STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345289	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CURRITUCK HEALTH & REHAB CENTER	**3907 CARATOKE HIGHWAY BARCO, NC 27917**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on observations, record review, staff interviews, and review of the Centers for Disease Control Prevention (CDC) guidelines for Responding to COVD-19 in Nursing Homes and facility's Infection Control policy the facility failed to implement CDC guidelines and their Infection Control policy when staff did not remove her isolation gown and gloves and perform hand hygiene, when she exited the facility's quarantine unit and failed to don new personal protective equipment (PPE) and perform hand hygiene when she reentered the quarantine unit and when she entered the room of a resident on enhanced droplet contact precautions for 1 of 1 staff (occupational therapy assistant #1) observed working on the facility's quarantine unit. This failure occurred during a COVID-19 pandemic. The findings included: The CDC guideline titled Responding to Coronavirus (COVID-19) in Nursing Homes and dated 7/15/2020 read in part: Removes gloves after contact with resident and/or surrounding environment using proper techniques to prevent hand contamination. Perform hand hygiene after removing gloves. Remove gown and perform hand hygiene before leaving the resident's environment. The facility's infection control policy dated March 2020, revealed staff were to perform hand hygiene and don gloves, isolation gown, eye protection and facemask when caring for residents on the quarantine unit. The policy specified, staff were to remove their gown and gloves and perform hand hygiene before leaving unit. On 9/30/2020 at 12:22 PM an interview was conducted with the MDS/Infection control nurse. The MDS/Infection control nurse stated the 100 Hall (where Resident #8 resided) was the facility's designated quarantine hallway and all residents that resided on this hallway were new admissions on quarantine for 14 days. On 9/30/2020 at 4:02 PM the occupational therapy assistant (COTA) #1 was observed on the facility's quarantine unit wearing an isolation gown and gloves. The COTA was observed to not remove her gown and gloves or perform hand hygiene when she exited the quarantine unit and went onto the facility's 300 Hall which was a general population unit. She was observed to use her right gloved hand to turn the door handle to open the door to the 300 hallway's supply closet to retrieve an item. On 09/30/20 at 4:04 PM COTA #1 was observed to reenter the facility's quarantine unit and then entered into Resident # 8's room while wearing the same isolation gown and gloves and not performing hand hygiene. There was enhanced droplet contact precaution signage on the door to Resident #8's room that specified perform hand hygiene, surgical mask when entering room, eye protection when entering room, and gloves when entering room. On 9/30/2020 at 4:05 PM an interview with COTA #1 revealed she had exited the quarantine unit and entered the facility's 300 hallway to get a pair of nonskid socks for Resident #8 to use while standing with therapy. On 9/30/2020 at 4:15 PM the MDS/Infection Control nurse stated that all staff were supposed to remove their gown and gloves and perform hand hygiene prior to leaving the quarantine unit. The MDS/Infection control nurse also stated staff were to perform hand hygiene and don a new gown and gloves prior to entering Resident #8's room. Resident #8 was recently admitted to the facility and was on enhanced droplet contact precautions. On 10/1/2020 at 2:20 PM an interview was conducted with COTA #1. The COTA stated Resident #8 did not have any clothes and therapy was working with the resident to assist with standing. Resident #8 was only able to stand with the assistance of the therapy and the therapy department was training staff on how to assist Resident #8. The COTA stated she was aware that she was not supposed to leave the quarantine unit with a gown and gloves on and needed to perform hand hygiene. The COTA stated she should have performed hand hygiene when she exited and reentered the quarantine unit and before entering the room of Resident #8, who was on enhanced droplet contact precautions. On 10/2/2020 at 3:26 PM an interview was conducted with the Administrator. The Administrator stated he expected that staff would don and doff personal protective equipment (PPE) and perform hand hygiene before leaving and entering the resident rooms and when entering and exiting the quarantine unit.

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.