STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345247	A. BUILDING _____ B. WING _____	06/09/2020

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VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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E 000	Initial Comments An unannounced on-site COVID-19 Focused Survey was conducted on 06/04/2020 with additional information obtained on 06/05/20, 06/08/20 and 06/09/20. Therefore the exit date of the survey is 06/09/2020. 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# NLMT11	E 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 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		6/30/20

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

Electronically Signed | 06/25/2020

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F 880	Continued From page 1 (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. §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:	F 880		

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F 880	Continued From page 2 Based on observations, review of the facilities staff education logs and infection control documents, record reviews, and staff, physician, Health Department Emergency Management/Infection Control/Assistant Health Director, and Associate Director of North Carolina Statewide Prevention of Infection and Epidemiology interviews, the facility failed to ensure staff performed proper hand hygiene after contact with a resident and objects in the residents room for 2 of 2 residents (Resident #1, and #2), failed to ensure proper Personal Protective Equipment (PPE) were donned and doffed when entering and exiting a resident room with signage that indicated Contact Precautions for 2 of 2 residents (Resident #1 and #2) and failed to clean and sanitize multi-use lift equipment after use in a room with signage that indicated Contact Precautions for 1 of 1 resident (Resident #2). This occurred for 2 of 2 sampled residents. Findings included: An undated facility document titled "Crisis Capacity Strategies for Gown per the CDC guidelines," which read in part that facilities may consider suspending the use of gowns for endemic multidrug resistant organisms (e.g., MRSA, VRE, ESBL-producing organisms). It further reads isolation gowns may be used for extended periods by the same health care provider if interactions were made with residents with the same confirmed infectious disease, housed in the same location, and could only be considered when no additional co-infectious diagnosis were present. When gowns were limited in availability, prioritization of isolation gowns should be used in activities where	F 880	Valley Nursing Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Valley Nursing Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Valley Nursing Center reserves the right to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or administrative or legal proceedings. Corrective actions for affected residents: Resident #1 and resident #2 reside on the wing of ventilator unit where all residents are on transmission-based precautions and are cohorted with colonization of like MDRO□s. Both resident #1 and resident #2 were assigned the dedicated care team made up of Nurse #1, RT #1, and CNA #1 and #2 on the cohort unit. On the afternoon of 6/4/20, the DON educated this designated staff on duty along with the Assistant Activity Director on the adherence to the infection control policies and procedures and using proper transmission-based precautions. This	

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F 880	Continued From page 3 splashes or sprays are anticipated, high-contact procedures such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care. A current review of the CDC guidelines dated 06/08/2020 revealed a three step approach to gown conservation strategies. The three steps included conventional capacity, contingency capacity, and crisis capacity. Contingency capacity included shifting gown usage to cloth gowns or coveralls. Crisis capacity included extended use of isolation gowns, re-use of cloth gowns, and finally prioritizing the use of gowns with a possible suspension of gowns for endemic multidrug resistant organisms (e.g. MRSA, VRE, ESBL-producing organisms). According to a facility document titled "Pandemic-Gloves and Handwashing" dated 04/02/20 revealed staff were to remove gloves before leaving the resident ' s room and wash their hands immediately with an antimicrobial agent or a waterless antiseptic agent. A facility document titled "Pandemic-Prevention of Person to Person Transmission" dated 04/02/20 revealed staff were to wear a gown when entering a room if you anticipate you will have substantial contact with the resident, environmental surfaces, or items in the resident ' s room. It further indicated when common use equipment or items is avoidable, then adequately clean and disinfect them before use for another resident. 1. Resident #1 was readmitted to the facility on 02/02/19. His diagnosis included chronic respiratory failure with hypoxia and hypercapnia	F 880	education included necessity of proper hand hygiene, PPE - particularly the required use of gowns and acceptable standards for gown conservation according to availability and current guidance, cleaning multi-use lifting equipment between residents, and infection control practices to prevent cross contamination with objects taken in and removed from the residents rooms. Each of these listed staff members exhibited understanding of posted precautions, proper and consistent hand hygiene, proper and consistent use of PPE, and infection control measures and disinfection process to prevent cross contamination through objects and equipment. Other residents having the potential to be affected: Any other resident on transmission-based precautions could have been affected, therefore on 6/5/20, the DON and the RN unit managers performed care observations of residents who were on transmission-based precautions to ensure that infection control practices were bring followed. They observed for hand washing or use of ABHR, availability of PPE, appropriate use of required PPE, disinfection of multi-use equipment between residents, and potential cross contamination of objects and surfaces. No other instances of non-adherence to the infection control practices based on posted precautions were observed on	

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F 880	Continued From page 4 including tracheostomy, ventilator dependence, ventilator associated pneumonia, and sepsis. A review of the care plan dated 10/25/19 revealed Resident #1 was at risk for respiratory complications related to ventilator and tracheostomy dependence. Review of an additional care plan dated 04/02/20 revealed Resident #2 was at risk for infection related to COVID-19. A lower respiratory culture dated 01/28/20 revealed Resident #1 to be positive with heavy growth for three isolated organisms that included Pseudomonas Aeruginosa, Providencia Stuartii, and Proteus Mirabillis. A quarterly Minimum Data Set (MDS) dated 04/16/20 indicted Resident #1 had some moderate cognitive impairment and required extensive to total dependence of staff for all activities of daily living (ADL). care. A continuous observation was made on 06/04/20 at 10:58 AM to 11:06 AM revealed the call light was on outside the room and Nurse #1 entered the room of Resident #1. Signage was present on the outside of the door that indicated Contact Precautions and included illustrations of the use of a gown and gloves when in the room. She was not wearing a gown or gloves when she approached the bed and touched the side of the bed with her torso and the call light with her hand to turn it off. Respiratory suctioning was needed, and the nurse performed hand hygiene and left the room to notify the respiratory department. A respiratory therapist then entered the room and approached the bedside of Resident #1, assessed he required a suctioning treatment, and	F 880	6/5/20. Measures initiated to prevent recurrence of alleged deficient practice: On 6/8/20, the DON initiated detailed facility wide in-service educational training, to be completed by all facility staff. This education covers different levels of transmission-based precautions and the importance of adherence to infection control standards. The educational training details when and how to perform proper hand hygiene, proper donning and doffing and consistent use of required PPE for each level of transmission based precautions, cleaning multi-use equipment between residents, and infection control practices to prevent cross contamination with objects taken into or removed from the residents room. This detailed in-service education was initiated on 6/8/20 and will run through 6/30/20. All staff must complete the required in-service by 06/30/20. Staff who have not completed the in-service by the required date of 06/30/20 will not be allowed to work until the training is completed. The DON received clarification on the transmission-based precautions required for residents who are cohorted and colonized with CRE. The clarification guidance included the implementation of Enhanced Barrier Precautions when there is no active CRE infection. These Enhanced Barrier Precautions only	

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F 880	Continued From page 5 he provided respiratory suctioning from the tracheostomy. He was observed leaving the bedside of Resident #1 and came around the curtain facing the exit door wearing a mask and gloves but no isolation gown. The Respiratory Therapist disposed of the used gloves in the trash receptacle and exited the door without completing proper hand hygiene which included washing his hands or using alcohol-based hand rub (ABHR) to sanitize his hands after care. An interview with Nurse #1 on 06/04/20 at 10:59 AM revealed she was the nurse for Resident #1 for day shift. Nurse #1 indicated she entered the room to see what Resident #1 needed because his call light was lit. She acknowledged Resident #1 had signage on the outside of his door which indicated Contact Precautions with illustrations of gown and glove usage when in the room and that PPE including gowns and gloves were available on the door of the room. She stated she never wore a gown in contact precaution rooms until she knew what the resident needed. An interview with Respiratory Therapist #1 (RT) was conducted on 06/04/2020 at 11:06 AM. The interview revealed RT #1 acknowledged he had provided respiratory suction to Resident #1. RT #1 indicated Resident #1 was on Contact Precautions which required a gown and gloves during care and that PPE which included gowns and gloves were available on the door. He stated he did not wear an isolation gown while providing care and had not performed hand hygiene during this observation. He stated he should have worn a gown and performed proper hand hygiene after providing suctioning care to Resident #1 and wasn't sure why he didn't on this date.	F 880	require anything greater than standard precautions when specific resident care tasks are being performed but have no other restrictions on the resident or their participation inside the facility. All posted transmission-based precaution signage for the residents of the cohort wing of the vent unit with CRE colonization and no active infection, was updated on 06/17/20 to reflect Enhanced Barrier Precautions instead of Contact Precautions as was previously posted. A full-time qualified RN with duties in the role of Infection Preventionist, was hired and began work on 6/22/20. The RN Infection Preventionist will be responsible for the facility infection control program including, but not limited to, ongoing infection control surveillience, staff monitoring, and the restructuring the infection control and prevention program. Facility monitoring to ensure compliance is sustained: The Director of Nursing initiated comprehensive Infection Control performance improvement observation audits on 06/17/20 to ensure staff are adhering to infection control practices per the posted transmission-based precautions. The Nursing Managers will conduct observation audits of rooms where residents are on transmission-based precautions. The RN auditor will observe to ensure staff adhere	

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F 880	Continued From page 6 An interview with the Unit Manager was conducted on 06/04/20 at 11:30 PM revealed she was responsible for supervision and part of the staff education for the nursing department. The Unit Manager indicated the facility initially had a shortage of PPE supplies in March 2020, but they were currently at a sufficient supply level and were using items as single use followed by its disposal. The Unit Manager indicated PPE which included gowns and gloves were supplied on the outside of Resident #1's room due to Contact Precautions. She stated staff had been educated to always wear masks when on duty, don and doff a gown and gloves when providing patient care in transmission-based precaution rooms and perform hand hygiene after removal of PPE. An interview with the Respiratory Therapy director was conducted on 06/04/20 at 12:00 PM via telephone. She stated her staff had received ongoing education on all transmission-based precautions, hand hygiene, and donning and doffing of PPE when providing resident care. She stated all respiratory therapy staff should wear gown, gloves, and a surgical mask when in the room with a resident on Contact Precautions. She further indicated the importance of performing hand hygiene both before and after patient care that included suctioning provided by respiratory therapy staff. An interview with the Director of Nursing (DON), Assistant Administrator, and Administrator was conducted on 06/04/20 at 12:20 PM revealed administrative staff had provided ongoing education on the use of PPE, hand hygiene, and transmission-based precautions. They collaboratively acknowledged multiple residents that included Resident #1 and 2 in the ventilator	F 880	to infection control standards of practices per the posted level of precautions. These observations include staff providing care or treatment to the resident as well as staff entering the room for social or environmental interactions. The audit includes availability of required PPE, proper donning and doffing of required PPE, hand hygiene at appropriate times using correct methods, cross contamination of objects brought in and out of rooms, and disinfection of multi-use equipment between patients. Under the direction of the DON, the Nursing Management team (comprised of the DON, Infection Preventionist, and 2 RN Unit Supervisors) will conduct 25 of these Infection Control observation / monitoring audits weekly beginning 06/17/20, and continue at various times on various shifts each week for through 07/31/20. The audits will then decrease to 15 audits weekly beginning 08/01/20 for two months through 09/30/20. Then the audits will decrease to 8 random audits weekly beginning 10/01/20 through 11/30/20 to ensure sustained compliance with the infection control practices for residents on transmission-based precautions. The results of each audit will be forwarded to the DON weekly. The DON and Infection Preventionist will review them for trends and patterns and will address staff as needed to ensure proper understanding and implementation of the transmission-based precautions. The Infection Preventionist RN will	

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F 880	Continued From page 7 unit had signage on the outside of the resident room that reflected Contact Precautions with illustration of need for gown and gloves when in the room. The DON and Assistant Administrator collaboratively indicated they had been advised through the Health Department, State Health Lab, and the Centers for Disease Control and Prevention that staff were not required to wear gowns when entering a room and providing care to residents with signage indicating Contact Precautions. The Assistant Administrator indicated she had received supplies through the local health department and through the Federal Emergency Management Agency (FEMA) since the start of the pandemic. The DON and Assistant Administrator agreed there were enough PPE supplied including gloves and gowns on the doors of the rooms that indicated Contact Precautions during the survey and that proper hand hygiene should be performed. An interview with the Alexander County Emergency Management Planner and Preparedness Coordinator on 06/05/20 at 03:19 PM revealed he had not been contacted and was unaware of a shortage of gowns at Valley Nursing Center during his weekly visits to deliver requested PPE since the start of the COVID-19 pandemic. He further stated he was told they had enough gowns and had recently shared a portion of their extra supply with another local health care entity who had a desperate need. He revealed he had provided the facility with an Emergency Respiratory Protection Plan at the start of the pandemic, delivered PPE supplies almost weekly, but had not given any advice to Valley Nursing Center related to non-necessity to wear a gown in a Contact Precaution room because it was beyond his scope of practice.	F 880	present the results of the Infection Control monitoring audits to the QAPI committee every month through the duration of the audit. The QAPI committee will review and monitor the results of this infection control performance improvement action plan monthly for a minimum of 5 months. The committee will make recommendations, extend, or modify the plan as necessary in order to ensure sustained compliance with F880 Infection Prevention and Control. Date corrective actions are completed: 06/30/20	

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An interview with the Alexander County Infection Control Nurse on 06/05/20 at 03:45 PM indicated she and the Alexander County Assistant Health Director had contact with Valley Nursing Center during the pandemic but were unaware of any shortage of PPE including gowns at the facility. She further stated she had not advised the facility of acceptable practice being not to use a gown when providing care in a room that indicated Contact Precaution. She further stated it was important to perform proper hand hygiene and to use gown and gloves when in rooms that indicated Contact Precautions in order to decrease the risk for transmission of infection from one resident to another through contact with an individual or surfaces potentially contaminated in the room.

An interview with the Alexander County Assistant Health Director on 06/05/20 at 05:27 PM revealed she had contact with Valley Nursing Center during the pandemic and was unaware of a shortage of gowns in the facility. She stated she had not advised the facility that it was acceptable practice to not wear gowns in rooms that indicated Contact Precautions and it was a necessity to perform proper hand hygiene and use the appropriate PPE including gown and gloves in a room of residents that Contact Precautions signage. She stated she had made a site visit following a complaint related to infection control she had received around 04/07/20 and had sent a toolkit to the facility with strategies for PPE during the pandemic.

A follow-up email from the Alexander County Assistant Health Director on 06/05/20 at 05:35 PM revealed she had made a site visit following

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an infection control complaint with a patient in the ventilator unit at Valley Nursing Center and COVID-19 testing supplies were supplied at that time. An email attachment revealed a toolkit was emailed to the Assistant Administrator on 04/22/20 at 09:32 AM. The Long-Term Care toolkit included preparation of gown conservation/optimization during the pandemic that had been provided by the Deputy Director/Section Chief of Division of Public Health.

An interview with the Physician on 06/08/20 at 10:29 AM revealed staff should wear proper PPE to include gown and gloves when providing patient care in rooms with signage indicating Contact Precautions. He further indicated he was unaware the facility had a shortage of isolation gowns and would follow-up.

An interview with the Associate Director of the North Carolina Statewide Program for Infection Control and Epidemiology on 06/08/20 at 1:37 PM revealed proper hand hygiene should be performed and PPE including gowns and gloves should be worn when in rooms with signage that indicated Contact Precautions to decrease the risk of transmission-based illnesses.

A follow-up interview was conducted with the Assistant Administrator on 06/09/20 at 08:09 AM. She revealed she felt the facility had a shortage of gowns to use in rooms with signage of Contact Precautions and then stated they had been denied on three occasions when she had made request for isolation gowns from Emergency Management. She stated she did not have records of any denials of PPE including isolation gowns. She further stated she had obtained her

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guidance that gowns were not necessary in rooms that indicated Contact Precautions from the CDC website.

2. Resident #2 was readmitted to the facility on 07/23/14 with current diagnoses that included chronic respiratory failure with hypoxia or hypercapnia, COPD, and dependence on a ventilator.

A review of the care plan dated 11/19/19 for Resident #2 revealed she was at risk for complications related to ventilator and tracheostomy dependence. Review of an additional care plans dated 04/01/20 revealed Resident #2 is at risk for infection and social isolation related to COVID-19.

An Annual Minimum Data Set (MDS) dated 05/12/20 revealed Resident #2 was cognitively intact and required extensive to total dependence of staff for bed mobility, transfer dressing, and hygiene. It further revealed no diagnoses of infection present.

A review of a progress note written by the Nurse Practitioner dated 05/19/20 revealed Resident #2 had been febrile with a temperature reading greater than 99.0 and was placed on COVID-19 protocol for testing, but no lower respiratory culture was available in the electronic medical record during the record review.

a. An observation was made on 06/04/20 at approximately 10:45 AM. The observation revealed an Assistant Activity Director carrying plastic bags with personal belongings down the hallway and enter the room of Resident #2 without applying any PPE that included a gown or

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gloves. Signage on the outside of the door of Resident #2's room indicated Contact Precautions and included illustrations of the use of gown and gloves when entering the room. After entering the room, she placed the plastic bags on a chair at the bedside of Resident #2. She began removing multiple items from the bag and showing them to the resident while the resident was in the bed. Items that were not requested by Resident #2 were placed back in the plastic bags and the remainder of the items she touched and put away in the room. She then performed hand hygiene and retrieved the plastic bags from Resident #2's chair and exited the room.

An interview with the Assistant Activity Director was conducted on 06/04/20 at 10: 50 AM. The interview revealed she had delivered personal items purchased from outside the facility. She acknowledged the signage on the door of Resident #2's room indicated the room was on Contact Precautions. She indicated she was not aware she needed to wear a gown since she was not providing patient care. She confirmed she placed the plastic bags in Resident #2's chair, touch surfaces in the resident room, and placed unwanted items back in the bags and removed them from the room without wearing a gown.

b. An observation was made on 06/04/20 beginning at 10:55 AM. The observation revealed two nursing aides (NAs) entered Resident #2's room. The signage on the door indicate Resident #2 was on Contact Precautions and the need for gown and gloves when in the room. NA #1 entered the room bringing a mechanical lift that had been retrieved from a storage closet at the end of the hall. Both NAs were wearing surgical masks and gloves but were not wearing isolation

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	345247	A. BUILDING _____ B. WING _____	06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY NURSING CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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gowns. NA #1 exited the room of Resident #2 and walked across the hall to a room then returned to Resident #2's room without wearing an isolation gown. The NAs completed incontinence care, dressing, and transferring Resident #2 using the mechanical lift before exiting the room. The mechanical lift was taken directly to the storage closet without being sanitized after use in a Contact Precaution room.

An interview with Nurse Aide #1 was made on 06/04/20 at 11:10 AM. The interview revealed she had provided activities of daily living (ADL) care for Resident #2. She acknowledged the signage on the door of the room indicated Resident #2 was on Contact Precautions which indicated the use of gown and gloves were necessary when in the room and stated she did not wear a gown during the care of Resident #2 during the observation but should wear one each time she entered the room. She stated she placed the mechanical lift in the storage closet without sanitizing it. She stated it should be sanitized between each use. She further indicated there were no wipes available in the lift storage room for use to sanitize multi-use equipment and she would have to ask a nurse for them.

Attempts to interview Nurse Aide (NA #2) were made on 06/04/20 without success.

An interview with the Unit Manager was conducted on 06/04/20 at 11:30 PM revealed she was responsible for supervision and part of the staff education for the nursing department. The Unit Manager indicated the facility initially had a shortage of PPE supplies in March 2020, but they were currently at a sufficient supply level and were using items as single use followed by its

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disposal. She stated staff always wore masks when on duty and don and doff a gown and gloves when providing patient care, contact with surfaces in the resident rooms, and perform hand hygiene after removal of PPE. She further indicated there were PPE including gown and gloves available on the outside of Resident #2 ' s door due to Contact Precautions during the survey.

An interview with the Director of Nursing (DON), Assistant Administrator, and Administrator was conducted on 06/04/20 at 12:20 PM revealed administrative staff had provided ongoing education on the use of PPE, hand hygiene, and transmission-based precautions. They collaboratively acknowledged multiple residents that included Resident #1 and 2 in the ventilator unit had signage on the outside of the resident room indicating contact precautions with illustration of need for gown and gloves when in the room. The DON and Assistant Administrator indicated they had been advised through the Health Department, State Health Lab, and the Centers for Disease Control and Prevention that staff were not required to wear gowns when entering a room and providing care to residents with signage indicating contact precautions. The assistant administrator indicated she had received supplies through the local health department and a through the Federal Emergency Management Agency (FEMA) since the start of the pandemic. The DON and assistant administrator agreed there were enough PPE supplied including gloves and gowns on the doors of the rooms that indicated Contact Precautions during the survey and that proper hand hygiene should be performed.

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An interview with the Alexander County Emergency Management Planner and Preparedness Coordinator on 06/05/20 at 03:19 PM revealed he had not been contacted and was unaware of a shortage of gowns at Valley Nursing Center during his weekly visits to deliver requested PPE since the start of the COVID-19 pandemic. He further stated he was told they had enough gowns and had recently shared a portion of their extra supply with another local health care entity who had a desperate need for gowns. He revealed he had provided the facility with an Emergency Respiratory Protection Plan at the start of the pandemic but had not given any advice to Valley Nursing Center related to non-necessity to wear a gown in a Contact Precaution room because it was beyond his scope of practice.

An interview with the Alexander County Infection Control Nurse on 06/05/20 at 03:45 PM indicated she and the Alexander County Assistant Health Director had contact with Valley Nursing Center during the pandemic but were unaware of any shortage of PPE including gowns at the facility. She further stated she had not advised the facility of acceptable practice being not to use a gown when providing care in a room that indicated contact precaution. She further stated it was important to perform proper hand hygiene and to use gown and gloves when in rooms that indicated Contact Precautions in order to decrease the risk for transmission of infection from one resident to another through contact with an individual or potentially contaminated surfaces in the room.

An interview with the Alexander County Assistant Health Director on 06/05/20 at 05:27 PM revealed

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she had contact with Valley Nursing Center during the pandemic and was unaware of a shortage of gowns in the facility. She stated she had not advised the facility that it was acceptable practice to not wear gowns in rooms that indicated contact precautions and it was a necessity to perform proper hand hygiene and use the appropriate PPE including gown and gloves in a room of residents that Contact Precautions signage. She stated she had made a site visit following a complaint related to infection control she had received around 04/07/20 and had sent a toolkit to the facility with strategies for PPE during the pandemic.

A follow-up email from the Alexander County Assistant Health Director on 06/05/20 at 05:35 PM revealed she had made a site visit following an infection control complaint with a patient in the ventilator unit at Valley Nursing Center and COVID-19 testing supplies had been provided. An email attachment revealed a toolkit was emailed to the Assistant Administrator on 04/22/20 at 09:32 AM. The Long-Term Care toolkit included preparation of gown conservation/optimization during the pandemic that had been provided by the Deputy Director/Section Chief of Division of Public Health.

An interview with the Physician on 06/08/20 at 10:29 AM revealed staff should wear proper PPE to include gown and gloves when providing patient care in rooms with signage that indicated Contact Precautions. He further indicated he was unaware the facility had a shortage of isolation gowns and would follow-up.

An interview with the Associate Director of the

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F 880	Continued From page 16 North Carolina Statewide Program for Infection Control and Epidemiology on 06/08/20 at 1:37 PM revealed proper hand hygiene should be performed and PPE including gowns and gloves should be worn when in rooms with signage that indicated Contact Precautions. A follow-up interview was conducted with the Assistant Administrator on 06/09/20 at 08:09 AM. She revealed she felt the facility had a shortage of gowns to use in rooms with signage of Contact Precautions and had been denied on three occasions when she had made request for isolation gowns. She stated she did not have records of any denials of PPE including isolation gowns. She further stated she had obtained her guidance that gowns were not necessary in rooms that indicated Contact Precautions from the CDC website.	F 880		