STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495390	A. BUILDING _____ B. WING _____	C 11/13/2020

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BIRMINGHAM GREEN	8605 CENTREVILLE ROAD MANASSAS, VA 20110

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 11/09/20 and continued with offsite review on 11/10/20 and 11/12/20 through 11/13/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey and complaint survey was conducted onsite 11/09/20 and continued with offsite review on 11/10/20 and 11/12/20 through 11/13/20. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. One complaint was investigated during the survey. The census in this 180 certified bed facility was 131 at the time of survey. Ninety-eight residents had tested positive for COVID-19, thirty-five had died from COVID-19 and sixty-three had recovered. Fifty-five employees had tested positive for COVID-19 and fifty-three had recovered at the time of survey.	F 000		
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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		12/26/20

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

Electronically Signed | 12/11/2020

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F 689	Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Based on information obtained during a complaint investigation, staff interviews, clinical record review, review of facility documents, and review of the facility's policies, the facility staff failed to provide the required supervision and institute interventions to prevent falls resulting in a right hip fracture (8/12/20) and a right humerus fracture (9/20/20) for 1 of 7 residents (Resident #4) in the survey sample resulting in harm; and failed to provide adequate supervision to prevent an unwitnessed exit from the facility for 1 of 7 residents (Resident #5) in the survey sample. The findings included: 1. Resident #4 was admitted to the facility 11/26/14. The resident was discharged to an acute care facility after a fall with injury on 8/12/20 and returned on 8/15/20 and discharged to an acute care facility after a fall with injury on 9/20/20 and returned to the nursing facility on 9/22/20. Resident #4's diagnoses included renal insufficiency, dementia with behavioral disturbances, and an anxiety disorder. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/15/20, coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired daily decision making abilities. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, locomotion on the unit, dressing, toileting	F 689	The submission of the Plan of Correction does not constitute agreement on the part of Birmingham Green that the deficiencies cited within the report represent deficient practices on the part of Birmingham Green. This plan represents the facility□s ongoing pledge to provide quality care that is rendered in accordance with all regulatory requirements. The Plan of Correction shall serve as our allegation of compliance. Birmingham Green utilized Health Quality Innovation Network (HQIN) resources (Program Manager support & webinars) in preparing the Plan of Correction. A1. The investigation findings/interviews from the 8/12 and 9/20 falls were reviewed again including the recommended actions to minimize reoccurrence. Interventions based on environmental and causal factors were added to the care plan of Resident #4. Interventions based on environmental and causal factors were added to the care plan on 11/9/20, 11/10/20, 11/18/20, & 11/20/20. Resident #4 has had no falls since 11/8/20. A2. Resident #5 had wander guard applied on 9/20/20 and initiation of increased observation by 30 minute checks around the clock on 9/20/20. Resident continues on 30 minute checks while awake and are documented. Care plan was revised/updated on 9/20/20 to	

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F 689	Continued From page 2 personal hygiene and walking off the unit, limited assistance of one person with transfers and walking on the unit, and total care of one person with bathing. The clinical record revealed a nurse's note on 8/12/20 which stated the resident had a fall in her room. An incident report revealed on 8/12/20, at 9:25 a.m., a certified nursing assistant (CNA) called the nurse to the Resident #4's room for the resident had experienced an unwitnessed fall. The report further stated upon the nurse's arrival to the room the resident was observed sitting on the floor leaning on the right hip with her back against the side of the roommate's bed. The call bell was in the resident's hand but it had not been activated. Prior to the fall the resident had been observed sitting in a stationary chair watching television. At 9:27 a.m. the nurse manager and nurse supervisor were called and after assessing the resident the nurse manager stated to keep the resident on the floor and call 911. On 11/13/20, at 8:40 a.m., an interview was conducted with the certified nursing assistant (CNA) who first observed Resident #4 on the floor on 8/12/20. CNA #6 stated he heard someone screaming for help when he was in another room assisting a resident. CNA #6 stated he followed the calling out which led him to Resident #4's room. CNA #6 stated he thinks the resident was wearing a gown, the resident had no shoes or socks on, doesn't recall a call bell or walker nearby. He stated "I can't fully recall details" then the nurse was notified. An interview was conducted with the Licensed	F 689	include current interventions to address the recent exit. Resident has had no further incidents of unsafe wandering or elopement. B1. An audit of resident falls with injury for the period 8/1/20 through 12/7/20 began on 11/17/20 to determine the investigations were thorough and care plans were updated appropriately. All identified issues will be corrected as needed. Care Plan interventions will be updated in the Kardex and task bar for direct caregivers. B2. An audit of residents who were assessed as a high risk for elopement was completed on 11/11/20. Residents who scored high risk, ambulatory, and wander guard issued their pictures and profile were updated in the elopement book located at the front desk and each unit. The care plans were reviewed for appropriate interventions in place. For those residents who scored high risk though no wander guard issued, a note was placed in the EMR indicating the rationale why no wander guard was in place. C1. Education on conducting a thorough investigation and sustaining a culture of safety that is responsive to residents risks and needs began on 12/7/20 by the long term care consulting group for nursing, social services, and administrative management. In services	

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F 689	Continued From page 3 Practical Nurse (LPN) #2 on 11/13/20 at approximately 8:50 a.m. LPN #2 stated she was the nurse assigned to Resident #4 on 8/12/20 and she had worked with resident many years. LPN #2 stated the resident was confused related to progressive dementia, exhibited impulsiveness and thought herself to be more independent than she was as evidenced by attempting to to walk without the walker and not asking for assistance. LPN #2 also stated the resident had a very unsteady gait and sometimes stated when she wanted to toilet that she was going home. LPN #2 further stated she didn't document certain required information on the report but she believes the resident was fully dressed and her brown moccasins were still on her feet. The room was bright, nothing was on the floor, the tray wasn't present and she had no recall of the walker. LPN #2 stated no one addressed details surrounding the fall with her after the report was completed therefore she didn't realize how important it was to fully describe the fall scene so the information could aid in developing interventions for fall prevention. LPN #2 stated the intervention she felt most appropriate for the resident upon return to the facility was to bring the resident out of her room to the dining area during awake hours so more staff could assist in monitoring her. Fall Risk Assessments were completed after each fall and each assessment indicated the risk for falls had increased. On 8/15/20 the score was 16, 9/20/20 the score was 19 and 9/22/20 the score was 25. Review of Resident #4's care plan revealed upon readmission to the facility on 8/15/20, she had a right hip fracture and the surgical site was held	F 689	on fall prevention and purposeful rounding for more supervision began on 12/10/20 and will continue to nurses, supervisors, managers, and all departments on all shifts by learning & development, nursing leadership and administration. Education by the interim Director of Nurses to the unit managers will be conducted on care plan interventions and updating Kardex & task assignments. C2. The elopement binders were updated on each unit and reception area on 11/11/20. Education was provided on 11/12/20 to nursing staff in regards to screening of high risk residents for elopement. Education on Code Green (Elopement) policy began on 11/30/20 with reception staff, nursing leadership, and staff and is ongoing across all shifts and departments by administrator and learning & development. Learning & Development will review Code Green with each new employee upon hire. Elopement binders are updated with any changes to resident elopement status. D1. Supervisors and Managers will conduct observational audits for supervision and to ensure that care plan interventions are being carried out across all shifts for three residents per day for 12 weeks. If variances are identified, involved staff will be immediately re-educated and corrections/action taken appropriate to the situation. We will record our findings for 12 weeks and corrections will be made as appropriate. Summary of audit findings	

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F 689	Continued From page 4 together with 36 staples. The only intervention added to the fall risk care plan was two people assistance with transfers (this was the assistance required since the right hip was fractured). The intervention to have the resident present in the dining area during awake hours wasn't added to the care plan as an intervention. Another incident report dated 9/20/20, revealed CNA #2 stated the resident was asleep in bed between 7:00 a.m. and 7:30 a.m., and at approximately 7:35 a.m., she heard someone calling for help and upon entering Resident #4's room the resident was observed on the floor with urine and feces also on the floor. The report further stated LPN #1 arrived to Resident #4's room at approximately 7:39 a.m., to find the resident lying on the floor beside her bed, on her right side, moaning in pain and holding her right shoulder. The report stated the resident was attempting to self-transfer from the bed and didn't use the call light to get help. A local hospital report dated 9/20/20, revealed Resident #4 suffered a closed right humerus fracture. A physician's progress note dated 9/28/20, revealed upon Resident #4's readmission to the facility on 9/22/20, the resident suffered a closed fractured of the right humerus which was being treated with a Wera sling and a narcotic for pain with an orthopedic consult. An interview was conducted with LPN #1 on 11/13/20, at approximately 9:49 a.m., regarding Resident #4's 9/20/20 fall. LPN #1 stated the resident's bed was dry and clean, she was lying on her right side, and she believes the resident	F 689	and corrections will be reviewed through monthly QAPI Committee for further recommendations as needed. D2. Nursing Leadership and Administration will review the elopement book weekly for 12 weeks. Code Green drills will occur monthly for 3 months across all shifts. We will audit and record our findings for 12 weeks and corrections will be made as appropriate. Summary of audit findings and corrections will be reviewed through monthly QAPI Committee for further recommendations as needed. If there are any variances to the desired performance during a Code Green drill the involved staff will be immediately re-educated and corrections/action taken as appropriate to the situation. E1. Date of completion □ 12/26/20 E2. Date of completion □ 12/26/20	

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was wearing a gown and socks, and was stating "get me up". LPN #1 further stated the resident bed was wasn't all the way to the floor and she didn't recall if side rails were present. LP #1 stated she didn't add all the above information to the report because she didn't realize it was important to describe the fall scene and she didn't recall anyone requesting additional information about the fall scene.

An interview was conducted with CNA #2 on 11/13/20, at approximately 10:00 a.m., about Resident #4's 9/20/20 fall. CNA #2 stated she was assigned to provide care for Resident #4 on 9/20/20. CNA #2 stated they were told if the resident wasn't awake on rounds don't awake her therefore she didn't get the resident out of bed during rounds between 7:00 a.m. and 7:30 a.m. CNA #2 also stated if Resident #4 was awake they should toilet her, provide a.m. care. CNA #2 further stated she provided frequent rounds on the resident because the resident thinks she can walk independently and constantly tries to get up unassisted. CNA #2 stated since the right arm fracture the resident goes to the dining room after a.m. care until after lunch, then she goes to bed for an afternoon nap. CNA #2 also stated Resident #4 was on every thirty minute checks for a while after the two fractures.

Review of Resident #4's care plan dated 9/29/20 revealed the following problem; At risk for injury from falls related to impaired cognition with poor safety awareness, use of psychotropic medications, arthritis and a history of falls. Resident refuses to allow staff to place gait belt when assisting her with ambulation. (name of resident) has a shuffling gait and tends to walk with her head looking downwards. The goal read;

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(name of resident) safety will be maintained as evidenced by having no significant injuries from falls this review. The interventions added after the second fracture to aid in fall preventions included; 9/24/20 use of a perimeter mattress, 10/15/20 low bed with fall mats.

Review of the clinical record revealed on 11/8/20, at approximately 2:25 p.m., Resident #4 was observed by the floor technician in the dining room, with no staff present. The resident slid from the wheel chair to the floor. The resident stated "I pooped. I have to go to the toilet". Upon toileting the resident eliminated some urine and a soft formed stool. No injuries were sustained. The intervention was to place the resident in the dining room in visual sight of staff.

An interview was conducted with the Floor Technician on 11/13/20, at approximately 10:13 a.m., the Floor Technician stated two nursing staff members were in the nursing station but no one was in the dining room with the residents when Resident #4 slid from the wheel chair on 11/8/20. The Floor Technician stated he informed the staff the resident was on the floor and needed help.

The facility was unable to provide "At Risk" meeting notes or other documentation the Interdisciplinary Team had reviewed Resident #4's two falls resulting in fractures or developed strategies/interventions to aid in decreasing opportunities for future falls. An At Risk" meeting note dated 11/9/20, was provided for review of the 11/8/20, fall.

The Fall investigation forms and the Fall Risk assessments information wasn't thorough enough to determine causative factors of the falls, trends

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or patterns and drive creative preventive measure to add to the care plan when the Interdisciplinary Team reviewed the falls.

The Fall Prevention and Management Program policy dated 10/5/15, stated the policy was to provide a comprehensive, consistent approach to assess residents at risk for falls and to implement interventions to reduce risk for recurrence and injury. #2 stated the Individual Service Plan is to contain a review and revision related to the causative factors and preventive measures. #7 stated the fall investigation form will be utilized in reviewing and revising the resident's Individual Service Plan to minimize the recurrence of falls or injury. #9 stated the Director of Nursing will review the incident report and fall investigation form and follow up on suggestions and or interventions implemented and ensure the care plan had been updated and communicated to the Interdisciplinary Team. #14 stated the Director of Nursing will assure that the recommended measures are put into place and the Individual Service Plan is updated to reflect the changes.

The above information was shared with the Administrator, the Assistant Administrator, the Director of Nursing and the Unit Manager on 8/13/20 at 2:00 p.m. The Unit Manager stated that prior to the 8/12/20, fall the resident had not had falls and she thought new interventions had been instituted after that fall to prevent future falls but she was unable to locate where on the care plan they were incorporated, neither could any facility's staff provide what information had been given to the direct care staff to aid in preventing future falls with injury.

2. Resident #5 was admitted to the facility

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5/18/17, discharged with return anticipated 7/1/19, and returned to the facility on 7/4/19. Resident #5's diagnoses included dementia with behavioral disturbances and an anxiety disorder.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 9/30/20, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #5's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision after se-up with transfers, walking on/off the unit, locomotion and eating, limited assistance of one person with bed mobility, toileting, and personal hygiene, extensive assistance of one person with bathing.

A nurse's note dated 9/20/20 stated Resident #5 exited the front door of the facility by herself for approximately 15 minutes per the receptionist and came back in by herself. A full body assessment was completed, no apparent injuries were noted. No complaint of pain. Physician and Responsible Party made aware. A wanderguard was applied to the resident's left lower leg. The Physician ordered every thirty minute checks for safety.

The resident's 7/14/20 wander risk assessment revealed a score of 13 which indicated the resident was at high risk. The assessment further revealed the resident was ambulatory, had a history of wandering, and a medical diagnosis of dementia.

An interview was conducted with CNA #1 on 11/10/20 at approximately 5:28 p.m. CNA #1

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stated on 9/20/20, Resident #1 received a meal from her family between 4:00 p.m. and 5:00 p.m., at the front desk and it was picked up from the front desk and delivered to the resident. CNA #1 stated the resident came to the desk to ask who brought the food to her and she stated her daughter but she was gone and the resident turned and walked away towards her room. CNA #1 further stated the resident enjoys reading, music talking on the phone and sleeping as well as sitting in the hallway near the bird cage. CNA #1 stated the bird cage wasn't actually on the unit but it was just outside the unit's doorway and in a frequently traveled area and the resident really enjoyed sitting in the area. CNA #1 wasn't aware of the resident wandering or having a history of exit seeking and she never noticed the resident wasn't on the unit.

A witness statement written 9/20/20 revealed CNA #8 went to Resident #5's room to let her call her daughter-in-law at approximately 4:40 p.m., but the resident wasn't in her usual area by the bird cage. CNA #8 wrote she checked the resident's room and bathroom but still was unable to locate the resident therefore the nurse supervisor was informed of the missing resident. CNA #8 further wrote she went to the front desk area to try and locate the resident and as she started to look outside the resident walked through the front door returning inside the facility.

An interview was conducted with the full time day shift front desk receptionist who stated she had worked in the position for three years. She there was only one resident who currently goes out to smoke with a staff member and stated no residents are allowed out the front door unattended. She further stated if a resident

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attempts to exit the facility unattended her roles would be to telephone nursing for assistance and attempt to get the resident to stay inside until the nursing staff arrives. The full time day shift front desk receptionist stated there had always been an elopement book at the front desk containing approximately 23-30 resident names and photographs and it is each receptionist duty to review the book daily and sign off that you have viewed the book and nursing staff are responsible for keeping the book updated.

An interview was conducted on 11/13/20 at approximately 11:00 a.m., with the front desk receptionist who was on duty when Resident #5 exited the door. The front desk receptionist stated he was fairly new to the long term care facility and he wasn't aware at the time the individual (Resident #5) who left the building was a resident and that known residents are not allowed to leave the building unescorted. The front desk receptionist stated he had training to the duties but he wasn't aware of an elopement book at the front desk, that residents were not allowed to exit the door unescorted and he didn't know until later the person he saw exit the door was Resident #5 and Resident #5 wasn't within his line of sight after she exited the door on 9/20/20. The front desk receptionist stated he made a mistake and accepted full responsibility for the the resident leaving the facility unescorted and since the education was provided he now knows the difference in his usual work environment and the long term care work environment.

The facility's investigation established that Resident #5's unescorted exit from the facility was simply a stroll outside to sit on a bench, while

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the resident waited to visit with her daughter-in-law, which was observed by the front desk receptionist.

A consultant's analysis dated 10/26/20, included Resident #5's exit from the building unescorted. The event was categorized as an elopement and/or unsupervised wandering and a note in the comments section stated "lets discuss what, why, resident outcome and action taken. The analysis also stated "the interim security guard let resident go outside" and the document stated the event was reported since the resident was on camera the entire time and the security guard was no longer employed.

A nurse's note was observed in Resident #5's clinical record dated 11/11/20 which stated a call had been placed to the resident's son to discuss the potential of moving the bird cage to the unit the resident resides on because the birds bring great comfort to the resident. The note further stated moving the bird cage to a low traffic area would increase the ability to monitor the whereabouts of the resident by the staff. The nurse's note stated the son was in full agreement with the potential of increased monitoring of the resident combined with one of her treasured activities.

On 11/13/20 at approximately 5:15 p.m., the evening shift front desk receptionist repetitively stated the Administrator the surveyors were attempting to make contact with wasn't listed on the extension list therefore calls were forwarded to the previous Administrator's voice mail. At that point an interview was conducted with the receptionist regarding allowing individuals to enter and leave the facility and if the elopement book

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	495390	A. BUILDING _____ B. WING _____	C 11/13/2020

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F 689	Continued From page 12 review was something she was familiar with. The evening shift front desk receptionist wasn't a regular employee of the long term care facility and the interview revealed she wasn't knowledgeable of identifying persons leaving the facility or how to determine if the person was a resident or what to do if a resident attempted to exit the front door. The above information was shared with the Administrator, the Assistant Administrator, the Director of Nursing and the Unit Manager on 11/13/20 at 5:00 p.m. The Assistant Administrator stated the resident sat on the bench in front of the building the entire time she was outside and remained within sight of the front desk receptionist. The Administrator provided a document which stated upon beginning the assignment at the facility 11/5/20, a review of the 9/20/20 event for (name of the resident) aided them to reconsider their protocol. It was determined that re-education on the elopement protocols with receptionist and security teams would be beneficial in addition to reconstruction of the elopement book and review of procedures was immediately performed. An additional measure was to trial moving the bird aviary on to the residential unit to engage Resident #5 in self-determined activities.	F 689		
F 880 SS=D	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	F 880		12/26/20

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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 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

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F 880	Continued From page 14 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 observations, staff interviews, clinical record review, and facility documentation review, the facility staff failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of a communicable disease (COVID-19) and other infectious diseases for 1 of 7 residents, Resident #1, in the survey sample. The findings included: The facility staff failed to ensure one resident wore a face covering for source control when leaving their room or around others according to CDC guidelines (1).	F 880	A. Resident #1 had no negative outcomes from not wearing the face covering from the room to the shower on 11/9/2020. On that occasion Resident #1 was immediately provided a face covering. Staff member involved was immediately re-educated and adequate supply was placed on the neighborhood. B. Observation rounds were completed on 11/9/2020 to determine that face coverings were being used for all residents out of the room. Sufficient supply of face coverings was noted on each neighborhood.	

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F 880	Continued From page 15 Resident #1 was originally admitted to the facility on 11/06/20 from the community. Resident #1's diagnoses included Unspecified Dementia without Behavior Disturbances and Chronic Kidney Disease. The Admission Assessment Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/13/20, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring a 99. This coded Resident #1 as having short-term and long-term memory problems. In section "G" (Physical functioning) the resident was coded as needing extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, eating, toileting and personal hygiene. Bathing required one person physical assistance. On 11/09/20 at approximately 1:20 p.m., an observation was made during the initial tour on the Garden Hill Unit (Observation Wing). Resident #1 was observed being transported by CNA (certified nursing assistant) #6 via wheelchair in the hallway near the nurse's station heading to the shower room. Resident #1 was not wearing a mask/facial covering. The door to the shower room remained opened as CNA #6 entered inside with Resident #1. The Unit Manager, (Registered Nurse-RN #1) standing nearby was asked what should have been done concerning the above issue. She stated, "Outside of rooms, residents should wear mask." In the meantime CNA #6 exited the shower room, proceeded down the hallway, entered a room, returned and approached the unit manager (who was now standing at the entrance of the shower room with the surveyor), saying "I can't find it." The nurse manager was observed removing an	F 880	C. Education began on 11/10/2020 to staff on proper PPE for residents out of the room. The inventory and distribution process for resident face coverings was reviewed with each unit on 11/18/2020. Par level and location of face coverings was established. Environmental Services replenishes face coverings daily on each neighborhood. D. Nursing Leadership and Administration will conduct observation rounds to communicate, audit, and reinforce compliance with appropriate resident PPE while out of the room. During the observation we will observe the daily replenishment of face coverings and appropriate resident PPE while out of the room. We will audit all shifts daily (five times per week) for 4 weeks and then all units daily (five times per week) for 8 weeks. Summary of audit findings will be submitted to monthly QAPI Committee for review and recommendations. E. Date of completion □ 12/26/20	

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item from the medication cart, handing it to CNA #6, who then entered the shower room where Resident #1 was waiting.

An interview was conducted with CNA (Certified Nursing Assistant) #6 at approximately, 1:30 p.m., concerning the above issue. She stated, "I was so busy, I didn't notice that she wasn't wearing a mask."

An interview was conducted on 11/10/20 at 4:50 p.m., with CNA #7 concerning residents wearing facial coverings. CNA #7 stated, "They should wear a mask until they get in the shower and take it off."

An interview was conducted on 11/13/20 at 4:43 p.m., with the Unit Manager (Registered Nurse) #1 concerning the above issue. She stated, "I got a mask and CNA #6 put it on her." She was asked if Resident #1 resisted getting her mask put on. She stated, "No, her cloth mask was in the laundry. I got her a surgical mask." She was then asked if she had revised the Resident's Care Plan on 11/10/20 after the above issue occurred. She stated, "Yes."

Revised Careplan Interventions read: Provide resident with a mask when out of room as she will allow. Resistant at times to wearing a mask. Initiated on 11/10/20, Created on 11/10/20, Created by Unit Manager, Registered Nurse #1.

(1) Per CDC Guidance: Implement Source Control Measures
"...Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility..."

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F 880	Continued From page 17 https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html On 11/13/20 at 5:00 p.m., an exit interview was conducted via phone with the Interim Administrator, the DON (Director of Nursing), the Assistant Administrator, Infection Control Nurse and Corporate Officer. All of the above observations, interviews and concerns were shared with the Administration staff.	F 880		