

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>345365</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>09/02/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>SIGNATURE HEALTHCARE OF KINSTON</b>		STREET ADDRESS, CITY, STATE, ZIP <b>907 CUNNINGHAM ROAD KINSTON, NC 28501</b>	
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  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide and implement an infection prevention and control program.</b>  Based on observations, staff interviews and review of the facility's infection control policy, the facility failed to implement their policy requiring staff to wear facemask while in the facility for 3 of 6 staff members. These staff members were observed in the kitchen, receiving a resident's meal tray in the dining area and in a resident's room on the 200 hallway. (Nursing Assistant #1, Nursing Assistant #2 and Dietary Aide #1) This failure occurred during the COVID-19 pandemic. The findings included: The facility's infection control policy for Novel Coronavirus dated on 8/18/20 stated for the duration of the state of emergency/COVID-19 pandemic, all direct care stakeholders were to wear a surgical facemask while in the facility. Non-direct care workers (such as dietary) out of resident care areas may utilize an antimicrobial mask. On 9/1/20 at 11:20 am nursing assistant #1 (NA) was observed standing inside a resident's room on the 200-hall. NA #1 was observed wearing a surgical mask below her chin exposing her mouth and nose. An interview was conducted with NA #1 on 9/1/20 at 1:15 pm. She stated masks were to be worn over the mouth and nose while in a resident's room and stated she had been trained on how and when to wear a mask while in the facility. On 9/1/20 at 12:10 pm NA #2 was observed in the dining room wearing a mask below her chin exposing her mouth and nose while receiving a resident's meal tray from the kitchen staff. An interview was conducted with NA #2 on 9/1/20 at 12:10 pm. NA #2 stated masks were to be worn covering the mouth and nose at all times and stated she had received training on how and when to wear a mask while in the facility. On 9/1/20 at 12:17 pm dietary aide #1 was observed in the kitchen standing by a steam table with her mask below her nose. An interview was conducted with dietary aide #1 on 9/1/20 at 12:20 pm. Dietary aide #1 stated she knew she was to be wearing her mask over her mouth and nose and had been trained on when and how to wear her mask. An interview was conducted with Director of Nursing (DON) at 1:30 pm on 9/1/20. The DON stated all staff had been trained to wear a mask over the mouth and nose at all times while in the facility. A telephone interview was conducted with the administrator at 2:00 pm on 9/2/20. The administrator stated all staff in the patient care areas and kitchen should wear a mask and the mask should be worn to cover the mouth and nose.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

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.