STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING _____ B. WING _____	**06/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRODIGY TRANSITIONAL REHAB	**911 WESTERN BOULEVARD TARBORO, NC 27886**

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 review, staff, nurse practitioner and physician interviews the facility failed to perform hand hygiene after removing soiled gloves and failed to change gloves and perform hand hygiene between the care of the buttocks wounds and lower leg wound on a resident with multiple wounds for 1 of 3 residents (Resident #2) reviewed for pressure ulcer care. Findings included: On 06/09/2020 at 10:00 AM wound care was observed for Resident #2. The facility treatment nurse performed hand hygiene and applied clean gloves prior to assisting Resident #2 turn onto his side. Resident #2 was observed to be incontinent of a large bowel movement (BM). The treatment nurse provided Resident #2 with incontinence care using wet wipes, removed Resident #2's soiled dressings from his left buttock wound, right buttock wound and left lower leg wound, then removed her soiled gloves and put on a clean pair of gloves without performing hand hygiene. The treatment nurse then cleaned Resident #2's left buttock wound with saline (saltwater) soaked gauze, discarded it, cleaned his right buttock wound with saline soaked gauze, discarded it and cleaned his left lower leg wound with saline soaked gauze and discarded it using her gloved fingers. She then applied a clean dressing to his left buttock wound, right buttock wound and left lower leg in that order. The treatment nurse was observed to use the same gloves for the entire procedure. Prior to exiting Resident #2's room, the treatment nurse removed and discarded her soiled gloves and washed her hands. In an interview with the treatment nurse on 06/09/2020 at 10:20 AM she stated she should have performed hand hygiene after incontinence care and removal of the soiled dressings before applying her clean gloves. She stated she should have been changed her gloves and performed hand hygiene between the care of Resident #2's buttocks wounds and leg wound to avoid cross contamination (introducing microorganisms (germs) present in the dirtier buttocks area into the cleaner lower leg wound). She stated this was to prevent infection. She stated she usually did these things but Resident #2 sometimes had back pain and she hadn't wanted him to be on his side too long. The treatment nurse went on to say she performed the daily wound treatment for [REDACTED]. She stated Resident #2 did not have any signs or symptoms of infection in his wounds and was not currently being treated for [REDACTED]. She stated the treatment nurse should have changed her gloves and performed hand hygiene between the care of Resident #2's buttocks wounds and his leg wound to avoid cross contamination of the wounds and prevent infection. On 06/09/2020 at 11:00 AM an interview with the assistant director of nursing (ADON) indicated he trained the Treatment Nurse for her position within the past year and would have expected her to perform hand hygiene after removing her soiled gloves before putting on clean ones. He stated the treatment nurse should have changed gloves and performed hand hygiene between the care of Resident #2's buttocks wounds and lower leg wound to avoid cross contamination of the wounds and prevent infection. On 06/09/2020 at 3:50 PM an interview with Resident #2's physician indicated the treatment nurse should have performed hand hygiene after removing her soiled gloves before putting on clean ones. He stated she also should have changed gloves and performed hand hygiene between care of Resident #2's buttocks wounds and leg wound to avoid cross contamination infection. He stated the buttocks wounds were in the same area and most likely contaminated with the same germs, however the lower leg wound was distant from these. He went on to say Resident #2's wounds were improving and were not currently infected. On 06/11/2020 at 9:00 AM an interview with the nurse practitioner (NP) indicated the treatment nurse should have performed hand hygiene after removing her soiled gloves before putting on clean ones. He went on to say she should have changed gloves and performed hand hygiene between the care of Resident #2's buttocks wounds and leg wound to avoid cross contamination of the wounds and prevent infection. He stated he last saw Resident #2's wounds on 06/05/2020, they were not infected and were improving. He indicated he would see Resident #2 today. The NP stated he had seen the treatment nurse's hand hygiene and infection control techniques many times during his weekly wound rounds and never had any concerns. He went on to say he felt the treatment nurse must have been nervous when observed by the surveyor and this caused her to make mistakes.

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