STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 09/29/2020 through 09/30/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# JRLK11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 09/29/2020 through 9/30/2020. The facility was found to be out of compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Two of the eight complaint allegations were substantiated resulting in deficiencies. Event ID#JRLK11.	F 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,	F 880		10/22/20

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

Electronically Signed | 10/23/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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		

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 identified under the facility's IPCP and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 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 observations, staff interviews and review of the facility's infection control policies, the facility failed to implement their hand hygiene policy for 17 of 17 residents observed during meal tray delivery on the North hall when 2 nurse aides (NA) failed to remove gloves and perform hand hygiene after assisting the residents and before leaving the residents' rooms (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and #17). These failures occurred during a COVID-19 pandemic. The findings included: Review of the facility's infection control policy, "Handwashing" version date 3/10/2020, revealed, "Wash hands immediately after gloves are removed, between residents ...and when otherwise necessary to avoid transfer of microorganisms to other residents ...Good hand hygiene is essential ....Wash hands using soap and water. Waterless hand agents may be used if hands are not visibly soiled ..." On 9/29/20 at 8:45 am an interview with the Administrator identified the North hall as a non-Covid hall. The Administrator also stated that	F 880	Graham Healthcare & Rehabilitation acknowledges receipt of The Statement of Deficiencies and Purposes 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. Graham Healthcare & Rehabilitation'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, Graham Healthcare & Rehabilitation 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. F 880 The position of Graham Healthcare and Rehabilitation has established and does	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 the health department has given a directive that all employees wear full personal protective equipment (PPE) at all times while in the facility. On 9/29/20 a continuous observation was conducted on the North hall from 11:30am until 11:55 am of NA #1 and NA #2 delivering meal trays. Each NA was wearing a face mask, a face shield, gloves and a gown. Both pushed the meal cart to the lower end of the hall where they began delivering meal trays, starting with Resident #1 and #2. NA #1 and NA #2 removed a meal tray and entered Resident #1 and #2's room. They failed to perform hand hygiene before entering the room. They delivered the meal trays and assisted with opening the disposable meal containers. After exiting the room, NA #1 and NA #2 proceeded to the meal cart, wearing the same gloves without performing hand hygiene. NA #1 and NA #2 continued delivering the meal trays to Residents #3, #4, and #5. NA #2 entered Resident #6's room, assisted the resident with removing the bed covers from over her arms and pulled the resident's sleeves down on both arms. She then proceeded to set up the meal tray. NA #2 left the resident's room, failed to perform hand hygiene and change gloves and proceeded to the meal cart, removed a meal tray for Resident #7. NA #2 entered Resident #7's room, placed the meal tray on the overbed table then assisted the resident with repositioning. NA #2 exited the room and proceeded to the meal cart without performing hand hygiene. NA#1 and NA #2 delivered meal trays to Residents # 8, #9, #10, #11, #12, #13, #14, #15, #16 and ended with Resident #17, wearing the same pair of gloves and failing to perform hand hygiene. The observation ended after all 17 residents on the North hall had been served a meal tray.	F 880	maintain an infection prevention and control program that is designed to provide a safe, sanitary and comfortable environment in addition to help prevent the development and transmission of communicable diseases and infections. The root cause analysis was completed utilizing tool recommended by CMS. Both Nurse Aides identified stated that they were confused regarding the procedure directed by the Health Department, to wear gloves at all times, even when in the hallway. In addition, both Nurse Aides were provided with education regarding the proper infection control procedure and hand hygiene while delivering meal trays to residents on 9/30/2020 by the Director of Nursing. The Staff Facilitator/Infection Control Nurse also completed a validation for Hand Hygiene Competency and Personal Protective Equipment (PPE) Competency. Upon review and investigation, facility identified that although staff received education regarding hand hygiene and glove usage, there were no competencies on file to validate understanding of the process. (The group of people that reviewed the data were as follows: DON, SDC/Infection Preventionist, and the Administrator determined root cause from data reviewed) Residents residing on North Hall identified as 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17 all received and continue to receive a Respiratory Assessment and Vital Signs every shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 An interview, conducted with NA #1 on 9/29/20 at 2:00 pm, revealed her main responsibility was to provide showers for the residents. She stated she has been pulled to work on the hall recently but not been passing meal trays to the residents. NA #1 revealed she had received recent COVID-19 pandemic training and was instructed to remove gloves and wash or sanitize her hands before exiting each resident's room after assisting residents and before they left the room. She stated there was access to a sink with soap and water from each room. She further stated she was confused about changing gloves since they were told they needed to wear gloves all the time, even when in the hallways. She stated the gloves were kept in the residents' bathrooms and were not easily accessible. An interview, conducted with NA #2 on 9/29/20 at 2:10 pm, revealed she was a NA whose responsibility was to provide showers for the residents. She stated she has been pulled to work on the hall recently and has not been passing meal trays to the residents. NA #2 revealed she had received recent COVID-19 pandemic training and was instructed to remove gloves and wash or sanitize her hands before entering and exiting each resident's room after assisting residents and before they left the room. She stated there was access to a sink with soap and water from each room. She further stated she thought she should be changing gloves but was confused about being told she needed to wear gloves all the time, even when in the hallways. She stated the gloves were kept in the residents' bathrooms and were not easily accessible.	F 880	Any abnormal results from these assessments lead to notification to the residents Physician and Representative. Residents residing on North Hall have been identified as having the potential of being affected by the alleged deficient practice. Residents residing on the hall have been monitored for any signs and symptoms of infection and have remained unaffected. The facility will continue to monitor. On 9/30/2020 an in-service was initiated by the Director of Nursing with staff regarding proper infection control procedures and hand hygiene while passing meal trays. The in-service was 100% completed as of 10/22/2020. All newly hired staff will be in-serviced regarding the correct Infection Control procedures and hand hygiene while passing meal trays during new employee orientation. On 9/30/2020 an audit was completed by the MDS Nurse to ensure that staff followed proper infection control procedures and hand hygiene while passing meal trays. Any identified areas of concern were immediately corrected by the MDS Nurse. On 10/01/2020 the Staff Facilitator/Infection Control Nurse initiated validations of staff for Hand Hygiene Competency and Personal Protective Equipment (PPE) Competency. These validations were 100% completed by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345355	A. BUILDING _____ B. WING _____	C 09/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAHAM HEALTHCARE AND REHABILITATION CENTER	811 SNOWBIRD ROAD ROBBINSVILLE, NC 28771

(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 An interview, conducted with the Infection Preventionist (IF) on 9/30/20 at 9:00 am, revealed, at the end of August 2020, the health department instructed the facility that all employees should wear full PPE at all times. The IF stated she provided in-services to all staff on COVID-19 precautions which included all staff should perform hand hygiene when entering and exiting a resident's room. She stated that she, the DON, the Nursing Supervisor and the Administrator observed staff daily to ensure they were following basic infection control policy and procedures. If staff were found not to be following policy and procedure, they were immediately educated. The interview further revealed she expected the NAs to perform hand hygiene and put on a new pair of gloves between residents when delivering the meal trays. An interview with the DON on 9/30/20 at 9:20 am revealed she participated in surveillance of the staff daily to ensure staff were following basic infection control policy and procedures. If staff were found not to be following policy and procedure, they were immediately educated. The interview further revealed she expected the NAs to perform hand hygiene and put on a new pair of gloves between residents when delivering the meal trays.	F 880	10/22/2020. All newly hired staff will be validated for Hand Hygiene Competency and Personal Protective Equipment (PPE) Competency during new employee orientation. The Administrative Nursing Staff will perform an audit and observation of infection control and hand hygiene while passing meal trays for 3-5 residents five times per week for two weeks, three times per week for two weeks, and then weekly for eight weeks. All identified areas of concern will be immediately corrected. The monthly QI committee will review the results of the meal tray pass audit tool monthly for 4 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator and/or DON will present the findings and recommendations of the monthly QI committee to the Quarterly Executive QA committee for further recommendations and oversight. Graham Healthcare and Rehabilitation□s compliance date is 10/22/2020.	