STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. BUILDING _____ B. WING _____	06/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEAK RESOURCES - SHELBY	1101 NORTH MORGAN STREET SHELBY, NC 28150

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.** Based on observations, staff interviews and record review, the facility failed to use face masks to cover both mouth and nose for 2 out of 25 staff members observed, failed to disinfect a sit/stand lift between resident use for 1 of 1 observation and failed to do hand hygiene after removing dirty gloves by 1 of 3 housekeepers observed. This failure occurred during a COVID-19 pandemic. The findings included: 1. During an observation on 6/2/20 at 9:40 AM on A hall, Nurse Aide (NA) #1 was seen coming out of room A6 and was not wearing a mask. A continuous observation was made 6/2/20 from 9:55 AM to 10:00 AM of NA #1 and NA #2 while providing care to Resident #1 in the shower room. NA #1 had a black cloth mask on with her nose exposed and the mask covering her mouth. NA #2 had a surgical mask on with her nose exposed and the mask covering her mouth. On 6/2/20 at 11:20 AM, an interview with NA #1 revealed she had taken off her cloth mask while providing care in room A6 because the mask kept on fogging up her glasses. She took her mask off and put it in her pocket. NA #1 stated she put her cloth mask back on after leaving room A6 but had to pull it down past her nose because the mask kept on fogging up her glasses while providing care to Resident #1 in the shower room. NA #1 further stated she should have worn her mask with both her nose and mouth covered but had problems with both cloth and surgical masks constantly fogging up her glasses. On 6/2/20 at 11:55 AM, an interview with NA #2 revealed she had to pull her mask down past her nose while providing care to Resident #1 in the shower room due to the room being hot and she was having trouble breathing with the surgical mask on over her nose. NA #2 stated she was aware that she was supposed to wear the mask with both nose and mouth covered but did not do this all the time because she had trouble breathing with the surgical mask on. On 6/2/20 at 12:40 PM, an interview with the Infection Preventionist (IP) revealed both NA #1 and NA #2 were checked off on PPE (Personal Protective Equipment) competency which included instruction on how to wear masks properly and observation of them putting masks on, securing on their face with nose, mouth and chin covered and removing the masks properly. The IP stated both NA #1 and NA #2 should have worn their masks to cover both nose and mouth, and that she was not aware that either NA had any issues with wearing masks over their nose. On 6/2/20 at 1:20 PM, an interview with the Administrator revealed she expected all staff members to wear masks properly at all times while inside the facility and that NA #1 and NA #2 should not have pulled down their masks to expose their nose while providing care to a resident. 2. A review of facility policy named Equipment Cleaning which was revised on April 2020 indicated that sit/stand lifts should be cleaned by wiping with disinfectant wipes between resident use. During a continuous observation on 6/2/20 from 9:55 AM to 10:15 AM on A hall, Nurse Aide (NA) #1 and NA #2 were seen using the sit/stand lift to transfer Resident #1 to her wheelchair while in the shower room. During the transfer, Resident #1 was observed holding on to the handlebars on both sides of the sit/stand lift. After the transfer, NA #1 pushed the sit/stand lift out of the shower room and left it in the hallway. The Medical Records (MR) clerk grabbed the sit/stand lift and pushed it inside Resident #2's room while waiting for NA #1 to help with Resident #2's transfer. NA #1 then helped the MR clerk transfer Resident #2 to the bedside commode using the sit/stand lift. During the transfer, Resident #2 was observed holding on to the handlebars on both sides of the sit/stand lift. After the transfer, NA #1 pushed the sit/stand lift out of the room and parked it in the hallway. On 6/2/20 at 10:20 AM, an interview with the MR clerk revealed she had been trained on resident care and usually helped the floor nurse aides. She stated she was not sure if the sit/stand lift that she pushed to Resident #2's room had been disinfected by NA #1. She added that the sit/stand lift should be cleaned by wiping with disinfectant wipes between resident use. On 6/2/20 at 11:20 AM, an interview with NA #1 revealed she did not disinfect the sit/stand lift that was used to transfer Resident #1 before using it to transfer Resident #2. NA #1 stated she was aware it should have been disinfected with disinfectant wipes, but the wipes were currently unavailable. NA #1 further stated she did not know of any alternatives to the wipes to clean the sit/stand lift with. On 6/2/20 at 12:35 PM, an interview with the Environmental Director (ED) revealed the floor technician was assigned to disinfect all equipment including the sit/stand lifts that were parked in the hallways at least three times a day. The floor technician used a disinfectant spray to clean the sit/stand lifts. The ED added that the sit/stand lift should have been disinfected by the nurse aides in between resident use. On 6/2/20 at 12:40 PM, an interview with the Infection Preventionist (IP) revealed the sit/stand lift should have been disinfected between resident use. The IP stated the facility was currently out of the germicidal wipes, but they had a disinfectant spray that should have been used to disinfect the sit/stand lift. She further stated the disinfectant spray was locked in the shower room and in the nurses' medication carts for easy access in the halls. On 6/2/20 at 1:20 PM, an interview with the Administrator revealed NA #1 should have disinfected the sit/stand lift prior to using on another resident especially the handlebars that Resident #1 had touched. 3. During an observation on 6/2/20 at 10:25 AM on B hall, Housekeeper #1 was seen leaving room B6 and taking off her gloves while in the doorway. She threw away her gloves in the trash receptacle on her cart. Housekeeper #1 then positioned her cart in front of room B7. Housekeeper #1 was not observed washing her hands or using hand sanitizer right after removing her gloves. On 6/2/20 at 10:25 AM, an interview with Housekeeper #1 revealed she had received education on use of PPE (Personal Protective Equipment) which included the use of gloves. Housekeeper #1 stated she used gloves to clean room B6 and removed them after she was finished cleaning the room. Housekeeper #1 admitted that she did not wash her hands or use hand sanitizer after removing her gloves because she was told it was fine to discard her dirty gloves and apply new gloves prior to entering the next room. Housekeeper #1 further stated she did use hand sanitizer after cleaning rooms that had a hand sanitizer right outside the door in the hallway but did not like to do this often because it was sticky. Housekeeper #1 added she only washed her hands when she was finished with cleaning the whole hall. On 6/2/20 at 11:40 AM, an interview with the Environmental Director (ED) revealed all housekeepers were expected to wear gloves when cleaning rooms and wash their hands after removing their gloves and prior to going to the next room. The ED stated Housekeeper #1 had been educated on handwashing after coming out of every room but did not follow what she had been instructed to do. On 6/2/20 at 12:40 PM, an interview with the Infection Preventionist revealed Housekeeper #1 was checked off on PPE competency which included handwashing after removal of gloves. The IP stated Housekeeper #1 should have washed her hands or used hand sanitizer before leaving the room. The IP added that each resident room had a sink with soap, water and hand sanitizer available for use. On 6/2/20 at 1:20 PM, an interview with the Administrator revealed Housekeeper #1 should have done hand hygiene after removing her gloves. The Administrator added that Housekeeper #1 had been given a disciplinary action, re-educated and would be monitored more frequently.

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