STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345151	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITE OAK MANOR - KINGS MOUNTAIN	**716 SIPES STREET KINGS MOUNTAIN, NC 28086**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, staff interviews and review of the facility's Infection Control policies and procedures, the facility failed to implement their policy on hand hygiene when 1 of 1 Certified Occupational Therapy Assistant working on the isolation hall failed to wash her hands after discarding dirty linen and trash in the hallway bins prior to entering the clean linen room to obtain a clean washcloth and non-skid socks for resident use. This failure occurred during a COVID-19 pandemic. The findings included: A review of the facility's Infection Control Policies and Procedures revised on April 2020 indicated the following statements regarding Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: a. When hands are visibly soiled (hand washing with soap and water): before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice); b. Before and after assisting a resident with personal care (e.g., oral care, bathing); c. After handling soiled or used linens, dressings, bedpans, catheters and urinals; d. After removing gloves or aprons; A continuous observation was made on 07/08/20 from 10:12 AM to 10:16 AM of Certified Occupational Therapy Assistant (COTA) #1. COTA #1 was observed coming out of resident room [ROOM NUMBER] carrying a bag of dirty linen and a bag of trash without gloves on her hands. She proceeded down to the end of the hallway and discarded the dirty linen and the trash bag in the appropriate bins. COTA #1 then proceeded back up the hallway and went into the clean linen closet and obtained a clean washcloth and non-skid socks and proceeded back into room [ROOM NUMBER]. At 10:21 AM COTA #1 was observed coming back out of room [ROOM NUMBER] with gloves in hand and discarded them in the trash bin outside the resident's room. She proceeded down the hallway passing dispensers of hand sanitizer in the hallway and a sink with soap at the nurse's station and walked down the hallway and turned right onto the next hallway and entered the clean shower room and washed her hands in the shower room with soap and water. An interview on 07/08/20 at 10:25 with COTA #1 revealed she had received education on COVID-19 precautions and was told to wash her hands often and after handling any kind of dirty objects or materials. She stated she always wore her gloves when providing resident care but stated she should have washed her hands before obtaining clean linen for the resident after handling dirty linen and trash. An interview on 07/08/20 at 10:38 with the Assistant Director of Nursing (ADON) and the Administrator revealed COTA #1 should have washed her hands immediately after handling dirty linen and trash and certainly prior to entering the clean linen closet. The ADON stated although room [ROOM NUMBER] was not on precautions he was on the hallway with other residents, who were on enhanced infection control precautions. In addition, the ADON stated COTA #1 should have sanitized her hands or washed her hands after discarding her gloves in the trash bin prior to walking all the way down the hall to the shower room to wash them. According to the ADON and Administrator, COTA #1 could have gone back into the resident's room and washed her hands, sanitized them with hand sanitizer from the dispensers or washed her hands at the nurse's station rather than going all the way down the hall and into the shower room to wash her hands. They both stated COTA #1 should have knowledge of proper hand hygiene technique. The Administrator stated staff had been educated on proper handwashing and it was her expectation that all staff follow proper handwashing techniques while providing care to the residents.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.