

AMENDED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 05/10/2011
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NAME OF PROVIDER OR SUPPLIER  CAMELOT MANOR NURSING CARE FAC	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNSET ST GRANITE FALLS, NC 28630
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F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</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>	F 441	<div data-bbox="982 1501 1299 1690" style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> <p>RECEIVED MAY 31 2011 BY: _____</p> </div>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  ✓ <i>Sandy E. Ford</i>	TITLE  ✓ <i>RN Don</i> ✓	(X6) DATE  5/25/11
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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.

Original Signature Date: 5-20-11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement infection control precautions for two (2) of six (6) sampled residents. (Residents #2 and #11)</p> <p>The findings are:</p> <p>1. Review of the facility's revised infection control policy dated 03/2011 revealed that under the heading Resident Transport the policy read, "Limit transport and movement of residents outside of room to medically necessary purposes. When transport or movement is necessary, instruct resident to wear a surgical mask and follow respiratory hygiene and cough etiquette."</p> <p>Resident #2, was admitted to the facility on 12/04/09. The resident's diagnoses included Methicillin Resistant Staph Aureus (MRSA) Infection in his lungs and sputum and had a tracheostomy. Resident #2's Minimum Data Set (MDS) dated 03/14/11 revealed he was cognitively intact and exhibited behaviors which included being resistive to care.</p> <p>Review of Resident #2's care plan dated 03/14/11 revealed a problem which addressed, a potential for altered respiratory function related to his tracheostomy. Listed under this problem was, MRSA of tracheostomy and nares; droplet precaution and antibiotic therapy. Additional approaches listed under this problem were "resident refuses to stay in his room; he is reminded to stay in his room." The care plan dated 03/14/11 also listed behavior as a problem,</p>	F 441	<p>Resident #2 was reassessed by newly Hired DON and resident observed to be in full compliance with use of tracheostomy coverage while in and out of his room. When resident is in room and does not have tracheostomy covered, staff continued to follow droplet precautions to prevent contact or respiratory exposure.</p> <p>No resistive behaviors noted on May 11<sup>th</sup>-13<sup>th</sup>, according to nursing notes.</p> <p>1) Current approaches to behavior were continued due to improved behavior and compliance by Resident for infection control instructions.</p>	5/13/2011	

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F 441	<p>Continued From page 2</p> <p>"resident continued to refuse to keep bib around his neck; remind/instruct resident to leave bandages/covering intact."</p> <p>Laboratory results of a respiratory/sputum culture collected on 03/24/11 revealed the resident had heavy growth of Methicillin Resistant Staphylococcus Aureus (MRSA). Review of a Physician's Assistant (PA) note dated 03/25/11 revealed the resident was assessed as having MRSA colonized in his lungs.</p> <p>Further review of Resident #2's laboratory reports revealed a sputum culture collected on 04/03/11 which specified a light growth of Pseudomonas aeruginosa, Klebsiella pneumoniae and heavy growth of Methicillin Resistant Staphylococcus Aureus. A hand written notation on this laboratory culture and sensitivity report dated 04/05/11 noted Tetracycline 500 milligrams and Cipro 500 milligrams. Both of these medications were ordered to be given twice a day for ten days.</p> <p>An observation on 04/27/11 at 7:01 AM revealed Resident #2 was sitting in his wheelchair in the doorway of his room. Resident #2 was not wearing a cover over his tracheostomy.</p> <p>On 04/27/11 at 7:02 AM an interview was conducted with Nursing Assistant (NA) #1. NA #1 reported that Resident #2 was not always compliant with keeping his tracheostomy covered and when this occurred staff would attempt to redirect him to his room.</p> <p>On 04/27/11 at 10:07 AM Resident #2 was again observed sitting in the doorway of his room with his tracheostomy uncovered. Licensed Nurse #1</p>	F 441	<p>Resident #2 noted to be colonized According to MD note on Wednesday 5/11/2011.</p> <p>RN Charge Nurse on each shift reported results of any cultures taken and validated positive MDRO's to MD immediately. Appropriate isolation precautions were initiated and appropriate PPE were available for all who entered resident's room or who came in contact with resident.</p> <p>Resident #2 was discharged to hospital with increased temperatures, nausea and vomiting resulting in an acute condition that warranted hospitalization. Hospice to continue to follow while in Hospital.</p> <p>RN Charge Nurses on each shift to continue to assess, document and intervene on resident and staff compliance with Infection Control procedures and practices. These to include standard, contact and droplet precautions and/or isolation with emphasis on wound care procedures.</p> <p>DON to oversee daily adherence to Infection Control policies by reviewing Audits completed by RN Charge Nurse and take action as indicated to include educational needs of staff.</p>	<p>5/11/2011</p> <p>5/11/2011</p> <p>5/13/2011</p> <p>6/3/2011</p> <p>6/03/2011</p>

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F 441	<p>Continued From page 3</p> <p>(LN) was observed to walk past Resident #2 and did not say anything to the resident about his tracheostomy being uncovered. After the staff member past by him the resident was observed to stick his finger into his tracheostomy cough and wipe sputum on the door of the room.</p> <p>An interview conducted on 04/27/11 at 10:10 AM with LN #1 revealed that he was the treatment nurse and he made rounds with the doctor when he saw residents for wound treatment. LN #1 further reported that his role on this day was to make sure that infection control precautions were being followed. LN #1 reported that Resident #2 was to wear a cover over his tracheostomy at all times.</p> <p>On 04/27/11 at 10:12 AM, Resident #2 was observed leaving his room in his wheelchair with his tracheostomy uncovered. The resident was observed to propel his wheel chair down the hall past the nursing station and around a corner. LN #1 was in sight of the resident when he left his room but did not redirect the resident to cover his tracheostomy stoma. Approximately three (3) minutes later the Director of Nurses (DON) was observed assisting Resident #2 back to his room in his wheel chair and the resident was holding a cloth cover over his tracheostomy.</p> <p>Interview with the Director of Nursing (DON) on 04/27/11 at 2:35 PM revealed that since his admission to the facility Resident #2 had been noncompliant with following infection control precautions including keeping his tracheostomy covered. The DON reported that Resident #2 was educated by staff regarding his MRSA and staff attempted to redirect his behaviors. The</p>	F 441	<p>Residents will be screened on Admission, reassessed when symptomatic and following Lab results for MDRO (Multi-Drug resistant organisms), placed on appropriate standard, contact, droplet precautions and/or isolation and wound care procedures as indicated.</p> <p>CDC guidelines for "<i>Type and Duration of Precautions Recommended For Selected Infections and Conditions</i>" will be utilized to determine type and duration of precautions needed.</p>	<p>6/3/2011</p> <p>6/3/2011</p>

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F 441	<p>Continued From page 4</p> <p>DON reported an incident when the resident sprayed sputum from his tracheostomy, while he was infected with MRSA, onto clean linen stored in a cart on the hall. The DON stated that Resident #2's MRSA was colonized but he was still contagious and could not be taken off of droplet precautions due to his behaviors. The DON further stated that their job was to take care of him and protect others.</p> <p>On 05/10/11 at 3:00 PM an interview was conducted with the Physician Assistant (PA). The PA reported that Resident #2 was colonized with MRSA in his sputum and lungs. The PA further stated that although Resident #2 was colonized and did not have an active infection he could spread the infection when he coughed through the tracheostomy onto other individuals or wiped his sputum on surfaces.</p> <p>2. Review of the facility's policy entitled "Infection Prevention and Control" revealed it was reviewed/revised on 03/2011 and had a listing of situations which required "Hand Hygiene". Review of this list revealed that hand hygiene should be performed by staff at times which included; before and after entering isolation precaution settings, before and after changing a dressing and after removing gloves.</p> <p>Resident #11 was admitted to the facility on 03/24/11 with the diagnoses osteomyelitis and Methicillin Resistant Staph Aureus (MRSA) in his right foot wound. Resident #11's Minimum Data Set (MDS) revealed that he was cognitively impaired and needed total assistance with activities of daily living. Resident #11's physician's orders dated 04/27/11 revealed that he was to</p>	F 441	<p>Resident #11 was admitted on 3/24/2011 with Osteomyelitis, MRSA and a Right Foot Wound</p> <p>1) Nurses are to perform all wound treatment on this resident and on all Residents beginning 5/12/2011.</p>	5/12/2011

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F 441	<p>Continued From page 5</p> <p>receive Vancomycin one (1) gram intravenously every other day for MRSA in his wound. Resident #11 also had a physician order dated 04/20/11 to cleanse the wound on his right forefoot with normal saline and apply silver calcium alginate and Batroban. The wound was then to be covered and wrapped with gauze.</p> <p>Observations on 5/10/11 at 1:30 P.M. revealed Medication Aide (MA) #1 was in Resident #11's room preparing to do a dressing change on the resident's right foot. The treatment cart was observed in the resident's room and was positioned at the foot of the resident's bed with its drawers opened. The opened treatment cart was approximately four (4) to five (5) inches from Resident #11's foot wound. MA #1 was observed to remove the old dressing from the resident's right foot, to clean the wound and to apply ointment directly from a tube onto the wound while wearing gloves. MA #1 then picked up some gauze 4x4's which were sitting on the open treatment cart and used them to apply the Calcium Alginate dressing to the resident's foot. Then without changing his gloves MA #1 was observed to reach into the treatment cart and retrieve several 4X4's from the large pack, place them on the resident's foot wound and then wrap the wound with gauze. MA #1 then reached into his pocket to obtain a pen and to initial and dated the resident's dressing. MA #1 was then observed to take off his gloves and to roll the treatment cart from the resident's room into the hallway. MA #1 exited the resident's room without washing his hands. MA #1 was observed to chart the dressing change on the computer which was attached to the medication cart and to walk back into Resident #11's room to wash his hands.</p>	F 441	<p>Reviewed wound care policy with Medication Aide (MA) with Emphasis on MDRO/Contact Precautions. Including Treatment Cart usage and storage; gloving hand washing and use of ointments and dressings.</p> <p>Inservice training scheduled for all employees conducted by NW AHEC, Wake Forest University Health Sciences by Phyllis Horton, MSN, RN Nurse Educator. Course entitled "Infection Control: Standards and Practice with integrated Behavioral Management practices Inservice held on Friday, May 20<sup>th</sup>, 2011 and offered x 3 to enable ALL employees to attend with 1.0 CEU attained</p> <p>Audits will be completed by RN Charge Nurses on each shift to oversee infection control practices on appropriate standard, contact, droplet precautions and/or isolation and wound care procedures as indicated.</p>	5/10/2011	5/20/2011	5/11/2011

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F 441	<p>Continued From page 6</p> <p>On 05/10/11 at 1:40 P.M. an interview was conducted with MA #1. MA #1 stated that he should have washed his hands prior to leaving the resident's room. He reported that he had recently been inserviced on infection control, which included hand hygiene. When asked if the tube of ointment that he used to treat Resident #11's foot wound was specifically for this resident MA #1 pulled the tube that he used from the treatment cart where it was stored with multiple other tubes of ointments. Observations of this tube of ointment revealed that it was labeled with another resident's name on it. MA#1 stated that he should have used the tube of ointment that had Resident #11's name on it when he treated the resident's foot wound.</p> <p>An interview was conducted with the Director of Nursing (DON) on 05/10/11 at 2:40 P.M. The DON reported it was her expectation that the treatment cart should not have been taken into Resident #11's room. The DON further stated that during this wound treatment MA #1 should have taken the supplies he needed out of the treatment cart into the resident's room and placed a barrier down for his supplies in the room. The DON stated that if MA #1 ran out of supplies he should have removed his gloves off, washed his hands and left the room to obtain for more supplies. The DON also specified that during this treatment MA #1 should have used the ointment which was designated specifically for Resident #11, removed his gloves prior to reaching into his pocket and should have washed his hands prior to leaving the resident's room.</p>	F 441	<p>Audit results and corrective actions will be reviewed in daily interdisciplinary meetings and weekly infection control/wound meetings.</p> <p>Audits will be completed daily x 1 month, weekly x 1 month Reports from the audits will be reviewed by the QAA Committee on a monthly basis until substantial compliance with infection control policies and procedures are sustained.</p> <p>Infection control reports to include compliance with infection control measures will be reported to the QAA Committee on a quarterly basis thereafter..</p> <p>DON to oversee RN Charge Nurses supervision related to Infection Control procedures/ practices by reviewing daily Audit results, and daily new order and labs, identifying any practice/ procedure problems and taking action to resolve any issues.</p>	<p>5/23/2011</p> <p>6/3/2011</p> <p>5/23/2011</p>