| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345551 | A. BUILDING _____ B. WING _____ | 04/16/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| PRUITTHEALTH-CAROLINA POINT | 5935 MOUNT SINAI ROAD DURHAM, NC 27705 |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, staff interview and record review, the facility failed to ensure staff performed hand hygiene after contact with objects and surfaces in the three residents' rooms (Residents #5, #6 & #7); failed to restrict two residents to their room or place a mask on residents who were not in their room (Residents #3 & #8); and place a mask on a resident who left the nursing home for [MEDICAL TREATMENT] treatment (Resident #10). These deficient practices affected 6 of 11 sampled residents reviewed for infection control and occurred during a COVID-19 pandemic (Residents #3, #5, #6, #7, #8 and #10). Findings included: 1. According to the Standard Precaution policy dated 3/5/19 under the topic of Hand Hygiene, it included two bullets that said: Hand hygiene is the single, most important activity for preventing the spread of infection and must be performed before and after patient care contact; and all healthcare center partners who come into contact either directly with patients or indirectly through equipment or environment are required to understand the importance of good hand hygiene practices and adhere to them. Resident #5 was readmitted to the facility on [DATE]. The Minimum Data Set (MDS) Quarterly Review dated 4/1/20 indicated he had moderate impairment of his cognition and he was totally dependent for eating assistance. According to the problem list for Resident #5 he had been diagnosed as COVID positive on 4/6/20. Resident #6 was readmitted on [DATE]. The MDS Quarterly Review dated 3/3/20 indicated she had moderate impairment in cognition and required extensive assistance with eating. According to the problem list for Resident #6, she had not been diagnosed as COVID positive, but did have fever on 3/31/20 and lobar pneumonia on 4/3/20. Resident #7 was admitted on [DATE]. The admission MDS dated [DATE] indicated the resident was cognitively intact and needed set up assistance with eating. According to the problem list for Resident #7 she was diagnosed as COVID positive on 4/6/20. On 4/9/20 at 12:15 PM, Transportation Aide #1 was observed distributing lunch to Resident #5 on the facility's isolation hall (100 hallway) that was designated to care for residents who tested positive for the COVID-19 virus. He entered the resident's room and with gloved hands placed the Styrofoam food container on the over-the-bed table. He moved the table and adjusted its height for Resident #5. He exited the room without removing his gloves, washing hands or using hand sanitizer. At 12:17 PM, while wearing the same gloves he went into Resident #6's room with a Styrofoam food container, set it down on the over bed table and exited the room without removing his gloves, washing his hands or using hand sanitizer. Transportation Aide #1 then went into Resident #7's room with a Styrofoam food container and set it down on the overbed table and exited the room without removing his gloves or performing any hand hygiene. At 12:17 PM Transportation Aide #1 was asked about performing hand hygiene after contacts with objects and surfaces in the resident's room environment. He said, I am not sure about when I should wash hands. I'm just helping out. After he was questioned, he asked Nurse #1 and Nurse Aide #1 about when he should use hand sanitizer. Nurse #1 was heard saying when you go inside of the room, you need to change gloves and sanitize hands. Transportation Aide #1 was interviewed on 4/15/20 at 1:23 PM. He said he normally did not distribute meals to residents, but on that day, he jumped in without being asked to help. He said that it was a learning experience and his coworker educated him about changing gloves and using hand sanitizer. He added that he had received training about COVID 19 through online computer sessions offered by the facility. Training required passing a test and electronic signatures. On 4/9/20 at 11:55 AM, during an interview Nurse #1 stated she had one nurse aide for the day for 21 residents. The transportation aide had volunteered to come in to do housekeeping. Nurse #1 further stated Transportation Aide #1 had been working with the residents for a long time. She indicated Transportation Aide #1 had been oriented and could assist with passing out meal trays, but he cannot feed residents. On 4/9/20 at 10:32 AM, the corporate nurse consultant stated the residents on halls 100, 500, 600 and some of 300 halls had been affected by COVID-19 virus. She stated the nursing home was in the process of cohorting residents affected by [MEDICAL CONDITION]. On 4/15/20 at 4:24 PM she stated it was her expectation that the staff member washed his hands before going to the next resident's room. 2. The Transmission Based Isolation Policy dated 3/6/2019, under the subheading Resident Transport read in part- Limit the movement of the resident from the room for essential purposes only and If transport is necessary, place a disposable mask on the resident during transport. a. Resident #3 was admitted to the facility on [DATE]. She had [DIAGNOSES REDACTED]. Resident #3's Quarterly MDS assessment dated [DATE] review indicated the resident's cognition was moderately impaired and wandering behavior was not exhibited. She was independent with locomotion on the unit with set up assistance. Resident # 3 was assessed as unsteady on her feet and used a wheelchair for ambulation. Resident #3's care plan updated on 3/23/20 indicated the resident was at risk for COVID-19. The goal was the resident will not develop signs and symptoms of COVID-19. The interventions were educating resident, family, staff, and visitors of changes. The Daily Census Report dated 4/9/20 indicated residents who were COVID 19 positive and who were negative, Resident #3 resided on a hall with seven other residents who had been diagnosed as COVID positive. On 4/9/20 at 1:09 PM, Resident #3 was observed sitting alone in the middle of the junction of the 600 and 300 halls. She was not wearing a mask. At that time, the Regional Vice President was on the hall helping to distribute meals to residents. He stated he would prefer Resident #3 wore a mask. On 4/9/2020 at 2:00 PM, the Corporate Clinical Nurse who was filling in for the Director of Nurses said, We want residents to wear masks outside of their room. On 4/15/20 at 4:19 PM the Corporate Clinical Nurse said Resident #3 had refused the COVID test and therefore was placed on the COVID unit because her status was unknown. She said all residents should wear a mask, if they were out of the room. On 4/15/20 at 9:55 AM the Nurse Practitioner (NP) confirmed Resident #3 refused testing. She said the resident liked to be with other residents or would wheel self to the nursing station and was alert and oriented to self, but in her own world. The NP stated that the nursing staff were making sure the residents did not leave their room and requesting them to stay in their rooms and were not taking no for an answer. b. Resident #8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #8's MDS quarterly assessment dated [DATE] review indicated the resident was assessed as cognitively impaired, with no behaviors, needed supervision to limited assistance with activities of daily living, and was occasionally incontinent of bowel and bladder. On 3/20/20, he was care planned to be at risk for his psychosocial well-being related to restriction in visitation and for risk of developing COVID-19. The goal was he would not develop signs and symptoms of COVID-19. Interventions included educate resident, family, staff, and visitors of changes. Document and inform social services and medical doctor as needed. On 4/9/20 at 11:15 AM, Resident #8 was observed alone on the 200 hall in the TV common area. He was not wearing a mask. According to the Area Vice President on 4/9/20 at 10:32 AM, this hall did not have any COVID positive residents residing on it. On 4/15/20 at 2:02 PM, the Activity Director who was working as a nurse aide said Resident #8 had been directed many times to go back to his room. We try to direct him to wear a mask and stay in room. On 4/9/20 at 11:34 AM, Nurse #2 said Resident #8 was allowed to be out of the because there was no COVID on the 200 hall. On 4/15/20 at 2:53 PM, she said I'm thinking he was in the clean unit, it was fine. He had masks in his room. He likes to go to the TV room. On 4/9/2020 at 2:00 PM, the Corporate Clinical Nurse stated, the resident should wear a mask even though he was on the COVID negative side of the building. She indicated when residents were out their room, they should wear a mask. On 4/15/20 at 4:19 the Corporate Clinical Nurse confirmed all residents should wear a mask, if they were out of the room. 3. The Transmission Based Isolation Policy dated 3/6/2019, under the subheading Resident Transport read in part- |

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

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| | **345551** | A. BUILDING _____ B. WING _____ | **04/16/2020** |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>Limit the movement of the resident from the room for essential purposes only and If transport is necessary, place a disposable mask on the resident during transport. Resident #10 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A significant change MDS assessment dated [DATE] indicated the resident had memory problems. The resident was coded as on [MEDICAL TREATMENT] and used oxygen. The care plan revised on 2/10/20 included a problem for potential for complications related to [MEDICAL TREATMENT] for [DIAGNOSES REDACTED]. Interventions included to make transportation arrangements for [MEDICAL TREATMENT]. Interview with the staff at the [MEDICAL TREATMENT] center on 4/15/20 at 3:51 PM<br>revealed on April 6, 2020, at approximately what time? Resident #10 was not wearing a mask when she arrived for [MEDICAL TREATMENT] and the center placed a facemask on the resident. According to a lab report, Resident #10 was tested for COVID 19 on 4/6/20 at 4:30 PM and was determined to be COVID 19 positive on 4/7/20 at 5:16 AM. Interview with the Corporate Clinical Nurse on 4/15/20 at 4:24 PM revealed Resident #10 was not showing any signs or symptoms of [MEDICAL CONDITION] prior to [MEDICAL TREATMENT] on 4/6/20. She was swabbed in the afternoon and there was no reason to mask the resident. She stated the [MEDICAL TREATMENT] center was notified of the result on 4/7/20. |