STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING _____ B. WING _____	C 12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN RIVER NURSING AND REHABILITATION CENTER	1341 PARADISE ROAD EDENTON, NC 27932

(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 recertification and complaint investigation survey was conducted on 11/29/22 through 12/2/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #RWJ011	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/29/22 through 12/2/22. Event # RWJ011. The following intakes were investigated NC00183706, NC00194263, NC00188301. 1 of the 7 complaint allegations was substantiated but did not result in a deficiency.	F 000		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor these interventions the committee put into place following the 3/4/21 focused infection control survey and recertification and complaint survey on 4/30/21. This was for a recited deficiency on the current recertification survey in the area of infection control. The continued failure during three federal surveys shows a pattern of the	F 867	Chowan River 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.	12/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/16/2022

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F 867	Continued From page 1 facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F880: Based on observation, staff interviews, record review, the facility failed to perform hand hygiene between glove changes and failed to change soiled gloves before placing a clean dressing on the pressure ulcer for 1 of 3 residents observed for pressure ulcer treatment (Resident #28). During the recertification and complaint survey on 4/30/21 the facility was cited for failing to implement their procedures for PPE and hand hygiene. During the focused infection control survey on 3/4/21 the facility was cited for failure to post transmission-based precaution signage on quarantined resident's doors. An interview was completed on 12/2/22 at 11:10am with the Administrator and Corporate Consultant. The Administrator indicated the QAA committee meets monthly to discuss the facility's ongoing performance improvement plans. The Corporate Consultant indicated it was her expectation the facility continued to follow the QAA process and monitor those issues within the facility so they would not receive a recited deficiency.	F 867	Chowan River Nursing and Rehabilitation Center 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, Chowan River 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. F867 QAPI/QAA Improvement Activities On 12/06/2022, the Administrator initiated an audit of previous citations and action plans from 3/1/2021 to 12/1/2022 F880 infection control to ensure the QA committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by QA Nurse for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to education of staff. Audit will be completed by 12/22/2022. On 12/15/22, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Infection Preventionist and Quality Assurance (QA) Nurse regarding the Quality Assurance (QA) process to include implementation of Action Plans,	

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F 867	Continued From page 2	F 867	Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include infection control. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 12/22/22, all newly hired Administrator, DON, ADON, Infection Preventionist and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include infection control will be taken to the Quality Assurance committee for review monthly x 3 months by the QA Nurse. The Quality Assurance committee will review the data and determine if plan of corrections is being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include infection control and all current citations and QA	

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F 867	Continued From page 3	F 867	plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON, ADON, Infection Preventionist and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	
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		12/22/22

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F 880	Continued From page 4 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 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	F 880		

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F 880	Continued From page 5 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, record review, the facility failed to perform hand hygiene between glove changes and failed to change soiled gloves before placing a clean dressing on the pressure ulcer for 1 of 3 residents observed for pressure ulcer treatment (Resident #28). Findings included: Record review of the Facility Infection Prevention and Control Program (IPCP) Policy dated 3/10/20 revealed the facility was responsible to establish and maintain an effective program that provides a safe, sanitary, and comfortable environment and attempts to prevent the development and the transmission of diseases and infections. The IPCP objectives included to provide hand hygiene procedures to be followed by staff involved in direct resident contact. Record review of the Facility Wound Dressing Change Observation Audit Tool (no date) revealed gloves should be changed and hand hygiene performed when moving from dirty to clean wound care activities (e.g., after removal of soiled dressings, before handling clean supplies). During a continuous observation of a pressure ulcer treatment on 12/01/22 at 9:40 am through 9:55 am the Wound Nurse was observed to perform hand hygiene, don clean gloves, and remove the soiled dressing from Resident #28's	F 880	Chowan River 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. Chowan River Nursing and Rehabilitation Center 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, Chowan River 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. F880 Infection Prevention & Control On 12/01/2022, the Director of Nursing (DON) and Infection Preventionist immediately educated the treatment nurse regarding hand hygiene to include hand hygiene between glove change and when	

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F 880	Continued From page 6 sacral wound. She then removed the dirty gloves and donned clean gloves. No hand hygiene was completed prior to donning the clean gloves. She then cleaned the wound bed and surrounding skin with normal saline and patted dry with gauze pads. The Wound Nurse did not perform hand hygiene or change the dirty gloves and placed the clean dressing on the sacral wound bed with the dirty gloves. The Wound Nurse then removed the dirty gloves and donned clean gloves and completed the pressure ulcer treatment. No hand hygiene was completed prior to donning clean gloves. During an interview on 12/01/22 at 9:57 am the Wound Nurse revealed she was required to use hand sanitizer before donning gloves and should have changed the dirty gloves before touching the new dressing for Resident #28's pressure ulcer treatment. The Wound Nurse stated she normally performed hand hygiene and changed gloves when performing wound treatments but was unable to state why she did not complete it correctly during the observation. During an interview on 12/01/22 at 1:50 pm the Infection Preventionist revealed the Wound Nurse was required to use hand sanitizer or soap and water in between glove changes and she was to remove the dirty gloves, perform hand hygiene and don clean gloves between cleaning the wound and applying the new dressing. During an interview on 12/02/22 at 9:35 am the Director of Nursing (DON) revealed hand hygiene with either liquid hand sanitizer or soap and water was to be performed when gloves were removed. The DON stated the Wound Nurse had received education on hand hygiene and should have	F 880	moving from dirty to clean wound care activities. On 12/08/2022, the treatment nurse under the supervision of the Infection Preventionist completed wound care for resident #28 using appropriate hand hygiene and clean dressing technique. On 12/08/2022, the Infection Preventionist and Quality Assurance Nurse initiated Resident Care Audit-Hand Hygiene with all nurses providing wound care. This audit was to ensure staff used appropriate hand hygiene between glove change and when moving from dirty to clean wound care activities. The Infection Preventionist and QA nurse will address all concerns identified during the audit to include education of the nurse. Audit will be completed by 12/22/2022. After 12/22/2022, any nurse who has not worked or completed the resident care audit will complete on next scheduled work shift. On 12/08/2022, the Infection Preventionist and Director of Nursing initiated an in-service with all nurses regarding Hand Hygiene during Wound Care with emphasis on hand hygiene between changing gloves and when moving from dirty to clean wound care activities. In-service will be completed by 12/22/2022 After 12/22/2022, any nurse who has not worked or received the in-service will complete prior to next scheduled work shift. All newly hired nurses will be in-serviced during	

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F 880	Continued From page 7 changed gloves and performed hand hygiene before touching the new wound dressing for Resident #28. During an interview on 12/02/22 at 9:44 am the Administrator revealed the Wound Nurse was expected to change gloves and perform hand hygiene as required during the pressure ulcer treatment for Resident #28.	F 880	orientation regarding Hand Hygiene during Wound Care The Infection Preventionist and/or Assistant Director of Nursing (ADON) will complete 5 Resident Care Audit-Hand Hygiene with all nurses providing wound care weekly x 4 weeks then monthly x 1 month. This audit is to ensure staff used appropriate hand hygiene between glove change and when moving from dirty to clean wound care activities. The Infection Preventionist/ADON will address all concerns identified during the audit to include re-training of staff. The Director of Nursing (DON) will review the Resident Care Audit-Hand Hygiene weekly x 4 weeks then monthly x 1 month to ensure all areas of concerns were addressed. The Director of Nursing (DON) will present the findings of the Resident Care Audit-Hand Hygiene to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audit-Hand Hygiene to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	