STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345192	A. BUILDING _____ B. WING _____	06/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LONGLEAF NEURO-MEDICAL TREATMENT CENTER	4761 WARD BOULEVARD WILSON, NC 27893

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 observations, staff interviews and review of the facility ' s Novel Coronavirus Prevention, Screening and Care policy, the facility failed to follow infection control procedures when staff failed to disinfect the oral thermometer between resident uses for 4 of 4 residents (#1 room [ROOM NUMBER], #2 room [ROOM NUMBER], #3 and #4) and remove gloves and perform hand hygiene between monitoring the temperatures of 2 of 2 residents (Resident #3, Resident #4). This failure occurred during a COVID-19 pandemic. Findings Included: The facility ' s Novel Coronavirus Prevention, Screening and Care policy dated 6/1/2020 revealed thermometers were shared among residents, and the equipment was cleaned and disinfected between use for each individual resident according to manufacturer ' s instructions using an Environmental Protection Agency registered disinfectant. The policy further noted standard precautions, which included hand hygiene, applied to all residents, and staff were to practice hand hygiene after contact with any resident and/or resident environment. On 6/2/2020 at 4:36pm, Nursing Assistant (NA) #1 was observed wearing a N95 face mask covered with a surgical mask, face shield, isolation gown and gloves while exiting #1 room [ROOM NUMBER] with an oral thermometer on a mobile cart. Prior to NA#1 rolling the mobile thermometer cart into #2 room [ROOM NUMBER], NA#1 was not observed to disinfect the thermometer. When NA#1 exited #2 room [ROOM NUMBER], no cleaning or disinfection materials were observed on the mobile thermometer cart as NA#1 rolled the thermometer cart into the nursing station. NA#1 was observed exiting the nurse ' s station without disinfecting the thermometer on the mobile cart and continuing to wear a N95 face mask covered with a surgical mask, face shield, isolation gown and gloves. An interview with NA #1 was conducted on 6/2/2020 at 4:58pm. NA #1 stated the N95 face mask, face shield, gown and gloves were required to work the quarantine unit and gloves were changed between residents. NA #1 stated she performed hand hygiene and applied new gloves in the resident ' s rooms. NA #1 stated the thermometer was supposed to be cleaned between residents, and she cleaned the thermometer sometimes with alcohol wipes. NA #1 stated she did not clean the thermometer between the residents in room [ROOM NUMBER] and room [ROOM NUMBER] and didn ' t have any alcohol wipes during the procedures. NA #1 explained she received training on applying personal protective equipment and wiping surfaces and items off with clothes twice a day. During the continuous observation on 6/2/2020 from 4:40pm to 4:47pm, NA #2, wearing a N95 face mask covered with a surgical mask, face shield, isolation gown and gloves, was observed to enter the nursing station and roll the mobile thermometer cart into Resident #3 ' s room (room [ROOM NUMBER]). NA #2 was observed taking an oral temperature on Resident #3 and disposing the thermometer probe in the trash can and exited Resident #3 ' s room without removing her gloves to perform hand hygiene and without disinfecting the thermometer. After exiting Resident #3 ' s room, NA #2 was observed wearing the same personal protective equipment and entering Resident #4 ' s room (room [ROOM NUMBER]) with the mobile thermometer cart. NA#2 was observed taking Resident #4 ' s temperature, disposing the thermometer probe in the trash can and exiting Resident #4 ' s room without removing her gloves to perform hand hygiene and without disinfecting the thermometer on the mobile cart. An interview was conducted with NA #2 on 6/2/2020 at 4:48pm. NA #2 stated changing the thermometer probe between the residents was an infection control measure but denied any knowledge of cleaning the thermometer between the residents. NA #2 stated gloves were worn all the time on the unit because of COVID-19 and were supposed to be changed between residents. NA #2 noted she washed her hands and applied new gloves in the hallway toilet room after leaving Resident #2 ' s room but did not remove gloves, perform hand hygiene or disinfect the thermometer between Resident #1 and Resident #2. When NA #2 was asked why she did not clean the thermometer, change gloves and perform hand hygiene between the residents, NA #2 stated she had not completed the new employee computer learning modules and had not received instructions verbally. On 6/2/2020 at 5:06pm during an interview, Nurse #1 stated thermometers were disinfected between residents with disinfectant wipes which were in the container with a purple top, and she pointed to a container of the disinfectant wipes at the nurse ' s station. Nurse #1 further stated training on infection control measures occurred on orientation, required computer courses annually and COVID-19 training with updates. On 6/3/2020 at 2:09pm a phone interview was conducted with the infection control preventionist. The infection control preventionist stated the facility had received guidance from the organization ' s physician to wear gloves at all times on units where COVID-19 was detected, and gloves were to be removed, hand hygiene performed, and new gloves applied between resident care. The infection control preventionist also stated thermometers were to be disinfected between residents using the disinfectant wipes in the purple top container, and staff had received education on the COVID policies including donning and doffing personal protective equipment and cleaning equipment. A phone interview was conducted with the standards management director (SMD) on 6/4/2020 at 4:10pm. The SMD stated although staff were requested to were gloves at all times on the units COVID-19 was detected, gloves were to be removed, hand hygiene performed, and new gloves applied between resident care. The SMD also stated thermometers were cleaned with the purple top disinfectant wipes between residents. During a phone interview with the Director of Nursing (DON) on 6/4/2020 at 4:58pm, the DON stated gloves were removed and hand hygiene performed after resident care, and thermometers were cleaned between residents. The DON noted all staff were required to complete infection control learning modules, and updates on policies were communicated to the staff through assistant directors, unit managers and shift reports. A phone interview was conducted on 6/4/2020 at 5:17pm with the administrator. The administrator stated gloves were to be changed and hand hygiene performed between residents, and medical equipment should be cleaned with the purple top disinfectant wipes between residents

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