

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 345179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2020
NAME OF PROVIDER OF SUPPLIER ACCORDIUS HEALTH AT MOORESVILLE		STREET ADDRESS, CITY, STATE, ZIP 752 E CENTER AVENUE MOORESVILLE, NC 28115	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, record review, staff and resident interviews the facility failed to implement the facility's policy on enhanced droplet precautions when staff failed to wear required personal protective equipment (PPE) when entering a resident's room and failed to perform hand hygiene when entering and exiting a resident's room for 1 of 3 (Resident #1) residents that were on enhanced droplet precautions. This failure occurred during a COVID-19 pandemic. The findings included: Review of a facility policy titled, COVID-19 Policy/Plan for Facilities updated 05/06/20 read in part, any resident placed in isolation for positive COVID-19 or as a person under investigation will be kept in Enhanced Droplet precautions or Airborne precautions modified for available PPE until such time as the physician determines such isolation is no longer clinically appropriate. This isolation utilizes private room or cohort with approved roommate situation with surgical mask or N95 (respirator mask) if available, eye protection, gloves, gown at all times when in the presence of the resident. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 was cognitively intact and required one person set up assistance with eating. Resident #1's physician order [REDACTED]. An interview with the Administrator on 08/18/20 at 9:28 AM revealed Resident #1 had been placed on isolation because she had spiked a temperature. The Administrator further indicated that results of Resident #1's COVID-19 test from 08/14/20 were still pending. An observation was made of Resident #1 on 08/18/20 at 10:30 AM. There was a sign on Resident #1's door that read Enhanced Droplet Precautions: Perform Hand Hygiene, N95 (respirator mask) when entering room, Eye protection when entering room, gown when entering room, gloves when entering room, and private room and keep door closed. Resident #1's door was open, and she was resting in bed with her eyes open. She indicated she needed to eat so she could take her medications. A continuous observation was made on 08/18/20 from 10:34 AM to 10:41 AM. Nurse Aide (NA) #1 was observed passing out breakfast trays on the unit where Resident #1 resided. She was observed to have on a N95 mask on but no other person protective equipment (PPE). NA #1 was observed to remove Resident #1's breakfast tray from the meal delivery cart and enter Resident #1's room without performing hand hygiene, or donning a gown, gloves or eye protection. Once NA #1 was in Resident #1's room she was observed to place the resident's breakfast tray on the bedside table and touch the end of Resident #1's bed and bedside table. Resident #1 requested a cup of coffee. NA #1 exited Resident #1's room without performing hand hygiene, NA #1 went to the meal cart and picked up a pitcher of coffee with her bare hands and poured a cup of coffee. NA #1 carried the cup of coffee from the meal cart and re-entered Resident #1's room again without performing hand hygiene or donning gown, gloves, or eye protection. Once NA #1 delivered Resident #1's coffee she exited the room and walked to a dispenser of hand sanitizer that was on a wall in the hallway and applied hand sanitizer to her hands. An interview was conducted with NA #1 on 08/18/20 at 11:31 AM. NA #1 confirmed that she usually worked on the unit where Resident #1 resided but did not generally take care of her. NA #1 confirmed that she took Resident #1's breakfast tray into the resident's room and forgot to put on her PPE, she added that she got busy and just forgot about the gear. NA #1 stated that she was expected to follow the instructions posted on the door when entering a resident's room, but she did not know why Resident #1 was on precautions. She further stated she would obtain the PPE needed from the cart that was located outside of the resident's room. NA #1 stated that she did not wear goggles when she entered Resident #1's room because she did not see many on the cart. She also stated she should have put on a gown, gloves, and a mask, but she also forgot to apply them when she delivered Resident #1's breakfast tray earlier in the shift. An interview was conducted with the Infection Control Preventionist (ICP) on 08/18/20 at 12:01 PM. The ICP confirmed that she ensures the residents who were on precautions had the appropriate PPE supplies available and she would randomly observe the staff donning and doffing the PPE to ensure proper usage. The ICP stated that the staff only wear PPE for residents that were on precautions and they were directed by the sign on the door as to what PPE they wear when they enter that room. The ICP stated that Resident #1 was on enhanced droplet precautions and the staff should follow the sign on her door and apply all the appropriate PPE when they enter her room and perform hand hygiene when they entered and exited the resident's room. She added that Resident #1 had a fever but was on 2 different antibiotics and her temperature had come down, but they were continuing to monitor her until her COVID-19 test came back. An interview was conducted with the Director of Nursing (DON) on 08/18/20 at 1:31 PM. The DON stated she had only been at the facility for 5 days and had discovered that the infection control program was lacking in some areas and was good in other areas. She stated that the staff needed some education in some areas. The DON confirmed that Resident #1 was a person under investigation for COVID-19 and was placed on precautions until her test results were back. She added that Resident #1 was on enhanced droplet precautions and before delivering Resident #1's breakfast tray NA #1 should have performed hand hygiene and applied the appropriate PPE that was listed on the sign on the door. Once in the room if she forgot something and needed to exit, she should have then removed the PPE performed hand hygiene or hollered for another staff member to obtain the needed item. The DON specified that before NA #1 re-entered Resident #1's room she should have put on the appropriate PPE and performed hand hygiene.</p>		

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