STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT SALISBURY	635 STATESVILLE BOULEVARD SALISBURY, NC 28144

(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 An unannounced COVID-19 Focused Survey was conducted on 08/28/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 3LT011	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted on 08/26/2020 to 8/28/2020. The facility was found not in compliance with 42 CFR §483.80 infection control regulations. Please see event ID 3LT011	F 000		
F 880 SS=E	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 conducted according to §483.70(e) and following accepted national standards;	F 880		9/25/20

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

Electronically Signed | 09/11/2020

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

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F 880	Continued From page 2 §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 observation, staff interviews and review of facility policies the facility failed to implement their policy on "Handwashing/Hand Hygiene" when staff failed to perform hand hygiene when delivering meal trays to resident rooms for 5 of 5 residents observed for infection control (Resident Rooms #202, #209, #214, #215 and #216). This failure occurred during a COVID-19 pandemic. Findings included: A review of the facility's policy titled "Handwashing/Hand Hygiene" revised August 2015 read in part; 2. All personnel shall follow the handwashing /hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hany hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b. Before and after direct contact with residents; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; o. Before and after eating or handling food; p. Before and after assisting a resident with meals. A continuous observation on August 26, 2020	F 880	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F 880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) • The corrective action for the residents found to have been affected by the deficient practice 1. All residents that were on 200 hall on 08/26/2020 had the possibility of being affected. Staff # 1 was immediately re-in serviced on the proper hand-washing technique and the importance of handwashing in the infection control process. Staff #1 also received a verbal warning related to not following policy. • The facility will review and identify any other residents having the potential to be affected by the same deficient practice 1. All residents have the potential to be affected by this deficient practice.	

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F 880	Continued From page 3 from 12:45 PM to 1:05 PM revealed staff #1 was delivering meal trays to resident rooms. At 12:50 PM staff #1 removed a lunch tray from the meal delivery cart and delivered the tray to a resident in room #202, staff #1 did not perform hand hygiene when she entered or exited room #202. Staff #1 delivered a meal tray to a resident in room #209, set up the tray for the resident and did not sanitize her hands when she entered the room, but when staff #1 exited room #209 she walked down the hallway and sanitized her hands by using hand sanitizer she obtained from the wall mounted dispenser. Staff #1 did not sanitize her hands when she exited room #214 and then was observed to remove a meal tray from the meal delivery cart and deliver the meal tray to a resident in room #215. Staff #1 did not perform hand hygiene when she entered or exited room #215. Staff #1 was observed to remove a meal tray from the meal delivery cart, delivered it to a resident in room #216, set up the tray for the resident and exited the room. Staff #1 did not sanitize her hands when she entered room #216. When staff #1 exited room #216 she walked down the hallway and asked a nurse to unlock the medication cart to obtain hand sanitizer and then she sanitized her hands. On August 27,2020 at 1:19 PM an interview was conducted with staff #1 who stated, before entering a room I will wash my hands or use hand sanitizer. Staff #1 stated that sometimes we just don't have time, because of being understaffed, "I try the best I can". Staff #1 stated that she does not go into the resident's rooms to wash her hands as some rooms don't have paper towels. Staff #1 stated that she had to go to the medication cart and get a nurse to unlock the cart to get some hand sanitizer. Staff #1 stated that	F 880	• The monitoring processes and systemic changes to ensure plan of correction is effective: 1. The Director of Nursing/Infection Preventist, the Unit Coordinator, and Supervisors will monitor delivery of meal trays for lunch 3 times a week for 2 weeks, then 2 times a week for two weeks, then once a week for 8 weeks to ensure the policy on Handwashing/Hand Hygiene is being followed. 2. On 08/31/2020 the Director of Nursing re-educated Staff #1 on the facility policy for Handwashing/Hand Hygiene. On 09/04/2020 Staff #1 was re-educated one on one by Director of Nursing on Hand Washing/Hand Hygiene. On 09/08/2020 Staff #1 was educated on Handwashing/Hand Hygiene by utilizing the “Clean Hands” Video recommended by the DPOC. 3. On 08/31/2020 the Director of Nursing re-educated, CNAs, Licensed staff, housekeeping, dietary, therapy, and administrative staff on Handwashing/Hand Hygiene per facility policy. 4. On 09/08/2020 the Director of Nursing re-educated CNAs, Licensed staff, housekeeping, dietary, therapy, and administrative staff on Hand Hygiene by utilizing the “Clean Hands” video recommended by the DPOC. 5. On 09/08/2020 the Administrator, Director of Nursing/Infection Preventionist,	

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F 880	Continued From page 4 there was only one wall mounted hand sanitizer dispensers on each unit. Staff #1 explained that It would help if there were more wall mounted dispensers. An interview was completed with the Director of Nursing (DON) on August 28, 2020 at 10:44 AM who stated staff are to wash their hands or sanitize their hands before entering or exiting a resident's rooms this includes when passing of meal trays. The DON stated a handwashing In-service was provided to staff and we keep reiterating hand hygiene; however, people learn in different ways. An interview was completed with the administrator on August 28, 2020 at 2:05 PM who stated it is her expectation that staff wash their hands or utilize hand sanitizer anytime they go into a resident's room.	F 880	Regional Director of Operations, and Nurse Consultant conducted a Root Cause Analysis. It was determined that Staff #1 was a PCA and required additional training due to her learning disability. The policy was reviewed, and it was decided to implement into the facilities orientation the “Clean Hands” video to ensure that all new hires receive training including both written policy and video. It was determined that additional hand sanitizer dispensers would be added to each hall. It was decided to place 5 additional dispensers throughout the facility. It was also determined that some rooms needed additional soap and paper towels. The Environmental Department checked and added supplies as needed. • The facility plans to monitor its performance to make sure that solutions are sustained by: Beginning September 16, 2020, the Director of Nursing will report the findings of the audits for delivery of meal trays and observations to the Quality Assurance and Performance Committee. For additional monitoring or modification of this plan monthly for 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Beginning September 16, 2020, the Director of Environmental Services will report monthly for 3 months the findings of the audits for checking rooms for	

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F 880	Continued From page 5	F 880	adequate soap and paper towels to the Quality Assurance and Performance Committee. For additional monitoring or modification of this plan it will be followed monthly for 5 months and as needed. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Date of compliance September 25, 2020	