STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	09/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

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** - Some	**Provide and implement an infection prevention and control program.** Based on observations, staff interviews and review of the facility's infection control policies, the facility failed to implement their hand hygiene policy for 17 of 17 residents observed during meal tray delivery on the North hall when 2 nurse aides (NA) failed to remove gloves and perform hand hygiene after assisting the residents and before leaving the residents' rooms (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and #17). These failures occurred during a COVID-19 pandemic. The findings included: Review of the facility's infection control policy, Handwashing version date 3/10/2020, revealed, Wash hands immediately after gloves are removed, between residents .and when otherwise necessary to avoid transfer of microorganisms to other residents .Good hand hygiene is essential Wash hands using soap and water. Waterless hand agents may be used if hands are not visibly soiled . On 9/29/20 at 8:45 am an interview with the Administrator identified the North hall as a non-Covid hall. The Administrator also stated that the health department has given a directive that all employees wear full personal protective equipment (PPE) at all times while in the facility. On 9/29/20 a continuous observation was conducted on the North hall from 11:30am until 11:55 am of NA #1 and NA #2 delivering meal trays. Each NA was wearing a face mask, a face shield, gloves and a gown. Both pushed the meal cart to the lower end of the hall where they began delivering meal trays, starting with Resident #1 and #2. NA #1 and NA #2 removed a meal tray and entered Resident #1 and #2's room. They failed to perform hand hygiene before entering the room. They delivered the meal trays and assisted with opening the disposable meal containers. After exiting the room, NA #1 and NA #2 proceeded to the meal cart, wearing the same gloves without performing hand hygiene. NA #1 and NA #2 continued delivering the meal trays to Residents #3, #4, and #5. NA #2 entered Resident #6's room, assisted the resident with removing the bed covers from over her arms and pulled the resident's sleeves down on both arms. She then proceeded to set up the meal tray. NA #2 left the resident's room, failed to perform hand hygiene and change gloves and proceeded to the meal cart, removed a meal tray for Resident #7. NA #2 entered Resident #7's room, placed the meal tray on the overbed table then assisted the resident with repositioning. NA #2 exited the room and proceeded to the meal cart without performing hand hygiene. NA#1 and NA #2 delivered meal trays to Residents # 8, #9, #10, #11, #12, #13, #14, #15, #16 and ended with Resident #17, wearing the same pair of gloves and failing to perform hand hygiene. The observation ended after all 17 residents on the North hall had been served a meal tray. An interview, conducted with NA #1 on 9/29/20 at 2:00 pm, revealed her main responsibility was to provide showers for the residents. She stated she has been pulled to work on the hall recently but not been passing meal trays to the residents. NA #1 revealed she had received recent COVID-19 pandemic training and was instructed to remove gloves and wash or sanitize her hands before exiting each resident's room after assisting residents and before they left the room. She stated there was access to a sink with soap and water from each room. She further stated she was confused about changing gloves since they were told they needed to wear gloves all the time, even when in the hallways. She stated the gloves were kept in the residents' bathrooms and were not easily accessible. An interview, conducted with NA #2 on 9/29/20 at 2:10 pm, revealed she was a NA whose responsibility was to provide showers for the residents. She stated she has been pulled to work on the hall recently and has not been passing meal trays to the residents. NA #2 revealed she had received recent COVID-19 pandemic training and was instructed to remove gloves and wash or sanitize her hands before entering and exiting each resident's room after assisting residents and before they left the room. She stated there was access to a sink with soap and water from each room. She further stated she thought she should be changing gloves but was confused about being told she needed to wear gloves all the time, even when in the hallways. She stated the gloves were kept in the residents' bathrooms and were not easily accessible. An interview, conducted with the Infection Preventionist (IF) on 9/30/20 at 9:00 am, revealed, at the end of August 2020, the health department instructed the facility that all employees should wear full PPE at all times. The IF stated she provided in-services to all staff on COVID-19 precautions which included all staff should perform hand hygiene when entering and exiting a resident's room. She stated that she, the DON, the Nursing Supervisor and the Administrator observed staff daily to ensure they were following basic infection control policy and procedures. If staff were found not to be following policy and procedure, they were immediately educated. The interview further revealed she expected the NAs to perform hand hygiene and put on a new pair of gloves between residents when delivering the meal trays. An interview with the DON on 9/30/20 at 9:20 am revealed she participated in surveillance of the staff daily to ensure staff were following basic infection control policy and procedures. If staff were found not to be following policy and procedure, they were immediately educated. The interview further revealed she expected the NAs to perform hand hygiene and put on a new pair of gloves between residents when delivering the meal trays.

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.