STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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, review of the facilities staff education logs and infection control documents, record reviews, and staff, physician, Health Department Emergency Management/Infection Control/Assistant Health Director, and Associate Director of North Carolina Statewide Prevention of Infection and Epidemiology interviews, the facility failed to ensure staff performed proper hand hygiene after contact with a resident and objects in the residents room for 2 of 2 residents (Resident #1, and #2), failed to ensure proper Personal Protective Equipment (PPE) were donned and doffed when entering and exiting a resident room with signage that indicated Contact Precautions for 2 of 2 residents (Resident #1 and #2) and failed to clean and sanitize multi-use lift equipment after use in a room with signage that indicated Contact Precautions for 1 of 1 resident (Resident #2). This occurred for 2 of 2 sampled residents. Findings included: An undated facility document titled Crisis Capacity Strategies for Gown per the CDC guidelines, which read in part that facilities may consider suspending the use of gowns for endemic multidrug resistant organisms (e.g.,[MEDICAL CONDITION], VRE, ESBL-producing organisms). It further reads isolation gowns may be used for extended periods by the same health care provider if interactions were made with residents with the same confirmed infectious disease, housed in the same location, and could only be considered when no additional co-infectious [DIAGNOSES REDACTED]. A current review of the CDC guidelines dated 06/08/2020 revealed a three step approach to gown conservation strategies. The three steps included conventional capacity, contingency capacity, and crisis capacity. Contingency capacity included shifting gown usage to cloth gowns or coveralls. Crisis capacity included extended use of isolation gowns, re-use of cloth gowns, and finally prioritizing the use of gowns with a possible suspension of gowns for endemic multidrug resistant organisms (e.g.[MEDICAL CONDITION], VRE, ESBL-producing organisms). According to a facility document titled Pandemic-Gloves and Handwashing dated 04/02/20 revealed staff were to remove gloves before leaving the resident ' s room and wash their hands immediately with an antimicrobial agent or a waterless antiseptic agent. A facility document titled Pandemic-Prevention of Person to Person Transmission dated 04/02/20 revealed staff were to wear a gown when entering a room if you anticipate you will have substantial contact with the resident, environmental surfaces, or items in the resident ' s room. It further indicated when common use equipment or items is avoidable, then adequately clean and disinfect them before use for another resident. 1. Resident #1 was readmitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. A review of the care plan dated 10/25/19 revealed Resident #1 was at risk for respiratory complications related to ventilator and [MEDICAL CONDITION] dependence. Review of an additional care plan dated 04/02/20 revealed Resident #2 was at risk for infection related to COVID-19. A lower respiratory culture dated 01/28/20 revealed Resident #1 to be positive with heavy growth for three isolated organisms that included Pseudomonas Aeruginosa, Providencia Stuartii, and Proteus Mirabillis. A quarterly Minimum Data Set ((MDS) dated [DATE] indicted Resident #1 had some moderate cognitive impairment and required extensive to total dependence of staff for all activities of daily living (ADL). care. A continuous observation was made on 06/04/20 at 10:58 AM to 11:06 AM revealed the call light was on outside the room and Nurse #1 entered the room of Resident #1. Signage was present on the outside of the door that indicated Contact Precautions and included illustrations of the use of a gown and gloves when in the room. She was not wearing a gown or gloves when she approached the bed and touched the side of the bed with her torso and the call light with her hand to turn it off. Respiratory suctioning was needed, and the nurse performed hand hygiene and left the room to notify the respiratory department. A respiratory therapist then entered the room and approached the bedside of Resident #1, assessed he required a suctioning treatment, and he provided respiratory suctioning from the [MEDICAL CONDITION]. He was observed leaving the bedside of Resident #1 and came around the curtain facing the exit door wearing a mask and gloves but no isolation gown. The Respiratory Therapist disposed of the used gloves in the trash receptacle and exited the door without completing proper hand hygiene which included washing his hands or using alcohol-based hand rub (ABHR) to sanitize his hands after care. An interview with Nurse #1 on 06/04/20 at 10:59 AM revealed she was the nurse for Resident #1 for day shift. Nurse #1 indicated she entered the room to see what Resident #1 needed because his call light was lit. She acknowledged Resident #1 had signage on the outside of his door which indicated Contact Precautions with illustrations of gown and glove usage when in the room and that PPE including gowns and gloves were available on the door of the room. She stated she never wore a gown in contact precaution rooms until she knew what the resident needed. An interview with Respiratory Therapist #1 (RT) was conducted on 06/04/2020 at 11:06 AM. The interview revealed RT #1 acknowledged he had provided respiratory suction to Resident #1. RT #1 indicated Resident #1 was on Contact Precautions which required a gown and gloves during care and that PPE which included gowns and gloves were available on the door. He stated he did not wear an isolation gown while providing care and had not performed hand hygiene during this observation. He stated he should have worn a gown and performed proper hand hygiene after providing suctioning care to Resident #1 and wasn't sure why he didn't on this date. An interview with the Unit Manager was conducted on 06/04/20 at 11:30 PM revealed she was responsible for supervision and part of the staff education for the nursing department. The Unit Manager indicated the facility initially had a shortage of PPE supplies in March 2020, but they were currently at a sufficient supply level and were using items as single use followed by its disposal. The Unit Manager indicated PPE which included gowns and gloves were supplied on the outside of Resident #1's room due to Contact Precautions. She stated staff had been educated to always wear masks when on duty, don and doff a gown and gloves when providing patient care in transmission-based precaution rooms and perform hand hygiene after removal of PPE. An interview with the Respiratory Therapy director was conducted on 06/04/20 at 12:00 PM via telephone. She stated her staff had received ongoing education on all transmission-based precautions, hand hygiene, and donning and doffing of PPE when providing resident care. She stated all respiratory therapy staff should wear gown, gloves, and a surgical mask when in the room with a resident on Contact Precautions. She further indicated the importance of performing hand hygiene both before and after patient care that included suctioning provided by respiratory therapy staff. An interview with the Director of Nursing (DON), Assistant Administrator, and Administrator was conducted on 06/04/20 at 12:20 PM revealed administrative staff had provided ongoing education on the use of PPE, hand hygiene, and transmission-based precautions. They collaboratively acknowledged multiple residents that included Resident #1 and 2 in the ventilator unit had signage on the outside of the resident room that reflected Contact Precautions with illustration of need for gown and gloves when in the room. The DON and Assistant Administrator collaboratively indicated they had been advised through the Health Department, State Health Lab, and the Centers for Disease Control and Prevention that staff were not required to wear gowns when entering a room and providing care to residents with signage indicating Contact Precautions. The Assistant Administrator indicated she had received supplies through the local health department and through the Federal Emergency Management Agency (FEMA) since the start of the pandemic. The DON and Assistant Administrator agreed there were enough PPE supplied including gloves and gowns on the doors of the rooms that indicated Contact Precautions during the survey and that proper hand hygiene should be performed. An interview with the(NAME)County Emergency Management Planner and Preparedness Coordinator on 06/05/20 at 03:19 PM revealed he had not been contacted and was unaware of a shortage of gowns at Valley Nursing Center during his weekly visits to deliver requested PPE since the start of the

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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	(continued... from page 1) COVID-19 pandemic. He further stated he was told they had enough gowns and had recently shared a portion of their extra supply with another local health care entity who had a desperate need. He revealed he had provided the facility with an Emergency Respiratory Protection Plan at the start of the pandemic, delivered PPE supplies almost weekly, but had not given any advice to Valley Nursing Center related to non-necessity to wear a gown in a Contact Precaution room because it was beyond his scope of practice. An interview with the(NAME)County Infection Control Nurse on 06/05/20 at 03:45 PM indicated she and the(NAME)County Assistant Health Director had contact with Valley Nursing Center during the pandemic but were unaware of any shortage of PPE including gowns at the facility. She further stated she had not advised the facility of acceptable practice being not to use a gown when providing care in a room that indicated Contact Precaution. She further stated it was important to perform proper hand hygiene and to use gown and gloves when in rooms that indicated Contact Precautions in order to decrease the risk for transmission of infection from one resident to another through contact with an individual or surfaces potentially contaminated in the room. An interview with the(NAME)County Assistant Health Director on 06/05/20 at 05:27 PM revealed she had contact with Valley Nursing Center during the pandemic and was unaware of a shortage of gowns in the facility. She stated she had not advised the facility that it was acceptable practice to not wear gowns in rooms that indicated Contact Precautions and it was a necessity to perform proper hand hygiene and use the appropriate PPE including gown and gloves in a room of residents that Contact Precautions signage. She stated she had made a site visit following a complaint related to infection control she had received around 04/07/20 and had sent a toolkit to the facility with strategies for PPE during the pandemic. A follow-up email from the(NAME)County Assistant Health Director on 06/05/20 at 05:35 PM revealed she had made a site visit following an infection control complaint with a patient in the ventilator unit at Valley Nursing Center and COVID-19 testing supplies were supplied at that time. An email attachment revealed a toolkit was emailed to the Assistant Administrator on 04/22/20 at 09:32 AM. The Long-Term Care toolkit included preparation of gown conservation/optimization during the pandemic that had been provided by the Deputy Director/Section Chief of Division of Public Health. An interview with the Physician on 06/08/20 at 10:29 AM revealed staff should wear proper PPE to include gown and gloves when providing patient care in rooms with signage indicating Contact Precautions. He further indicated he was unaware the facility had a shortage of isolation gowns and would follow-up. An interview with the Associate Director of the North Carolina Statewide Program for Infection Control and Epidemiology on 06/08/20 at 1:37 PM revealed proper hand hygiene should be performed and PPE including gowns and gloves should be worn when in rooms with signage that indicated Contact Precautions to decrease the risk of transmission-based illnesses. A follow-up interview was conducted with the Assistant Administrator on 06/09/20 at 08:09 AM. She revealed she felt the facility had a shortage of gowns to use in rooms with signage of Contact Precautions and then stated they had been denied on three occasions when she had made request for isolation gowns from Emergency Management. She stated she did not have records of any denials of PPE including isolation gowns. She further stated she had obtained her guidance that gowns were not necessary in rooms that indicated Contact Precautions from the CDC website. 2. Resident #2 was readmitted to the facility on [DATE] with current diagnoses that included chronic [MEDICAL CONDITION] with [MEDICAL CONDITION] or hypercapnia, [MEDICAL CONDITION], and dependence on a ventilator. A review of the care plan dated 11/19/19 for Resident #2 revealed she was at risk for complications related to ventilator and [MEDICAL CONDITION] dependence. Review of an additional care plans dated 04/01/20 revealed Resident #2 is at risk for infection and social isolation related to COVID-19. An Annual Minimum Data Set ((MDS) dated [DATE] revealed Resident #2 was cognitively intact and required extensive to total dependence of staff for bed mobility, transfer dressing, and hygiene. It further revealed no diagnoses of infection present. A review of a progress note written by the Nurse Practitioner dated 05/19/20 revealed Resident #2 had been febrile with a temperature reading greater than 99.0 and was placed on COVID-19 protocol for testing, but no lower respiratory culture was available in the electronic medical record during the record review. a. An observation was made on 06/04/20 at approximately 10:45 AM. The observation revealed an Assistant Activity Director carrying plastic bags with personal belongings down the hallway and enter the room of Resident #2 without applying any PPE that included a gown or gloves. Signage on the outside of the door of Resident #2's room indicated Contact Precautions and included illustrations of the use of gown and gloves when entering the room. After entering the room, she placed the plastic bags on a chair at the bedside of Resident #2. She began removing multiple items from the bag and showing them to the resident while the resident was in the bed. Items that were not requested by Resident #2 were placed back in the plastic bags and the remainder of the items she touched and put away in the room. She then performed hand hygiene and retrieved the plastic bags from Resident #2's chair and exited the room. An interview with the Assistant Activity Director was conducted on 06/04/20 at 10: 50 AM. The interview revealed she had delivered personal items purchased from outside the facility. She acknowledged the signage on the door of Resident #2's room indicated the room was on Contact Precautions. She indicated she was not aware she needed to wear a gown since she was not providing patient care. She confirmed she placed the plastic bags in Resident #2's chair, touch surfaces in the resident room, and placed unwanted items back in the bags and removed them from the room without wearing a gown. b. An observation was made on 06/04/20 beginning at 10:55 AM. The observation revealed two nursing aides (NAs) entered Resident #2's room. The signage on the door indicate Resident #2 was on Contact Precautions and the need for gown and gloves when in the room. NA #1 entered the room bringing a mechanical lift that had been retrieved from a storage closet at the end of the hall. Both NAs were wearing surgical masks and gloves but were not wearing isolation gowns. NA #1 exited the room of Resident #2 and walked across the hall to a room then returned to Resident #2's room without wearing an isolation gown. The NAs completed incontinence care, dressing, and transferring Resident #2 using the mechanical lift before exiting the room. The mechanical lift was taken directly to the storage closet without being sanitized after use in a Contact Precaution room. An interview with Nurse Aide #1 was made on 06/04/20 at 11:10 AM. The interview revealed she had provided activities of daily living (ADL) care for Resident #2. She acknowledged the signage on the door of the room indicated Resident #2 was on Contact Precautions which indicated the use of gown and gloves were necessary when in the room and stated she did not wear a gown during the care of Resident #2 during the observation but should wear one each time she entered the room. She stated she placed the mechanical lift in the storage closet without sanitizing it. She stated it should be sanitized between each use. She further indicated there were no wipes available in the lift storage room for use to sanitize multi-use equipment and she would have to ask a nurse for them. Attempts to interview Nurse Aide (NA #2) were made on 06/04/20 without success. An interview with the Unit Manager was conducted on 06/04/20 at 11:30 PM revealed she was responsible for supervision and part of the staff education for the nursing department. The Unit Manager indicated the facility initially had a shortage of PPE supplies in March 2020, but they were currently at a sufficient supply level and were using items as single use followed by its disposal. She stated staff always wore masks when on duty and don and doff a gown and gloves when providing patient care, contact with surfaces in the resident rooms, and perform hand hygiene after removal of PPE. She further indicated there were PPE including gown and gloves available on the outside of Resident #2 ' s door due to Contact Precautions during the survey. An interview with the Director of Nursing (DON), Assistant Administrator, and Administrator was conducted on 06/04/20 at 12:20 PM revealed administrative staff had provided ongoing education on the use of PPE, hand hygiene, and transmission-based precautions. They collaboratively acknowledged multiple residents that included Resident #1 and 2 in the ventilator unit had signage on the outside of the resident room indicating contact precautions with illustration of need for gown and gloves when in the room. The DON and Assistant Administrator indicated they had been advised through the Health Department, State Health Lab, and the Centers for Disease Control and Prevention that staff were not required to wear gowns when entering a room and providing care to residents with signage indicating contact precautions. The assistant administrator indicated she had received supplies through the local health department and a through the Federal Emergency Management Agency (FEMA) since the start of the pandemic. The DON and assistant administrator agreed there were enough PPE supplied including gloves and gowns on the doors of the rooms that indicated Contact Precautions during the survey and that proper hand hygiene should be performed. An interview with the(NAME)County Emergency Management Planner and Preparedness Coordinator on 06/05/20 at 03:19 PM revealed he had not been contacted and was unaware of a shortage of gowns at Valley Nursing Center during his weekly visits to deliver requested PPE since the start of the COVID-19 pandemic. He further stated he was told they had enough gowns and had recently shared a portion of their extra supply with another local health care entity who had a desperate need for gowns. He revealed he had provided the facility with an Emergency Respiratory Protection Plan at the start of the pandemic but had not given any advice to Valley Nursing Center related to non-necessity to wear a gown in a Contact Precaution room because it was beyond his scope of practice. An interview with the(NAME)County Infection Control Nurse on 06/05/20 at 03:45 PM indicated she and the(NAME)County Assistant Health Director had contact with Valley Nursing Center during the pandemic but were unaware of any shortage of PPE including gowns at the facility. She further stated she had not advised the facility of acceptable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY NURSING CENTER	**581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681**

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	(continued... from page 2) practice being not to use a gown when providing care in a room that indicated contact precaution. She further stated it was important to perform proper hand hygiene and to use gown and gloves when in rooms that indicated Contact Precautions in order to decrease the risk for transmission of infection from one resident to another through contact with an individual or potentially contaminated surfaces in the room. An interview with the(NAME)County Assistant Health Director on 06/05/20 at 05:27 PM revealed she had contact with Valley Nursing Center during the pandemic and was unaware of a shortage of gowns in the facility. She stated she had not advised the facility that it was acceptable practice to not wear gowns in rooms that indicated contact precautions and it was a necessity to perform proper hand hygiene and use the appropriate PPE including gown and gloves in a room of residents that Contact Precautions signage. She stated she had made a site visit following a complaint related to infection control she had received around 04/07/20 and had sent a toolkit to the facility with strategies for PPE during the pandemic. A follow-up email from the(NAME)County Assistant Health Director on 06/05/20 at 05:35 PM revealed she had made a site visit following an infection control complaint with a patient in the ventilator unit at Valley Nursing Center and COVID-19 testing supplies had been provided. An email attachment revealed a toolkit was emailed to the Assistant Administrator on 04/22/20 at 09:32 AM. The Long-Term Care toolkit included preparation of gown conservation/optimization during the pandemic that had been provided by the Deputy Director/Section Chief of Division of Public Health. An interview with the Physician on 06/08/20 at 10:29 AM revealed staff should wear proper PPE to include gown and gloves when providing patient care in rooms with signage that indicated Contact Precautions. He further indicated he was unaware the facility had a shortage of isolation gowns and would follow-up. An interview with the Associate Director of the North Carolina Statewide Program for Infection Control and Epidemiology on 06/08/20 at 1:37 PM revealed proper hand hygiene should be performed and PPE including gowns and gloves should be worn when in rooms with signage that indicated Contact Precautions. A follow-up interview was conducted with the Assistant Administrator on 06/09/20 at 08:09 AM. She revealed she felt the facility had a shortage of gowns to use in rooms with signage of Contact Precautions and had been denied on three occasions when she had made request for isolation gowns. She stated she did not have records of any denials of PPE including isolation gowns. She further stated she had obtained her guidance that gowns were not necessary in rooms that indicated Contact Precautions from the CDC website.