| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345552 | A. BUILDING _____ B. WING _____ | 09/30/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| THE SHANNON GRAY REHABILITATION & RECOVERY CENTER | 2005 SHANNON GRAY COURT JAMESTOWN, NC 27282 |

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) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, record review, review of enhanced droplet/contact precautions policy, preparing for COVID-19 in nursing homes policy and What to do when COVID-19 gets into your long term care facility policy, staff interview and physician interview, the facility failed to implement their policies and procedures when 1 of 3 staff members (nursing assistant (NA) #1) who worked with residents who were on enhanced droplet/contact precautions, was observed not wearing PPE including; gloves or gown and not performing hand hygiene when entering and exiting the residents room. These failures occurred during the COVID19 pandemic. Findings included: The document titled What to do when COVID-19 gets into your long term care facility dated 3-26-20 was reviewed and revealed in part; consider having health care providers wear all recommended PPE to include gown, gloves, eye protection and face mask for the care of all residents regardless of presence of symptoms. The document titled preparing for COVID-19 in nursing homes dated 3-28-20 revealed in part under the sub-heading create a plan for managing new admissions and readmissions whose COVID-19 status is unknown; Health care providers should wear face mask, eye protection, gloves and a gown when caring for these residents. Review of the facility's enhanced droplet/contact precautions policy and procedure dated August 2020 revealed in part; Hand hygiene shall be performed before and after any direct contact with a patient or patient equipment, before contact with the next patient and before leaving the patient room. A face mask shall be worn when providing care to a patient, gloves should be worn before entering a patient room and removed before leaving the patient room, gowns are worn before entering the patient room and removed before leaving the patient room. During an interview with the Administrator on 9-29-20 at 10:38am, the Administrator discussed the facility not having any positive cases of COVID19. He stated the facility did have a quarantine unit for new admissions and residents returning from the hospital on hall 400. He further explained each resident on hall 400 were on enhanced droplet/contact precautions. Observation of the quarantine hall occurred on 9-29-20 at 1:30pm. The observation revealed 13 residents were present and located in separate rooms. Each room was observed to have an enhanced droplet/contact precaution sign posted on the door frame. There were isolation carts located outside of each resident room that contained gowns, gloves and goggles/face shield. Hand sanitizing dispensers were also observed spaced out between the resident rooms. NA #1 was observed on 9-29-20 between 1:35pm and 1:45pm. NA #1 was noted to be feeding Resident #4 on the quarantine hall without donning a gown or gloves. The NA was observed leaving Resident #4's room without performing hand hygiene and returned the resident's lunch tray to the food cart, then, walked into Resident #5's room without performing hand hygiene, touched items on the resident food tray without gloves, walked out of the resident room without performing hand hygiene and brought the residents food tray to the food cart then proceeded into Resident #6's room without performing hand hygiene, touched items on the residents food tray without gloves, walked out of the residents room without performing hand hygiene and brought the resident's lunch tray to the food cart. An interview with NA #1 occurred on 9-29-20 at 2:13pm. NA #1 stated she had received education on hand hygiene, enhanced droplet/contact precautions and the use of proper PPE. She confirmed she had not performed hand hygiene before or after contact with a resident. The NA said, I just forgot to sanitize my hands between each room, but I should have. She also confirmed she had not been wearing a gown or gloves while feeding a resident and she stated she did not know she needed to wear a gown and gloves when she was feeding a resident. The NA acknowledged the residents she was in contact with were on enhanced droplet/contact precautions. During an interview with the Administrator on 9-29-20 at 2:26pm, the Administrator stated all staff had been educated on the use of PPE, enhanced droplet/contact precautions and infection control. He further discussed the facility would provide further education. The Infection Control Preventionist (ICP) was interviewed on 9-29-20 at 3:16pm. The ICP stated NA #1 was a new employee and had received training in orientation related to infection control, enhanced droplet/contact precautions, hand hygiene and COVID19. She discussed the quarantine unit being a 14-day isolation unit for new admissions or residents returning from the hospital. She further discussed the expectation on the quarantine unit was for staff to wear full PPE every time they enter a resident room. The ICP explained she provided education to the staff weekly regarding different topics of infection control measures, hand hygiene, enhanced droplet/contact precautions and COVID19. The facility physician was interviewed on 9-30-20 at 9:49am by telephone. The physician stated the facility had discussed the issue of the NA not using PPE and proper hand hygiene. He discussed he did not know what happened because staff was educated weekly but felt the situation was concerning. He further commented that there was a chance of cross contamination if one of the quarantine residents would become positive. |

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.