure has the potential to affect all 61 residents in the facility. Findings include: Facility census provided by V1 (Administrator) showed 61 residents in the facility. On 9/14/20 at 10:45 AM, V3 (LPN) and V4 (RN) were observed sitting at the nursing station. Surveyor asked both nurses which residents they took care of on the floor, both V3 and V4 responded, "We take care of all of them." Surveyor asked the number of residents currently on isolation to prevent Covid-19 spread. V3 stated, "We only have one right now but she is put on isolation for PUI (patients under investigation) because she came from the hospital." V4 pointed down the hallway to show surveyor the room where R2 resided which was behind a plastic curtain with a zipper in the center for staff to enter. Asked if (R2) was tested for Covid-19 and what the results were, V3 stated, "I do not know." On 9/14/20 at 11:05 AM, V5 (Restorative nurse) was observed exiting R2's isolation room and with V4 who was seen unzipping the plastic curtain to let both V5 who accompanied her out from the isolation hall. Surveyor asked both V4 and V5 to accompany the surveyor back to see R2. V4 stated when asked about PPE, "The PPE is located right outside R2's door. We are supposed to first wash and disinfect our hands, put on a gown, then glove and wear a mask each time we	F 880	I. Corrective Action for R3: R3 was on a 14 day observation following hospital readmission. Resident was monitored for covid symptoms twice per shift and none were noted . Isolation garbage can was placed in R3's room. All nursing staff have been re educated and demonstrate competency in using PPE correctly to prevent transmission. II. Identify other residents : Audit all observation, PUI, and covid unit residents and notified all departments and nursing staff daily and every shift of PPE I.C.requirements . All covid negative residents are tested weekly. All hospital readmissions are quarantined and kept under observation for 14 days. III. Measures to ensure the problem will be corrected and will not recur : 1. Conduct a Directed Inservice on facility's covid infection control policy and procedures ; focusing on the appropriate use of PPE to prevent the spread of potential communicable diseases. This will be accomplished using the CDC you tube video published 4/27/20 of 12 minutes and one second as an online resource for training. This link has been sent to all nursing staff , and department heads beginning 10/02/2020 . 2.DON conducted in person directed inservices focusing on appropriate use of PPE to prevent covid transmission, such as on correct mask useage technique and emphasizing and correcting specific staff errors and misconceptions to prevent	

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F 880	Continued From page 13 enter R2's room. When we leave R2's room we are supposed to take off all our PPE and throw them out in the garbage in R2's bathroom." Surveyor asked V5 the same question, V5 stated, "Yes that's what we do and I did that when I saw R2." Surveyor asked if there were any specific isolation bins PPE's were discarded as there were none present in the room, V4 stated, "No they go into the plain waste basket in the bathroom." Surveyor asked if she took off her full PPE as she was not seen with any when exiting the plastic curtain in the hall, V5 stated, "I threw them out in the bathroom." Surveyor then entered the room to view where V5 claimed she disposed of the PPE when caring for R2 but there were no used PPE's in the bathroom waste can or the other waste can next to the door. Surveyor interviewed R2 at 11:15 AM and asked if V5 just came in to care for her and if she was wearing full PPE, R2 stated, "She was not wearing a gown but she is supposed to. They never wear a gown when they see me. Are they supposed to do that?" Records show R2 readmitted from the hospital on 9/4/20 with diagnoses of acute kidney failure, renal disorder, anemia, bilateral upper and lower extremity edema, and pressure sore on her coccyx area. Per nursing notes, R2 is alert and oriented times 3-4, 14 day isolation until 9/18/20 to monitor for COVID-19. On 9/15/20 at 9:35 AM, V3 (LPN) was seated at the nursing station on the phone with her mask worn below her nose and with several residents seated immediately in front of her asleep in their recliner. Upon noticing the surveyor approach the	F 880	future noncompliance. 3. Housekeeping Director conducted Spanish and English inservice on appropriate PPE, focusing on PPE doffing sequencing to prevent transmission, using CDC doffing sequence poster in English/ Spanish. 4. Dietary staff have been inserviced on PPE use in the kitchen. Dietary staff dishwashers were provided with visors in addition to masks and were inserviced to use them if unavoidable to stand within 6 feet of a coworker in addition to facial mask. 5. Conduct a root cause analysis (RCA) with assistance from the infection preventionist, QAPI committee and governing body. The RCA will be incorporated into the intervention plan . 6. The interdisciplinary team will review the facility's infection control policy and procedure to ensure compliance with CMS/IDPH guidance on covid.This is accomplished using the weekly IDPH sponsored "Covid 19 updates and Q&A for long term care and congregate residential settings" live webinar, recording, or slides, to keep abreast of updates in guidance. 7. Administrator will develop or obtain a QAPI tool to monitor for compliance,which was downloaded from Telligen QI resources.	

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F 880	Continued From page 14 nursing station, V3 put back her mask over her nose. Asked about the mask V3 stated, "I know I put it down to talk on phone." On 9/15/20 at 9:45 AM V10 (c.n.a.) accompanied surveyor to R2's isolation room. V10 stated, "I have not seen her yet this morning but she is my resident today. I know the nurse (V4) saw her. " Surveyor asked V10 to check the two large isolation bins that were present in the room today but were not present the previous day. Both isolation bins were empty of any used PPE's of any staff who may have come in to the isolation room. V3 (LPN) and V11(RN) were asked who was taking care of R2 today. V3 and V11 both responded "We both do." Surveyor asked who came in to provide care for R2 this morning, V3 responded we both did. Asked if both wore PPE's when entering her room, V3 and V11 stated, "We have to wear full PPE and we take them off and throw them in the isolation bin before we leave and we did that this morning before you got here. Surveyor asked who cleans the rooms and empties the trash bins, V3 stated, "That is housekeeping." On 9/15/20 at 10:00 AM, V8 (housekeeper) was interviewed, "I clean the rooms and empty the waste baskets. I have not gone into (R2)'s room yet because I do her last at the end of my shift because she is isolation. I throw out the isolation garbage and replace the liners at end of my shift." Facility policy dated 3/9/20 titled, "Covid-19 Policy & Procedure" states, "Purpose: To reduce the risk of transmission of the Coronavirus Disease in this healthcare setting. Responsibility: Physicians, Physician assistants, nurse practitioners, facility staff, students and volunteers will assess	F 880	8. DON or designee will audit the Quality Improvement Data Collection Form for completion weekly until the covid pandemic has ended. 9. DON or designee will report the results of the audits with the facility IDT during the weekly QAPI meetings while the pandemic is present. Methods for improvement and overall performance will be discussed by the team to ahieve improved results. 10. Facility infection control committee will post reminder infection control PPE posters at the entrance and exit of each and every resident door reminding staff to use appropriate PPE for each resident , in a HIPPA compliant manner. 11. A daily and q shift huddle with all nursing staff reporting isolation rooms and residents and reminding staff of appropriate PPE use to prevent transmission to reinforce infection prevention and PPE policies and procedures. 12. Add additional compliance audit monitors by educating each charge nurse on three shifts on data collection and reporting forms to increase the frequency and thoroughness of compliance monitoring . Conduct compliance monitoring on each shift and each unit. IV. QAPI plans to assure that corrections are achieved and permanent:	

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F 880	Continued From page 15 situations and implement Standard and Transmission-Based Precautions to break the chain of infections. Policy: The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of Covid-19. Ensure adherence to standard, contact and droplet precautions. A.) Perform hygiene before and after all resident contact and before donning and upon removal of PPE, including gloves. B.) Use personal protective equipment appropriately. Don mask: ensure bands are secured behind ears and fit snug to cover nose and below chin.	F 880	Weekly compliance monitoring of all staff to ensure that the problem will be corrected and will not recur, and that infection prevention and PPE policies and procedures are performed at all times will be conducted by administrator or designee using Telligen QI tools that will obtain measurable data to monitor progress over time . Compliance audits will be conducted with both overt and covert"ghost/ blind" compliance assessors to enhance compliance monitoring. Weekly reporting to QAPI Committee of compliance audits results , with non compliance and corrections discussed and any changes to the compliance auditing system adapted and will be made to policy to assure that corrections are achieved and permanent . V. Date of Completion: October 9th, 2020	