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
	345033	A. BUILDING _____ B. WING _____ OCT 28 2011	09/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOWAN HOSP-SNF	211 VIRGINIA RD PO BOX 629 EDENTON, NC 27932

(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 000	INITIAL COMMENTS This Statement of Deficiencies was amended on 10/19/2011 to correct the survey exit date to 9/8/2011.	F 000	**483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES**	9/27/11
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interviews and record review, the facility failed to resolve a grievance voiced by family member for 1 (Resident #23) of 1 resident. Finidings include: Resident #23 was admitted to the facility on 10/12/2009. Cumulative diagnoses included hypertension, diabetes mellitus, and Alzheimer's disease. Review of the annual Minimum Data Set (MDS) assessment, dated 07/19/11, revealed the resident had short and long term memory problems and was unable to make daily decisions. The assessment indicated Resident #23 was totally dependent on staff for all activities of daily living. On 09/06/11 at 2:30 PM, an interview was conducted with a family member of Resident #23. During the interview, the family member relayed the resident had a blanket missing for the last 2	F 166	**A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.** Established log to track resolution of any lost personal items of residents. (Attachment A) Nursing Services educated on 9/26 and 9/27 on the use of the log and policy to insure resolution of the lost items. (Attachment B, C, A) Employees were also informed that failure to follow this policy would result in referral to the disciplinary process per hospital policy. Monitoring will be conducted through Manager and/or SNF Supervisor review of log and random patient/family rounds monthly to insure resolution of any lost personal items reported by patient or family complaint for 90 days to insure 100% compliance demonstrated and quarterly thereafter for four quarters by Manager and/or SNF Supervisor. Noncompliance by hospital staff will be followed up by the Manager. (Attachment D) Monitoring/auditing results will be reported through PSQI Committee.	

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

Jeffrey Mackeown | 9/29/11

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.

N-K-S-R-K

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F 166	Continued From page 1 months and she had reported it to the staff. She indicated the staff had remarked on occasion the blanket had not been located. The family member stated the last information she received from a nurse was that the Social Worker (SW) would be contacting her. She indicated she still had not received a call from the SW. An interview, on 09/08/11 at 10:00 AM, was conducted with the Unit Manager (UM). The UM confirmed the blanket was reported missing: many staff had looked for it; but, had been unable to find the blanket. The UM indicated the facility did not use a reporting system for lost items such as the blanket. She indicated if the lost item was dentures, hearing aide or any of those types of items, the facility would file a report regarding the item with risk management but not for a blanket. The UM stated the staff was aware and had continued to look for the blanket. She relayed the staff had talked with the family member regarding not being able to find the blanket. When asked about the family member being told the SW would contact her, the UM relayed she was unsure which staff might have said that but she would check with the SW. She indicated the nursing staff would have information in the daily nursing notes of the contacts made with the specific family member regarding the blanket not being found. An interview, on 09/08/11 11:50 AM, was conducted with Nurse Aide (NA) #1. NA#1 relayed that she was not working here at the time the blanket got lost, but the family member had told her about the missing blanket and had said the facility was looking for the blanket. An interview, 09/08/11 12:23 PM, was conducted with NA #2. NA #2 indicated he had taken care	F 166		

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F 166	Continued From page 2 of Resident #23, but was out ill when the blanket was lost. He relayed the family member had told him when he came back to work and the facility had continued to look for the blanket. On 09/08/11 2:10 PM, the UM presented the daily nursing documentation, date 07/08/1110:30 PM, which read in part: "(Family member) here very upset stated her mom's blanket was missing. Stated it fits a twin bed and is brown plaid on one side and beige on the other with ties all around the edges. Will notify manager and request staff to cont (continue) looking for blanket. " The UM relayed she was not able to find any other documentation related to the missing blanket. She also stated she had checked with the SW and the SW stated she was never informed she needed to make contact with the family member. The UM also indicated that a care plan was held after the 07/08/11 and no one in attendance had mentioned the missing blanket. The UM did acknowledge the family member, who had voiced the concern, was not in attendance at the care plan meeting. An interview, on 09/08/11 3:15 PM, was conducted with Nurse #2. Nurse #2 relayed if the nurses are told something is lost like a blanket, the nurses would tell the unit secretary. She indicated the unit secretary would call the laundry to see if the blanket might be found in the laundry. Nurse #2 stated if any missing item was not found, the nurse would inform the UM of the missing item. An interview, on 09/08/11 at 3:30 PM, was conducted with the UM. The UM stated multiple attempts had been made to locate the resident's blanket; and the family member was aware the facility had continued to look for the blanket. She indicated she would have expected a resolution	F 166		

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F 166	Continued From page 3 for the family member, who had voiced the concern, to have been informed the blanket was not able to be located. An interview, on 09/08/11 at 3:40 PM, was conducted with Director of Nursing (DON). The DON stated the staff had looked for the blanket and she would have expected to have had the family member, who had voiced the concern, to have received notification the blanket was not able to be located.	F 166		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observations and staff interviews, the facility failed to maintain refrigerator temperatures at 41 degrees fahrenheit or below and prevent dents in canned food containers. Findings Include: 1. An initial kitchen tour was conducted on 9/6/11 at 11:29am with the Infection Control Manager and Marketing Director. At 11:58am the reach-in refrigerator temperature reading was 45 degrees	F 371	**483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** **The facility must -** **(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and** **(2) Store, prepare, distribute and serve food under sanitary conditions** The refrigerator found to be outside the required temperature range has been permanently removed from service. A replacement refrigerator has been ordered with an air curtain to insure constant temperature when the door is opened. A continuous monitoring sensor will be placed in the refrigerator along with traditional temperature monitoring. Dietary staff were re-educated on 9/8 and 9/9 on how to properly monitor refrigerator temperatures. (Attachments E, E1, F) Employees were also informed that not following policy would result in referral to the disciplinary process per hospital policy. Monitoring will be conducted by Facility Services continuously via sensor and manually on the Dietetics Sanitation and Infection Control Surveillance form by Manager twice a day and/or her designee. Noncompliance by hospital staff will be followed up by Manager. (Attachments G, H, I)	9/9/11

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F 371	Continued From page 4 fahrenheit. There was food present in this refrigerator. An interview with the Dietary Manager (DM) on 9/6/11 at 11:49am indicated she was going to get a new thermometer for the reach-in refrigerator. An observation on 9/7/11 at 11:37am revealed the reach-in refrigerator was closed. The reach-in refrigerator remained closed until 11:58am. At 11:58am, the temperature reading of the reach-in refrigerator was 42 degrees fahrenheit. There was food present in the refrigerator. An observation on 9/7/11 at 2:55pm revealed the reach-in refrigerator contained 2 thermometers. The first thermometer read 42 degrees fahrenheit and the second thermometer read 45 degrees fahrenheit. There was food present in the refridgerator. An interview with the DM on 9/8/11 at 12:12pm revealed she would expect the refrigerator temperatures to be 35 to 40 degrees fahrenheit. She thought this refrigerator was on a computer monitoring system but it was not. 2. An initial kitchen tour was conducted on 9/6/11 with the Marketing Director and Infection Control Manager at 11:29am. There was a total of 3 dented canned food containers stored on a can rack in the dry storage area. There were dents in 2-#10 size cans of tomato sauce and 1-50 ounce can of cream soup. An interview with the DM on 9/8/11 at 12:12pm revealed she was not sure of how there were	F 371	Monitoring/auditing results will be reported through PSQI Committee. Dietary staff were re-educated on 9/8 and 9/9 on how to properly handle the storage of cans and how and what to do with dented cans. (Attachments J, J1, F) Employees were also informed that not following policy would result in referral to the disciplinary process per hospital policy. Monitoring will be conducted daily as part of the Dietetics Sanitation and Infection Control Surveillance form by the Manager and/or her designee. Noncompliance by hospital staff will be followed up by Manager. (Attachment G) Monitoring/auditing results will be reported through the PSQI committee. **483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS**	

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F 371	Continued From page 5 dented cans stored. Her staff procedures are to inspect canned foods once delivered and they would not store dented cans.	F 371	**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.** **(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.** **(c) Linens** **Personnel must handle, store, process and transport linens so as to prevent the spread of infection.** Nursing services staff reeducated on 9/26 and 9/27 on appropriate hand washing per Hand Washing policy. (Attachment K, L)	9/27/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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. (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. (c) Linens Personnel must handle, store, process and	F 441		

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F 441	Continued From page 6 transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to ensure that staff washed their hands when changing gloves and after removing gloves for 1 of 1 resident observed during wound care (Resident #25). Resident #25 was admitted to the facility on 04/14/11 with multiple diagnoses including Sacral Pressure Ulcer. Nurse #1 was observed to provide wound care for Resident #25 on 09/08/11 at 1:48 PM. The nurse put on gloves, removed one side of the incontinent brief, removed the dressing on the resident ' s sacral area and discarded the dressing in the trash can. There was soft stool observed in the peri-anal area and the nurse removed incontinent wipes from a container and cleaned stool from the resident. The nurse again removed incontinent wipes from a container and continued to clean stool from the resident, discarding the soiled wipes in the trash. The nurse then removed her gloves and put on clean gloves without washing her hands or using any form of hand hygiene. The nurse used a syringe of saline to irrigate the sacral wound and folded a 4 " x4 " piece of gauze and used a syringe to saturate the gauze with normal saline and applied to gauze to the sacral wound and covered with dry 4x4s and taped the gauze in place. The nurse removed the gloves, removed a pen from her	F 441	Employees were also informed that not following policy would result in referral to the disciplinary process per hospital policy. Monitoring will be conducted through random observation of staff in all aspects of patient care weekly for 90 days to insure 100% compliance is demonstrated and quarterly thereafter for four quarters by SNF Supervisor and/or her designee. Noncompliance by hospital staff will be followed up by Manager. (Attachment M) Monitoring/auditing results will be reported through the PSQI Committee.	

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F 441	Continued From page 7 pocket and dated the dressing and replaced the pen in her pocket. The nurse removed a set of keys from her pocket and unlocked a cabinet in the room and removed a can of granulex and sprayed on the resident ' s bottom and reapplied the incontinent brief. The nurse put the unused dressing supplies in a dresser drawer and replaced the granulex in the cabinet and repositioned the resident ' s catheter bag. The nurse removed the bag of soiled materials from the trash can, tied up the top of the bag, placed the bag on the floor and then washed her hands. On 09/08/11 at 1:55 PM Nurse #1 stated in an interview that she did not wash her hands when she changed her gloves between the incontinent care and the wound care. The Nurse stated that she usually washed her hands when changing her gloves and after removing gloves. The Unit Manager stated in an interview on 09/08/11 at 2:07 PM that the nurse should have washed her hands when changing gloves between incontinent care and wound care. The Director of Nursing (DON) stated in an interview on 09/08/11 at 2:46 PM that the nurse should have washed her hands when she removed her gloves after cleaning stool and after removing gloves at the completion of wound care prior to handling clean items in the room.	F 441		

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	345033	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/28/2011

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CHOWAN HOSP-SNF	211 VIRGINIA RD PO BOX 629 EDENTON, NC 27932

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 09/28/2011 the following doors failed to latch when closed a. ICH 110 b. ICH 152	K 018	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. a. Door to room 1 CH 110: patient shoe rack was removed from room door and installed on patient room restroom door. b. Door to room 1 CH 152: door hinge to Beauty Parlor was tightened to bring door back into alignment with the frame and prevent catching on frame preventing closure All Corridor Doors and FRR doors will be placed on a Preventive Maintenance Building Maintenance Plan (BMP) for inspection Bi-monthly to repair any deficiencies. The BMP will be monitored to ensure that at a minimum 90% of all corridor and FRR doors are working at any given time. In the event less than 90% are functional at any bi-monthly inspection the hospital will conduct a risk assessment to determine if a more frequent PM should be conducted. Conversely, in the event the facility achieves 90% compliance with door function the hospital will conduct an annual risk assessment to determine if the door PM can be extended to quarterly or semi-annually.	9/28/11

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Joseph R Shackleford | Recruiter | 10/13/11

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