

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345552</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/30/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE SHANNON GRAY REHABILITATION &amp; RECOVERY CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2005 SHANNON GRAY COURT</b> <b>JAMESTOWN, NC 27282</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments  A COVID-19 Focused Emergency Preparedness Survey was conducted on April 29-30, 2020. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. The census was 91. Event ID# D45T11.	E 000			
F 000	INITIAL COMMENTS  A COVID-19 Focused Infection Control Survey and complaint investigation survey was conducted from 4/29/20 through 4/30/20. 1 of the 5 complaint allegations was substantiated, resulting in deficiency F880. Event ID# D45T11.	F 000			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		5/18/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/21/2020

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	<p>Continued From page 1</p> <p>conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p>	F 880			

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F 880	<p>Continued From page 2 infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews and review of the facility's "Hand Hygiene" policy and procedure, the facility failed to perform hand hygiene after exiting 2 of 2 resident rooms (Room #807 and Room #812) and after resident contact. These failures occurred during a COVID-19 pandemic.</p> <p>The findings included:</p> <p>A review was conducted of the facility policy titled, "Hand Hygiene", reviewed on 3/11/20. The policy specified that hands should be washed for at least 20 seconds using soap and water under the following conditions: before and after having direct contact with a resident. The policy also stated hand sanitizers may be used when soap and water not readily available.</p> <p>On 4/29/20 at 9:35 AM, an observation was made of Nurse Aide (NA) #1 entering room #807 without gloves and exiting the room with a breakfast tray. NA #1 was observed to place the breakfast tray in the dining area and then enter Room #812 without washing or sanitizing her hands. NA #1 exited room #812 carrying two more breakfast trays and placed them in the dining room. NA #1 was than observed comforting a resident in the hallway by placing her right hand on the resident's right shoulder than pushing the wheelchair forward a short distance without washing or sanitizing her hands</p>	F 880	<p>On 4/30/2020, an interview was conducted with the CNA (certified nursing assistant) to determine when and how alleged issues occurred. The appropriate residents were identified and were placed on increased monitoring for signs, symptoms, or complications. After a 14 day monitoring period for symptoms, both residents were asymptomatic of any issues which could have been linked to the CNA not using gloves or cleansing hands after touching meal trays. Please note, the CDC released information on 5/19/2020 "How COVID spreads" (<a href="https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads">https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads</a>) that transmission of COVID-19 is very unlikely on surface objects including the alleged events on 4/30/2020.</p> <p>To ensure no other residents were affected, the facility continued to monitor all residents and all residents remain COVID-19 free and asymptomatic in the facility 14 days after 4/30/2020 and through the time of this submission, 5/21/2020. Please note that this facility is currently and has remained COVID-19 free for residents.</p>		

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F 880	<p>Continued From page 3 and without wearing gloves.</p> <p>On 4/29/20 at 9:40 AM, an interview was conducted with NA#1. She stated she sanitized her hands every chance she got. She stated she washed or sanitized her hands after providing care to the residents when she removed her gloves. NA #1 stated she usually did sanitize her hands when picking up trays, but she didn't that time.</p> <p>On 4/29/20 at 9:42 AM, an observation was conducted of the 800 hall nurses station. A large approximately gallon jug of hand sanitizer over half full was observed on top of the desk.</p> <p>On 4/29/20 at approximately 12:30 PM, an interview was conducted with the Director of Nursing. She revealed hand hygiene should be conducted after contact with residents.</p> <p>On 4/30/20 at 2:45 PM, an interview was conducted with the Infection Control Nurse. She stated extensive education regarding infection control and prevention had been ongoing and they were encouraging staff to wash their hands instead of using hand sanitizer. Hand washing education had been completed with staff demonstration and was being monitored.</p>	F 880	<p>Again on 4/30/2020, an all staff in-service was conducted to increase staff knowledge related to hand hygiene measures. Staff were educated to cleanse hands in between activities including tray pass/pick up and all contact with residents. Staff education was conducted by the Director of Nursing (DON) and the Director of Clinical Services. Further educational material was presented to staff as well. CDC handwashing fliers were also posted throughout the facility to increase staff knowledge base and remind them of expectations. Staff educated includes CNAs, Nurses, Activity Staff, Therapy Staff, Social Workers, Admissions Coordinator, Concierge, Medical Supply, Medical Records, Housekeeping, Nursing Home Administrator and Dietary staff. Formal hand hygiene education will be repeated with care staff monthly until the CDC or CMS declare an end of the COVID-19 pandemic. Education and re-education specific to hand hygiene expectations will be conducted upon hire and as needed thereafter as part of our surveillance. To further encourage compliance with hand hygiene, additional hand sanitizer dispensers were placed on each unit. Staff are encouraged to use hand sanitizer near each of their work areas in between each care task as an adjunct to standard hand washing practices.</p> <p>To ensure staff understands correct hygiene practices, the Hand Hygiene Monitoring QA Tool was developed for</p>		

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F 880	Continued From page 4	F 880	<p>use. This tool enables administrative team members to conduct surveillance at set intervals to ensure compliance with hand hygiene. The administrative team members conducting surveillance include the DON, Unit Coordinators, Director of Clinical Service, MDS coordinator and the Nursing Home Administrator. Random surveillance began 5/11/2020, at twice per week intervals, and will continue until the CDC or CMS declare an end of the COVID-19 pandemic. The above members also serve on a QA team specific to hand hygiene (Hand Hygiene QA Team). This QA team started meeting on 4/30/2020 and will continue meeting monthly until the resolution of the COVID-19 pandemic per CDC or CMS declaration. The Director of Clinical Services will present the action items, the surveillance results and any additional follow ups to the Executive Quarterly QA meeting team. This team meets again 6/17/2020.</p> <p>The facility states compliance with this plan of correction, effective 5/18/2020.</p>		