STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCORDIUS HEALTH AND REHABILITATION	38 CARTERS ROAD GATESVILLE, NC 27938

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and review the facility's Handwashing/Hand Hygiene policy the facility failed to implement their Handwashing/Hand Hygiene policy when delivering meal trays to the rooms of 4 of 4 sampled residents (Residents #1, #12, #22 and #27). The facility also failed to implement the facility's Wound Care policy during wound care when staff exited and reentered a resident's room wearing the same gloves, staff did not clean scissors prior to using them to cut medical tape, and failed to change gloves and sanitize hands between the removal of an existing dressing and the application of a new dressing for 1 of 1 resident observed for wound care (Resident #4). The findings included: 1. Review of the facility policy titled, Handwashing/Hand Hygiene (Revised [DATE]) stated the facility considered hand hygiene the primary means to prevent the spread of infection. The policy interpretation and implementation included (7) Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: (b) Before and after direct contact with residents; (l) after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; (o) before and after eating or handling food; (p) before and after assisting a resident with meals. On [DATE] at 11:40 AM nursing assistant (NA) #1 was observed to carry a meal tray to Resident #1's room. The NA did not perform hand hygiene before entering the resident's room. The NA placed the meal tray on Resident #1's bedside table and placed a glove on her right hand. The NA then readied the meal tray for the resident, removed the glove from her right hand, and left the room without performing hand hygiene. On [DATE] at 11:45 AM, NA #1 was observed to deliver a meal tray to Resident #22's room. NA #1 did not perform hand hygiene when she entered, while she was in the room and when she exited the resident's room. The NA then removed a meal tray from the meal cart and carried the meal tray to Resident # 27's room and placed the tray on the resident's bedside table and exited the resident's room. The NA did not perform hand hygiene before she entered the room, while she was in the room and when she exited the room An interview was conducted with NA #1 on [DATE] at 2:20 PM. The NA stated that she had washed her hands before she started passing out the meal trays. On [DATE] at 11:49 AM NA#2 was observed to carry a meal tray to Resident #12's. The NA did not perform hand hygiene before entering the resident's room. The NA set the tray on the resident's bedside table and left the room without performing hand hygiene. An interview was conducted with NA#2 on [DATE] at 12:01 PM. NA#2 stated she was to wash her hands before entering a resident's room and after leaving the resident's room. The NA stated that she did not realize she had not washed her hands when she entered Resident #12's room to deliver the resident's meal tray and when she exited the resident's room. An interview was conducted with the Director of Nursing (DON) on [DATE] at 1:36 PM. The DON stated that staff were to wash their hands before setting up a resident's meal tray and before leaving the resident's room. 2. Review of the facility policy titled, Wound Care (Revised [DATE]) stated the purpose of this procedure was to provide guidelines for the care of wounds to promote healing. The policy steps included (1) use disposable cloth (paper towel is adequate) to establish clean field on residents overbed table. Place all items to be used during the procedure on the clean field. Arrange the supplies so they can be easily reached. (2) Wash and dry hands thoroughly. (4) Put on exam glove. Loosen tape and remove dressing. (5) Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly. (6) Put on gloves. (7) Use no touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. On [DATE] at 10:07 AM, an observation was conducted of Nurse #2 providing wound care for Resident #4. The nurse was observed to don gloves and place a barrier on resident's bedside table. The nurse left the room without removing her gloves and went to the treatment cart. Nurse # 2 removed gauze, and a tube of ointment with the resident's name and directions on it from the treatment cart. While at the treatment cart Nurse #2 also removed a pair of scissors from her pocket and without cleaning the scissors she cut two strips of medical tape. Nurse #2 laid the scissors on top of treatment cart, reentered Resident #4's room carry the two pieces of tape which she laid on the barrier. The nurse returned to the resident's bedside and was observed to remove the resident's right stump dressing wearing the same gloves. There was no drainage noted on the bandage. The nurse placed the old dressing in the trash and removed her gloves. Nurse #2 donned a new pair of gloves but did not wash her hands in between glove changes. Nurse #2 sprayed wound cleanser directly to the resident's wounds and cleaned with dry gauze. The nurse then squeezed the ointment on two individual gauze pads and placed them on the two open areas to Resident #4s right stump. Additional dry gauze was placed over treatment area which was secured with the two pieces of tape the nurse cut while she was at the treatment cart. On [DATE] at 10:14 AM An interview was conducted immediately with Nurse #2. The nurse stated she washed her hands in the resident's bathroom and put on gloves prior to the dressing change and changed her gloves when she removed the old dressing. Nurse #2 stated the scissors were her personal scissors and she cleaned with an alcohol swab. The nurse stated she always kept her personal scissors on her and wiped them off after each patient. Nurse #2 stated she had cleaned scissors prior to placing them in her pocket. An interview was conducted with the DON on [DATE] at 10:32AM, who was also the facility's Infection Control Nurse. The DON stated she expected that the nurse would have washed hands and changed gloves before leaving the room and after removing the old dressing. The DON stated Nurse #2 should have performed hand hygiene and donned a new pair of gloves when she reentered the resident's room.
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on staff interviews and record reviews the facility failed to designate a qualified Infection Preventionist (IP), who had completed specialized training in infection prevention and control, to be responsible for the facility's Infection Prevention and Control Program. The findings included: A review of the facility's Director of Nursing job description indicated the DON over saw the employee health program in cooperation with the Medical Director and the Staff Development Coordinator. The facility did not have an infection preventionist job description. Review of the Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) job descriptions did not specify the completion of specialized infection prevention and control training was needed. An interview was conducted with the Director of Nursing (DON) on 9/16/2020 at 1:39 PM. The DON stated she was hired as the facility's Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) in April of 2020 and when she was hired, she had not received any specialized training on infection prevention and control. The DON stated she was promoted to her current position on 09/14/20. The DON explained she would serve as the facility's infection control nurse until the ADON/SDC position was filled but had not complete any specialized infection prevention and control training. An interview was conducted with the Administrator on 9/15/2020 at 11:13 AM. The Administrator stated her ADON/SDC had been promoted to Director of Nursing on 9/14/2020. The Administrator stated she was not aware if the current DON or the previous DON had completed any specialized training in Infection prevention and control. The Administrator stated the DON would serve as the infection preventionist until the facility could hire an ADON/Staff Development Coordinator who would then be designated as the facility's IP and would have completed specialized training in infection prevention and control. An interview was conducted with the Administrator on 9/16/2020 at 1:42 PM. The Administrator stated there were no staff currently employed by the facility that had completed specialized training in infection prevention and control.

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

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F 0882 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1)