| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345449 | A. Building<br>B. Wing | 06/24/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| King Health and Rehabilitation Center | 115 White Road<br>King, NC 27021 |

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) |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on observations, record review and staff interviews, the facility failed to implement their policies and procedures for hand hygiene when NA #1 failed to perform hand hygiene after handling dirty linens and NA #2 failed to perform hand hygiene while handling residents water cups and passing fresh ice and water. This was for 2 of 5 staff members observed for infection control practices (NA #1 and NA #2).Findings included:A review of the facility policy titled Hand Washing Requirements with effective date of 2/6/20 stated in part: Hand hygiene should be performed after handling soiled equipment or utensils, after removing gloves or aprons, and after any contact with potentially contaminated objects. There was no mention of how to handle soiled linens in the policy.a. A continuous observation was completed on 6/21/26 from 11:33AM to 11:40AM. NA #1 came out of a resident's room and removed her gloves and threw them in the trash bin in the hallway. She did not perform hand hygiene, and a wall mounted hand sanitizer dispenser was observed nearby on the wall in the hallway. NA #1 entered another resident's room and donned a pair of gloves. She gathered up a pile of dirty linens from the resident's room and carried them into the hallway and placed them into a dirty linen bin. NA #1 then removed her gloves and threw them in the trash but did not perform hand hygiene. NA #1 then proceeded to remove a clean washcloth from 1 the linen cart in the hall at which time she was asked if she had completed hand hygiene. NA #1 stated she had not and that she was just nervous and she should have completed hand hygiene. b. A continuous observation was completed on 6/21/26 from 11:45AM to 11:48AM. NA #2 entered a resident's room, and with her bare hands removed the lid from the resident's water cup and placed it on the bedside table. NA #2 exited the room out into the hallway and filled the cup with ice from an ice cooler in the hallway. NA #2 then took the cup back into the room and filled it with water from the bathroom sink and placed the cup back onto the resident's bedside table. NA #2 left the resident's room and did not complete hand hygiene. NA #2 then walked across the hallway to another resident's room and removed the lid from the resident's water cup and placed it on the bedside table. NA #2 exited the room out into the hallway and filled the cup with ice from an ice cooler in the hallway. She then went into the bathroom and filled the cup with water and then placed it back on that resident's bedside table. NA #2 left that resident's room and did not complete hand hygiene before entering the next resident's room. The Surveyor then intervened and asked NA #2 to come out into the hallway. NA #2 was asked if she had been completing hand hygiene while passing ice and water. NA #2 stated she did not complete hand hygiene but should have because she could have brought germs from one resident to the next because she did not clean her hands between handling their dirty cups. An interview with the Director of Nursing (DON) was completed on 6/24/26 at 11:30AM. She stated that all staff were trained on hand hygiene during their new hire orientation as well as annually and as needed. She stated NA #1 had told her she had been observed by a state surveyor not completing hand hygiene and the DON reeducated on hand hygiene immediately. The DON stated both NA #1 and NA #2 should have completed hand hygiene and the entire staff would be reeducated on proper hand hygiene. She also stated the facility had very recently hired an Infection Preventionist, but she had just begun her employment and had not completed her training yet. In an interview with the Administrator on 6/24/26 at 3:00PM, he stated he expected the staff to follow proper hand hygiene. |

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.

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