STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345478	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARNETT WOODS NURSING AND REHABILITATION CENTER	**604 LUCAS ROAD DUNN, NC 28334**

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, interviews, record review, and review of the facility ' s Contact Precautions policy, the facility failed to follow infection control procedures when a staff member removed and disposed an isolation gown outside a resident ' s room, who was on contact isolation, and failed to apply an isolation gown and gloves when she reentered the resident ' s room for 1 of 1 resident reviewed for contact isolation (Resident #1). This failure occurred during a COVID-19 pandemic. Findings Included: The facility ' s Infection Control Policy dated 3/10/20 for Contract Precautions revealed a gown and clean gloves were worn when entering the resident ' s room and caring for the resident and the gown was removed and disposed of before leaving the resident ' s room. Resident #1 ' s physician orders [REDACTED].#1 was started on antibiotic therapy for a urinary tract infection on 5/20/20. The culture and sensitivity report dated 5/22/20 identified Escherichia coli (E-coli) as the organism growing in the urine. On 5/28/20 at 2:29 pm, Nursing Assistant (NA) #1 was observed removing her yellow isolation gown outside Resident #1 ' s room (room [ROOM NUMBER]) beyond the room ' s door frame. NA #1 was observed disposing of the yellow isolation gown that she was wearing into a trash compartment on the sectional hamper sitting in the hallway. After receiving a bed protection pad from a staff member, NA#1 turned and re-entered Resident #1 ' s room without applying an isolation gown or gloves. A container with yellow isolation gowns and gloves was observed hanging on the left side of resident ' s room door. The right side of the resident ' s door was observed to have two signs: a Contact Precautions sign that instructed staff to wear a gown and gloves when entering the room and an Attention All Staff sign that instructed staff to apply proper isolation precautions before entering the room regardless of the type of care performed or the resident receiving care in the semi-private room. Observations on 5/28/20 at 2:32 pm revealed NA#1, who was not wearing a gown or gloves, was at the bedside of Resident #1 pulling up the resident ' s covers, lowering the bed and opening the privacy curtain. NA #1 was observed to perform hand hygiene with soap and water and exit the room. An interview was conducted with NA #1 at 2:33 pm on 5/28/20. NA #1 stated Resident #1 was on contact precautions and staff were required to wear a gown and gloves when entering the resident ' s room. NA#1 specified after she changed Resident #1 ' s adult brief, she exited the room and removed her isolation gown and gloves on the hallway side of Resident #1 ' s room door, disposed the gown and gloves in a trash compartment of the hamper located in the hallway. She stated she then reentered the resident ' s room without wearing a gown and gloves to apply a bed protective pad under the resident. NA#1 stated she had received training on Contact Precautions and when asked why personal protective equipment was not applied and removed per the facility ' s Contact Precautions procedure, the NA #1 stated, I was not thinking. An interview conducted with the Director of Nursing (DON) on 5/28/20 at 3:07 pm revealed Resident #1 was on contact isolation for Extended Spectrum Beta-Lactamases (ESBL). The DON stated Contact Precautions required a gown and gloves to be applied before entering the resident ' s room for any reason, and the gown and gloves were to be removed inside the resident ' s room before exiting. In a follow up phone interview on 5/29/20 at 3:58pm, the DON stated Resident #1 was placed on Contract Precautions by the hall nurse on 4/22/20 after the urine culture and sensitivity reported E-Coli in the urine and ESBL was suspected. An interview conducted with the Administrator on 5/28/20 at 3:47 pm revealed staff were to follow the signage on the resident ' s door for personal protective equipment (PPE) requirements of contact precautions. The Administrator stated with Contact Precautions PPE was applied prior to entering the room and removed before exiting the room. The Administrator further stated removal of the gown outside the door and disposing the gown into a trash container on the hamper in the hallway was not acceptable per the facility ' s infection control policy.

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