STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345190	A. BUILDING _____ B. WING _____	**09/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MURPHY REHABILITATION & NURSING	**3992 EAST US HWY 64 ALT MURPHY, NC 28906**

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, staff interviews, record reviews, and review of the facility's infection control policies, the facility failed to implement their hand hygiene policy when staff 1. failed to perform hand hygiene when they entered and exited resident rooms, and before and after using a phone, 2. Staff also failed to clean and disinfect a telephone before and after use for 3 of 3 residents reviewed for infection control practices (Resident #1, #2, and #3). These failures occurred during a COVID-19 pandemic. The findings included: A review was completed of a facility policy titled, Hand Hygiene, and Environmental Infection Controls, revised July 2020. The policy specified an alcohol-based hand sanitizer to be used before and after resident contact and with objects in the immediate vicinity of the resident. All Non-dedicated, non-disposable medical equipment used for patient care must be cleaned and disinfected according to the manufacturer's instructions and between patient use. On 9/17/2020 at 10:00 AM interview with the Infection Control Nurse revealed the 300, hall was identified as a non-COVID-19 hallway. An observation was conducted on 09/17/2020 at 1:20 PM of Nurse Aide (NA) #1 in Resident #1's room after transporting the resident from the shower room. NA#1, while using the portable phone with her right hand and touching the resident's hair, back and wheelchair with her left hand and without the use of gloves, switched the portable phone from her right hand to her left hand and continued using the portable phone while she walked out of the room and replaced the phone back in to the wall mounted charging cradle next to room [ROOM NUMBER]. NA#1 did not wash her hands or use the available hand sanitizer after leaving the residents room, nor, clean and disinfect the portable phone prior to and after use. NA#1 then proceeded to Resident #2's room where she used the available hand sanitizer before entering the room. There was a container of cleaning disinfectant wipes on the laundry cart by the phones, while hand sanitizer dispensers were observed mounted on the walls on both sides of the 300 hallway. An interviewed was conducted on 9/17/2020 at 1:20 PM of NA#1 revealed she was uncertain she received training of the cleaning and disinfecting the phones prior to and after use. NA #1 revealed she had received recent COVID-19 pandemic training and was instructed to wash or sanitize her hands when entering and exiting each resident's room. NA #1 stated she forgot to disinfect the phone prior to and after using it in room [ROOM NUMBER] and confirmed she did not perform hand hygiene before entering the resident's room in #312. An observation was conducted on 09/17/2020 at 1:25 PM of NA #2 in the 300 Unit delivering meal trays to residents in their rooms. NA#2 was observed answering the landline phone located on the wall by room [ROOM NUMBER], without cleaning and disinfecting the phone prior to or after using the phone. NA#2 also did not perform hand hygiene prior to and after using the phone. NA#2 was summoned Resident # 2's room by NA #1 to help in repositioning Resident #2. NA#2 entered the room without washing her hands or using hand sanitizer and did not perform hand hygiene prior to repositioning Resident #2. NA#2 used hand sanitizer after leaving the room before returning to delivering meal trays. NA#1 used hand sanitizer after leaving room Resident #2's room. A container of cleaning disinfectant wipes was observed on a laundry cart by the phone used by NA#2, while hand sanitizer dispensers were observed mounted on the walls on both sides of the 300 hallway. An interview was conducted on 9/17/2020 at 2:00 PM with NA#2. NA#2 stated she was uncertain she received training on the cleaning and disinfecting the phones prior to and after use. NA #2 revealed she had received recent COVID-19 pandemic training and was instructed to wash or sanitize her hands when entering and exiting each resident's room. NA#2 stated she forgot to disinfect the phone prior to and after answering the phone and confirmed she did not perform hand hygiene before entering room [ROOM NUMBER] to assist Resident#2. An observation on 9/17/2020 at 1:28 PM revealed Nurse #1 entered the 300 Unit and immediately used hand sanitizer before walking down the hallway. Nurse#1 answered the landline phone located on the wall by room [ROOM NUMBER], and then replaced the phone back onto the wall mounted cradle without cleaning and disinfecting prior to or after using the phone. Nurse #1 then proceeded to walk into Resident #3's room without performing hand hygiene to assist Resident #3 and handed Resident#3 her private cell phone. Nurse#1 exited the room and used hand sanitizer before entering the Alzheimer's Unit. Observation on 9/17/2020 at 1:30 PM revealed a container of unopened disinfecting wipes, was on the laundry cart by the phone used by Nurse#1. Interview was conducted on 9/17/2020 at 1:40 PM with Nurse#1. Nurse #1 revealed she was uncertain she received training on the cleaning and disinfecting the phones prior to and after use. Nurse#1 revealed she had received recent COVID-19 pandemic training and was educated to wash and sanitize her hands when entering and exiting each resident's room. Nurse#1 stated she forgot to disinfect the phone prior to and after answering it and confirmed she did not perform hand hygiene before entering Resident #3's room to assist Resident #3 with her private cell phone. Interview was conducted on 09/17/2020 at 1:40 PM, with the Infection Control Nurse (ICN), who stated all staff had been educated to perform hand hygiene when entering and exiting a resident's room. ICN confirmed she provided in-servicing and COVID-19 training to all staff, including hand hygiene and cleaning and disinfecting the phone equipment prior to and after phone usage. ICN provided staff signed logs confirming staff received this training. The ICN confirmed staff were to use disinfecting wipes for disinfecting the phone and multi-use equipment.

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