STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(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 05/27/2020. 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# 7RZY11.	E 000		
F 880 SS=E	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: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		

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

Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(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
F 880	Continued From page 1	F 880		

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:
Based on observation, record review, staff, and health department interview, the facility, did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(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
F 880	Continued From page 2	F 880		

implement social distancing among staff during COVID 19 screening for 8 of 8 staff reviewed for infection control, and 1 of 2 staff did not wear recommended Center for Disease Prevention (CDC) personal protective equipment (PPE) when entering a COVID-19 positive resident's room. These failures occurred during a COVID-19 pandemic.

Findings included:
The facility's policy from March 2020 for Employee screening during COVID 19 Pandemic stated that employees would be screened upon arrival and prior to entry for signs and symptoms, and prior to admittance to the building. The May 2020 CDC recommendations included to ensure all healthcare personnel wore a facemask for source control while in the facility and maintained good social distance of about 6 feet.
1. An observation of the employee screening process was conducted on 05/21/20 at 2:37 PM. Screening for all facility staff was being done in the employee breakroom, which could be entered from the employee parking lot. Nurse Aide (NA) #3 conducted the screening for the oncoming staff and was seated at the table in the breakroom with a mask on. Employees entered from the parking lot, took their own temperatures and were asked screening questions by NA #3 who recorded the answers on the log at the table. There were 8 employees in the breakroom waiting to be screened without masks on, and not practicing social distancing. Staff did not wear masks until the screening was completed and they were going to the unit.
An interview with NA #1 on 05/21/20 at 1:23 PM was done. The NA stated they were screened before their shift in the breakroom where she did hand hygiene, stood in line, took her temperature

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(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
F 880	Continued From page 3	F 880		

and responded to a series of questions. She stated she didn't put a mask on until she went out on the hall.
An observation on 05/21/20 at 2:47 PM revealed Housekeeper #3 coming into the breakroom from the hallway, where staff were being screened without a mask on.
Housekeeper #3 was interviewed on 05/21/20 at 2:47 PM. She stated she was working in the laundry and came to the breakroom to get pain medication for a headache. She stated she left her mask in the laundry room and walked through the facility without a mask on to get to the breakroom.
An observation was made of Nurse #4 on 05/21/20 at 2:50 PM. The nurse clocked in on the timeclock, did hand hygiene, took her temperature, answered the screening questions and then applied a mask. Six staff, without masks, were within 3 feet of her at the table.
An interview was conducted with Nurse #4 on 05/21/20 at 2:50 PM, she stated they conducted the screening process in the breakroom before each shift and the temperature needed to be below 100 degrees Fahrenheit in order to stay at work.
An interview with the DON and the Nurse Consultant was conducted on 05/21/20 at 3:00 PM regarding the employee screening process. They both stated staff should be social distancing and have a mask on during the screening process. The screener checked the temperature and asked the screening questions, if staff needed a mask when they came in, they would be given a surgical mask. The DON stated if they needed a N95 they came to the DON for it. She stated staff could use the area in the dining room to eat and should not be utilizing the breakroom for breaks or meals. She further stated they had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(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
F 880	Continued From page 4	F 880		

a lot of PPE donations, and had a good supply now.
2. The facility's policy dated March 2020 stated gown use should be prioritized for ... high contact resident care activities that provide opportunity for transfer of pathogens to the hands and clothing of healthcare personnel.
An observation was conducted on 05/21/20 at 2:31 PM with Housekeeping Staff #2 going into a Covid-19 positive resident's room to clean. The resident was on droplet, airborne and contact isolation. This required head covering, face mask, face shield, gown, gloves and shoe covers. The employee had donned shoe covers, gloves, mask and a poncho, with both arms exposed from the elbows to the wrists. Gowns and full foot to head suits were available to wear.
An interview was conducted with Housekeeping Staff #2 on 05/21/20 at 2:31 PM about room cleaning and PPE. The staff stated he liked the poncho instead of the gown. He was encouraged to put a gown on for better coverage and he stated he liked the poncho. A follow up interview with Housekeeping Staff #2 at 4:19 PM revealed his job duties included mopping and wiping down surfaces in COVID-19 positive rooms each day.
An interview with the DON and the Housekeeping Director on 05/21/20 at 12:35 PM was conducted. They stated there were plenty of gowns, shoe covers, head covers, gloves and face shields on the 400 hallway where the COVID-19 positive resident's room were located. The Housekeeping Director stated that Housekeeping staff should follow the same precautions as nursing staff for entering COVID positive rooms and should be fully covered with a gown.
A follow-up interview was conducted with the DON and the Nurse Consultant on 05/21/20 at 2:58 PM about PPE use and storage. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345103	A. BUILDING _____ B. WING _____	05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE	600 FULLWOOD LANE MATTHEWS, NC 28105

(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
F 880	Continued From page 5 and the Nurse Consultant both stated the housekeeping staff should have worn a gown or full body suit with the arms covered. The DON stated they had a variety of PPE over the last several weeks and initially when they had a shortage, they had used the ponchos and washable reusable gowns and staff had been instructed to wash their arms and hands before if ponchos were used. She stated all staff had been educated on all the PPE, storage and the recommendations for when to use it. She also stated that staff going into the COVID-19 positive rooms were required to wear a gown and gloves, mask, face shield if close to resident, and hair and foot covers. An interview with the Health Department nurse on 05/26/20 at 1:50 PM was conducted. She stated the housekeeping staff should wear full PPE attire if available and cover arms when entering a COVID-19 positive isolation room.	F 880		