STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NURSING AND REHABILITATION CENTER	711 SUSAN TART ROAD DUNN, NC 28335

(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 12/04/2020. 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. Event ID# BD9B11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 12/04/2020. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Event ID #BD9B11. 1 of the 1 complaint allegation was substantiated resulting in a deficiency.	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:	F 880		1/8/21

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

Electronically Signed | 12/18/2020

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F 880	Continued From page 1 §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: (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	F 880		

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F 880	Continued From page 2 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: Based on observation, staff interviews and record and policy review, the facility failed to implement infection control practice by failing to screen the temperature of one of six staff listed on the working schedule for the COVID unit in the facility. This failure occurred during the COVID 19 pandemic. Findings included: A review of the Coronavirus Testing Policy dated 10/1/2020, stated under the heading of Policy Explanation and Compliance Guidelines: 2.The facility will screen all staff each shift, each resident daily, and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19. An observation was made on 12/1/2020 at 9:15 AM of staff being screened and temperatures taken upon entrance and exit of the facility. A screening sheet was recorded and signed. In a telephone interview on 12/2/2020 at 3:18 PM, Nurse #1 stated she is always screened, and her temperature is always taken when she enters and	F 880	F 880 Carrolton of Dunn Nursing and Rehabilitation 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 in order 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. Carrolton of Dunn Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Carrolton of Dunn Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

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F 880	Continued From page 3 leaves the facility. A review of the screening sheet for the COVID unit (500 hall) for 11/30/2020 revealed all scheduled staff were screened with temperatures taken except Nursing Assistant (NA) #3. On 12/2/2020 at 4:35 PM, in a telephone interview, the facility Administrator stated NA #3 had tested positive for COVID and she had been unavailable for notification. The Administrator noted he met NA #3 in front of the facility on 11/30/2020 and informed her of her positive status, asked her if she had any symptoms, and she stated she did not. The Administrator indicated NA #3 was asked the screening questions and informed her she could work on the COVID unit. The Administrator accompanied NA #3 to the outside entrance to the COVID unit but did not take her temperature. The Administrator stated the screening sheet had not been put on the table at the entrance to the COVID unit yet on 11/30/2020. In a telephone interview on 12/3/2020 at 11:20 AM, NA #3 stated the Administrator met her at the door to the facility on 11/30/2020 and told her she was positive for COVID. NA #3 noted she told the Administrator she had no symptoms and he accompanied her to the outside door to the COVID unit, she entered the unit, donned Personal Protective Equipment (PPE) and went to work. NA #3 stated she did not remember if her temperature was taken on 11/30/2020. On 12/3/2020 at 11:05 AM, the Administrator stated the absence of the screening sheet at the COVID unit entrance was why NA #3 did not have her temperature taken.	F 880	On 11/30/2020, a Root-Cause Analysis was conducted by the Administrator, Director of Nursing (DON), and Corporate Infection Control Preventionist. It was determined that the root cause of this deficient process was that the Staff/Visitor Screening Log was not placed at the entrance of the COVID unit, therefore resulting in failure to obtain a temperature on NA#3. On 11/30/2020, the Staff/Visitor Screening Log was placed at the COVID unit entrance by the Administrator. On 11/30/2020, the 500 Hall Nurse was assigned to the staff screening station at the COVID unit entrance to ensure all staff entering the COVID unit had completed the screening questionnaire, and a temperature was obtained and documented, in addition to the date and time with the staff name on the Staff/Visitor Screening Log. On 12/2/2020, an 100% audit of all Staff/Visitor Screening Logs was completed by the Corporate Infection Control Preventionist to ensure all staff and visitors were screened correctly upon entry to the facility to include a completed and documented temperature, screening questionnaire, and the date and time of screening process with the staff member's name on the Staff/Visitor Log. Any concerns identified during the audit were immediately addressed by the Administrator, DON, or the Corporate Infection Control Preventionist to include	

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F 880	Continued From page 4	F 880	staff re-education. On 12/14/2020 in in-service for all staff to include NA #3 was initiated by the Corporate Infection Control Preventionist on Screening Station Instructions with emphasis on ensuring the Staff/Visitor Logs are correctly completed to include staff temperature, completion of screening questionnaire, and the date and time of screening process with the staff member's name on the Staff/Visitor Log. This in-service will be completed by 1/8/2021. All newly hired staff to include agency staff will receive this in-service during orientation by the Administrator, DON, ADON, Nurse Manager, or the Staff Facilitator (SF) regarding Screening Station Instructions with emphasis on ensuring the Staff/Visitor Logs are correctly completed to include staff temperature, completion of screening questionnaire, and the date and time of screening process with the staff member's name on the Staff/Visitor Log. All Staff/Visitor Logs will be reviewed during the morning Interdisciplinary Team (IDT) meeting 5 times weekly for 8 weeks, then once weekly x 1 month, using the Screening Log Monitoring tool to ensure all Staff/Visitor Logs are completed accurately to include staff temperature, completion of screening questionnaire, and the date and time of screening process with the staff member's name on the Staff/Visitor Log. Any areas of identified concern will be immediately addressed by the Administrator and/or the	

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F 880	Continued From page 5	F 880	DON to include re-education of staff. The Administrator and/or the DON will initial the Screening Log Monitoring tool upon completion of Staff/Visitor Log review. The Administrator and/or the DON will present the findings of the Screening Log Monitoring tool to the Executive Quality Improvement (QI) Committee monthly for 3 months. Any issues, concerns, and/or trends identified will be addressed by implementing changes as necessary, to include continued frequency of monitoring. The Administrator and the DON will be responsible for the implementation of corrective actions to include all 100% audits, in-services, and monitoring related to the plan of correction.	