

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 345552	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2020
NAME OF PROVIDER OF SUPPLIER THE SHANNON GRAY REHABILITATION & RECOVERY CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 F 0880	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p>Level of harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 interviews and review of the facility's Hand Hygiene policy and procedure, the facility failed to perform hand hygiene after exiting 2 of 2 resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) and after resident contact. These failures occurred during a COVID-19 pandemic. The findings included: A review was conducted of the facility policy titled, Hand Hygiene, reviewed on 3/11/20. The policy specified that hands should be washed for at least 20 seconds using soap and water under the following conditions: before and after having direct contact with a resident. The policy also stated hand sanitizers may be used when soap and water not readily available. On 4/29/20 at 9:35 AM, an observation was made of Nurse Aide (NA) #1 entering room [ROOM NUMBER] without gloves and exiting the room with a breakfast tray. NA #1 was observed to place the breakfast tray in the dining area and then enter room [ROOM NUMBER] without washing or sanitizing her hands. NA #1 exited room [ROOM NUMBER] carrying two more breakfast trays and placed them in the dining room. NA #1 was then observed comforting a resident in the hallway by placing her right hand on the resident's right shoulder than pushing the wheelchair forward a short distance without washing or sanitizing her hands and without wearing gloves. On 4/29/20 at 9:40 AM, an interview was conducted with NA#1. She stated she sanitized her hands every chance she got. She stated she washed or sanitized her hands after providing care to the residents when she removed her gloves. NA #1 stated she usually did sanitize her hands when picking up trays, but she didn't that time. On 4/29/20 at 9:42 AM, an observation was conducted of the 800 hall nurses station. A large approximately gallon jug of hand sanitizer over half full was observed on top of the desk. On 4/29/20 at approximately 12:30 PM, an interview was conducted with the Director of Nursing. She revealed hand hygiene should be conducted after contact with residents. On 4/30/20 at 2:45 PM, an interview was conducted with the Infection Control Nurse. She stated extensive education regarding infection control and prevention had been ongoing and they were encouraging staff to wash their hands instead of using hand sanitizer. Hand washing education had been completed with staff demonstration and was being monitored.</p>		
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.