

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

PRINTED: 12/06/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>DEC 10 2011</u> B. WING _____	(X3) DATE SURVEY COMPLETED C 11/22/2011
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NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803
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<p>F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to provide privacy to 1 of 1 (Resident #1) sampled residents. Findings include:</p> <p>Resident #1 was admitted to the facility on 3/7/11 with cumulative diagnoses of dementia, muscle weakness and hypertension. Resident #1 was severely impaired in cognition.</p> <p>In an observation on 11/21/11 at 2:14 PM of Nursing Assistant (NA) #1, the door to Resident #1's room was closed. Entry was made after knocking and being invited in. On entering the room, the privacy curtain between the door and Resident #1's bed had been pulled to the end of the bed. From the foot of the bed Resident #1 was observed lying on the bed unclothed with no coverings. The privacy curtain between the beds had not been pulled closed. The window blinds in the room had not been shut and several people were seen from inside the room. Resident #1's roommate was sitting in a wheelchair between the beds between the middle and the foot of the beds.</p> <p>In an interview on 11/21/11 at 2:46 PM with NA #1 she indicated that she had exposed Resident</p>	<p>F 241</p> <p>“Submission of this response to the Statement of Deficiency by the undersigned does not constitute an admission that the deficiency existed and/or were correctly cited and/or require correction.</p> <p>F Tag 241</p> <p>Resident #1 was interviewed by the Director of Social Services regarding her concerns over the delivery of her care and respect for her dignity. The resident expressed no concerns. This was done on December 6, 2011. The Director of Nursing met with the nurse aide involved and reviewed expectations for maintaining resident dignity during care delivery. This was done on November 22, 2011.</p> <p>Residents residing in the facility have the potential to be affected by the deficient practice, but no additional residents were identified.</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Freda Wright</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/10/11</i>
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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.

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F 241	Continued From page 1 #1's body too much. She stated that she had forgotten to pull the privacy curtain between the beds. NA #1 stated she did not realize that the blinds were open. She indicated that she should have pulled the privacy curtain and closed the blinds so that Resident #1 was not exposed. In an interview on 11/22/11 at 6:00 PM with the Director of Nursing (DON), she indicated she expected her staff to provide privacy to the residents by closing the door, pulling the privacy curtains closed and closing the blinds. She would expect staff to cover residents and not leave them exposed.	F 241	Nurse aides, nurses and staff were in-serviced by the Director of Nursing on December 5, 2011 on maintaining resident dignity, especially during care delivery. Ambassadors, during rounds, will observe staff to ensure they are maintaining resident dignity. During these rounds, care givers who are not compliant will be re-educated on dignity and respect of individuality. Any re-education will be written by the observer and submitted to the Director of Nursing. The Director of Nursing maintain the re-education forms and they will be reviewed at the monthly Quality Assurance Committee meeting for 3 months		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide ongoing assessment of a pressure ulcer for 1 of 3 (Resident #1) sampled residents whose wound care was observed. Resident #1 was admitted to the facility on 3/7/11 with cumulative diagnoses of dementia, muscle	F 314			

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F 314	Continued From page 2 weakness and Parkinson's disease. Resident #1's quarterly Minimum Data Set (MDS) dated 9/6/11 indicated Resident #1 was severely impaired in cognition and needed the limited assistance of 1 person for bed mobility. Resident #1 had a stage 4 pressure ulcer and did not reject care. Review of the facility's Wound Care/Treatment Guidelines released in 2007 stated in part, "A weekly assessment should be done on all wounds requiring treatment. This should include measurement and a description. Documentation of the treatment should be done immediately after the treatment." Review of the Record of Skin/Wound Healing sheets showed documentation of measurements and descriptions for 9/5/11 and 9/19/11. The next assessment of Resident #1's wound that the facility was able to provide was for 11/14/11. In an interview on 11/22/11 at 4:07 PM with the MDS nurse, she indicated that wound measurements were found in the wound book. She stated that measurements were taken on a Monday so they were available for the Standards of Care (SOC) meetings held on Wednesdays. She indicated that she was not sure who was consistently doing the wound measurements. She stated she did not know who was responsible for measuring the wounds weekly or even if they were being measured. In an interview on 11/22/11 at 4:40 PM with the Assistant Director of Nursing (ADON), she indicated that a Registered Nurse (RN) was	F 314	F Tag 314 Resident #1 had wounds measured by Registered Nurse on November 23, 2011 and recorded in wound book. All residents had a skin assessment completed by the Director of Nursing/Assistant Director of Nursing/Registered Nurse on November 23, 2011. All residents with wounds had wound measurements completed on 11/23/11. The Interdisciplinary team reviewed all resident with wounds for current treatments and appropriateness on 11/29/11. The MD was notified and new orders were obtained as indicated. The family was notified of any changes. All new admissions 8 page assessment, including skin assessment, will be reviewed by the Interdisciplinary team at next clinical portion of morning stand up.	12/12/11	

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F 314 Continued From page 3
required to do wound measurements. She stated that from mid September until November she and RN #2 took over doing wound measurements for Resident #1. Beginning in November she was responsible for measuring and documenting Resident #1's wounds. She indicated that all wound measurements were done weekly and documented on the wound sheets. The ADON stated that she did not measure Resident #1's wound on 11/21/11 or 11/22/11. She stated that the "person ultimately responsible was the person taking the measurements and that would be me."

In an interview on 11/22/11 at 4:55 PM with the Director of Nursing (DON), she indicated it was her expectation that wound measurements were taken weekly and transcribed to the wound sheets immediately following the measurements being taken.

F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

- (a) Infection Control Program
The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective actions related to infections.

F 314 The Director of Nursing educated the Assistant Director of Nursing on Wound Protocol. The was completed on November 30, 2011. Nursing in-service for Licensed nurses on Wound Documentation, Wound Protocol, 8 Page Admission assessment, family/physician notification and treatments was completed on November 30, 2011 by the Director of Nursing and Assistant Director of Nursing. Return treatment demonstration with charge nurses for wound treatment procedure was completed on December 9, 2011.

F 441

Registered Nurse will do weekly wound measurements. The MD and family will be notified of any changes. These will be reviewed weekly by the Interdisciplinary team in the Standards of Care meeting.

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F 441	<p>Continued From page 4</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to ensure that staff practiced proper handwashing techniques between touching dirty and clean surfaces for 1 of 1 (Resident #1) sampled residents. The facility also failed to ensure staff followed wound care guidelines for placement of dressing supplies for 1 of 3 (Resident #4) sampled residents whose wound care was observed. Findings include:</p> <p>1. The facility's Nursing Procedures/Certified Nursing Assistant Policy undated, stated in part, "All staff members will wash their hands before</p>	F 441	<p>The Director of Nursing will maintain a weekly wound log. The results of this log will be reviewed monthly at the Quality Assurance meeting for 3 month</p> <p>F Tag 441</p> <p>Resident #1 and Resident #4 was assessed by the charge nurse for signs or symptoms of infection. There was no indication of infection in either resident.</p> <p>Residents in that assigned section were assessed for signs or symptoms of infection. This was monitored for 7 days with no untoward results.</p> <p>On December 5, 2011 at the All Staff Meeting, the Director of Nursing reviewed Infection Control Protocols and Hand Washing.</p> <p>Return demonstration of staff on proper hand washing procedure completed by</p>	12/12/11
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F 441	Continued From page 5 and after direct resident care and after contact with potentially contaminated substances to prevent, to the extent possible, the spread of nosocomial infections." Resident #1 was admitted to the facility on 3/7/11 with cumulative diagnoses of dementia, muscle weakness and hypertension. In an observation on 11/21/11 at 2:14 PM of Nursing Assistant (NA) #1, the NA emptied Resident #1's urinary catheter into a graduated container with gloved hands. The container was emptied into the toilet by the NA. The nursing assistant did not wash her hands or change her gloves. The NA proceeded to dress the resident in her clean clothes. When the resident was dressed the NA went to Resident #1 ' s dresser, opened the drawer and rummaged around inside the drawer for socks for Resident #1. NA #1 was still wearing the same gloves she had on when she emptied the urinary catheter and disposed of the urine. In an interview on 11/21/11 at 2:46 PM with NA #1, she indicated she should have changed her gloves and washed her hands after emptying Resident #1's urinary catheter. She stated she should not have gone into Resident #1's dresser drawer before washing her hands and changing her gloves. In an interview on 11/22/11 at 8:10 AM with the Assistant Director of Nursing (ADON), she stated there had been an in-service on hand washing within the last 6 months. She indicated there should be a shield between dirty and clean and gloves should be changed and hands washed	F 441	Director of Nursing, Assistant Director of Nursing, Housekeeping Supervisor, Dietary Manager, and Licensed Nurse by December 10, 2011. Ambassadors will observe staff during daily rounds for non-compliance. Staff who are not compliant will be re-educated on hand washing and a return demonstration will be done and documented by the nurse in charge on the day observation was made. Weekly random hand washing demonstrations and dressing change procedures will be monitored by the Director of Nursing and Assistant Director of Nursing for infection control for the next 12 weeks. The results of these audits will be maintained by the Director of Nursing and reviewed at the Monthly Quality Assurance Meeting for the next 3 months.		

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F 441	<p>Continued From page 6</p> <p>prior to touching clean items. She stated that NA #1 should have washed her hands and changed her gloves after handling the graduated container and urinary catheter. She indicated that by not washing her hands and changing her gloves, NA #1 had contaminated everything in the dresser drawer.</p> <p>In an interview on 11/22/11 at 6:00 PM with the Director of Nursing (DON), she stated she expected the staff to change gloves and wash their hands anytime they were moving from a dirty to a clean environment. She indicated she would consider this to be an infection control problem.</p> <p>2. The facility's Patient Care Policy entitled WOUND CARE/TREATMENT GUIDELINES in the Infection Control Manual, dated 2007, stated in part; "Supplies (other than the trash bag) are not to be placed on the bed. Supplies should be placed on a clean surface."</p> <p>Resident #4 was readmitted to the facility on 12/01/10 with cumulative diagnoses of diabetes mellitus, chronic skin ulcers, anemia, hypertension, and depression.</p> <p>A wound care observation was made of Nurse #1 on 11/22/11 at 2:15 PM. Nurse #1 walked into the room and placed an open sleeve of non-sterile gauze dressings, a bottle of skin cleanser, two packages of foam dressings, and a roll of adhesive gauze dressing on Resident #4's bed directly on the blanket. After Nurse #1 completed wound treatments on Resident #4's right and left hip areas, she picked up the</p>	F 441		
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F 441	Continued From page 7 remaining supplies from Resident #4's bed and placed the open gauze dressings, bottle of skin cleanser, and roll of gauze adhesive dressing and placed them by the sink area as she proceeded to wash her hands. Nurse #1 picked up the supplies and said; "I better leave these in here," and placed the skin cleanser and open gauze pads on top of Resident #4's bedside table. Nurse #4 walked out of Resident #4's room and placed the roll of gauze adhesive and two empty foam packages on top of the treatment cart in the hallway. In an interview with Nurse #1 on 11/22/11 at 2:30 PM, she said she should not have put the roll of gauze adhesive and empty wrappers back on the treatment cart since she had laid them on the resident's bed because it could spread infection. Nurse #1 said she should have covered the table with a towel and placed the supplies on the table. During an interview with the Administrator and Director of Nurses (DON) on 11/22/11 at 6:05 PM, the DON said the facility's policy was for the nurse to place her wound care supplies on a piece of wax paper that would be placed on top of the resident's over bed table. The DON said she would not expect any clean supplies to be placed directly on a resident's bed or taken out of the room after they had been placed on the bed as the bed was considered to be a dirty surface.	F 441			