DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 10/9/2020. 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# MTVK11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 10/9/2020. The facility was not found in compliance with 42 CFR §483.80 infection control regulations which resulted in a deficiency. See event ID #MTVK11 _1_ of the _2_ complaint allegation(s) was substantiated resulting in deficiency.	F 000		
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	F 880		10/30/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed; TITLE; (X6) DATE 10/28/2020

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
	345534	A. BUILDING ______ B. WING ______	C 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	**2702 FARRELL ROAD SANFORD, NC 27330**

(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 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 corrective actions taken by the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	**2702 FARRELL ROAD SANFORD, NC 27330**

(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

§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, staff interview, and review of the facility ' s COVID 19 plan, the facility failed to implement their COVID plan when two activity staff did not wear a face mask at all times while in the facility and when a nursing assistant failed to preform hand hygiene following resident contact when delivering resident meal trays to prevent the transmission of COIVD-19 virus for 3 of 12 staff (Activity Director, Assistant Activity Director, and Nursing Assistant #1) observed for infection control. These failures occurred during the COVID-19 pandemic.

Findings included:

The facility ' s COVID-19 plan created in March 2020 included methods to prevent transmission by using hand sanitizer or soap and water after each resident contact and to wear face masks while in the facility according to the Centers for Disease Control and Prevention (CDC) guidelines.

1. On 10/9/2020 at 10:40 am observation on Hall 400 (the facility ' s secured unit) revealed two activity staff were seated together in an office and they both were not wearing a mask. The Assistant Activity Director had no mask on and

F 880

Activity Director and Assistant observed without mask being worn appropriately. When questioned by Administrator, Administrator identified knowledge deficits on proper continuous placement, mandatory area for use of masks, and appropriate location for breaks.
Immediate in servicing to include Licensed Nurses and Certified Nursing Assistants (on duty at the time of the concern) was provided immediately upon notification of concern to include proper placement and mandatory area for mask use, and appropriate social distancing was provided by the Administrator on 10/06/2020, with questions & answers and return demonstration. No resident was affected by this deficient practice.

100% in service was provided by the Staff Development (Facility Infection Preventionist) and the Director of Nursing on proper placement of mask and appropriate use of mask initiated on 10/9/20 and completed on 10/12/20. This included all office staff, Licensed Nurses, Certified Nursing Assistants, Housekeeping, Dietary, and Rehabilitation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	**2702 FARRELL ROAD** **SANFORD, NC 27330**

(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 was sitting immediately (within 2 feet) next to the door to the office which was opened to the 400 hall way where residents resided. The Activity Director was sitting about 5 feet away from the office ' s door and had a mask around her neck that was not covering her nose or mouth. Observations from 10:40 am to 11:00 am revealed the two activity staff remained in their office, with the office door opened to the hallway and were not wearing a mask. Residents and staff were observed passing the office in the hallway during this 20-minute observation. At 11:05 am the two activity staff did not don a mask when a surveyor entered their office. The Activity Director was interviewed on 10/9/2020 at 11:05 am. The Director stated that the facility was following COVID-19 restrictions. She also commented there were recently employees with positive COVID-19 infection results (the Activity Director and assistant were not wearing a mask in their office with the door open). The Activity Director did not comment on why she and her assistant were not wearing a mask. On 10/9/2020 at 11:20 am Unit Manager #1 was interviewed while on Hall 400 and commented that "all staff were required to wear a mask upon entry to the facility when screened and staff were aware of this." Unit Manager #1 stated she would talk with the activity staff about not wearing a mask in their office. Unit Manager #1 entered the activity office and neither staff member was wearing a mask. She then directed the staff to wear their mask. Unit Manager #1 verified that activity staff were not wearing their mask and did not know why.	F 880	Services. This education will be incorporated in the orientation of new staff. 100% audit of all staff was conducted over 3 days. This audit included observations for appropriate use of face masks, proper placement, and staff breaks taken in appropriate places. These audits were conducted on 10/11/20, 10/12/20, and 10/13/20 by the Director of Nursing, Staff Development and the Administrator, no issues were identified. The Director of Nursing, Staff Development (Facility Infection Preventionist), and Administrator will conduct random daily audits of face mask placement and appropriate use on at least 10 staff members, daily x 4weeks. Then audits will be conducted 3 days a week x 8 weeks. The Director of Nursing will bring the random audit results to the Quality Assurance Committee monthly x 3 months. Nursing Staff member observed to not use hand sanitizer or hand wash with soap and water after placing a meal tray on the resident's bedside table and exited the room. Staff member then removed another tray from the meal cart, entered another resident's room and placed the tray on the tray table and exited the room. Nursing staff stopped in the hall to assist a resident back to her room. Nursing staff touched the resident's items in the room	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	**2702 FARRELL ROAD SANFORD, NC 27330**

(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 was conducted with the Administrator on 10/9/2020 at 11:40 am. She stated all staff members "were required to wear a face mask at all times." The Administrator comment she was informed that activity staff were not wearing face masks and that she would in-service them immediately. The Administrator also commented that she understood this failure to wear a face mask was not following facility policy for COVID-19. The Director of Nursing was interviewed on 10/9/2020 at 11:55 am. As part of the COVID-19 plan all staff were screened upon entry to the facility and were required to wear a face mask while inside the facility. 2. The Director of Nursing was interviewed on 10/9/2020 at 11:55 am. He commented as part of the COVID-19 plan all staff were required to clean their hands either with hand sanitizer or soap and water after each resident contact. On 10/9/2020 from 12:15 pm to 12:22 pm an observation of Hall 100 (general population) meal tray pass was completed. On 10/09/20 at 12:15 pm Nursing Assistant (NA) #1 was observed to not use hand sanitizer or hand wash with soap and water after placing a meal tray on the resident ' s bedside table and exited the room. NA #1 then removed another tray from the meal cart, entered another resident room and placed the tray on the tray table and exited the room. NA #1 stopped in the hall to assist Resident #1 back to her room. NA #1 touched the resident and items in the resident ' s room. NA #1 returned to the meal cart and then retrieved Resident #1 ' s meal tray from the cart, placed the tray on the bedside table and set up the food. NA #1 exited the resident ' s room without performing hand	F 880	and returned to the meal care without performing hand hygiene. Nursing staff member was immediately in-serviced on proper hand hygiene protocols. 100% in service was provided by the Staff Development (Facility Infection Preventionist) and the Director of Nursing on proper hand hygiene while providing care, assisting residents, any contact, and as needed initiated on 10/9/20 and completed on 10/12/20. This included office staff, Licensed Nurses, Certified Nursing Assistants, Housekeeping, Dietary, and Rehabilitation Services. This education will be incorporated in the orientation of new staff. 100% audit of all staff was conducted over 3 days. This audit included observations for appropriate use of hand sanitizer/hand washing while providing care, assisting residents, any contact, and as needed in between resident care. These audits were conducted on 10/11/20, 10/12/20, and 10/13/20 by the Director of Nursing, Staff Development and the Administrator, no issues were identified. The Director of Nursing, Staff Development (Facility Infection Preventionist), and Administrator will conduct random daily audits of proper hand hygiene while providing care, assisting residents, any contact, and as needed in between resident care on at least 10 staff members, daily x 4weeks. Then audits will be conducted 3 days a week x 8 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING ______ B. WING ______	C 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 hygiene. At 12:22 pm NA #1 returned to the meal cart and went to handle another tray and was asked to stop. NA #1 had not used hand sanitizer or hand wash with soap and water between 3 residents for the meal service which included physical assistance. NA #1 was interviewed on 10/9/2020 at 12:22 pm. The NA responded that she had forgotten to clean her hands between the residents for this meal service. The NA #1 stated she would "do that now" (she cleaned her hands with hand sanitizer from the hallway dispenser). NA #1 commented that she was aware of the importance to clean the hands between resident care due to COVID-19 virus for the residents and her own safety. On 10/9/2020 at 1:00 pm an interview was conducted with the Administrator who was informed of a staff ' s failure to clean her hands between resident meal service and assistance. The Administrator stated that staff was expected to clean their hands between providing care, assistance to the residents, any contact, and as needed. The Administrator stated she would follow up with education.	F 880	The Director of Nursing will bring the random audit results to the Quality Assurance Committee monthly x 3 months.	