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

PRINTED: 04/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING ______ B. WING ______	C 03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST-ACUTE CARE-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(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 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 transport linens so as to prevent the spread of infection.	F 441	Submission of this Plan of Correction does not constitute admission of the under-signed that the deficiency was correctly cited or required correction. F: 441 It is the intent of the facility that the current CDC approved isolation signage be posted on the doors of any resident with an infect-ion that requires isolation. Residents # 57 and #185 was being provided with proper isolation precautions. On 3/21/13 the incorrect signage was removed and replaced with correct CDC signage. On 3/21/13 all incorrect signage was destroyed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Barnett
TITLE: NHA
(X6) DATE: 4/16/13

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F 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post the proper signage per Centers for Disease Control (CDC) guidelines for 2 of 3 residents observed on isolation (Residents # 57 & 185). The findings included: 1. Resident # 57 had a diagnosis of recurrent Clostridium difficile colitis (C-diff) (an infection of the colon caused by bacteria). Review of the physician readmission orders dated 12/18/12 revealed a diagnosis of sepsis secondary to clostridrium colitis. Review of a physician ' s progress note dated 3/13/13 revealed the resident had recurring C-diff and would finish Vancomycin (anti-infective) on 3/24/13. Observations on 3/18/13 at 8:20 AM, 3/19/13 at 9:00 AM and 1:00 PM and 3/20/13 at 9:10 AM revealed a sign was posted on the resident's door which read "Isolation-Please check with nurse before entering." An interview with Nurse #1 on 3/20/13 at 11:22 AM revealed the resident was on isolation for C-diff since he returned from the hospital on 12/18/12. She further stated that the resident's isolation would be discontinued that afternoon because the resident no longer had loose stools. In an interview with Infection Nurse (ICN) #1 on 3/21/13 at 11:20 AM she stated that resident #57 has been on and off isolation for C-diff.	F 441	Licensed staff was in-serviced on 3/21/13 re: "Isolation Precautions." Reviewing the approved CDC signage identifying: Airborne, Droplet and/or Contact Isolation. Both resident's #'s 57 and 185 were taken off of isolation on 3/22/13. QI Nurse/Designee will monitor signage for any resident(s) requiring isolation weekly until they no longer require isolation. Any identified issues will be taken to the Monthly Performance Improvement Committee for review. All issues identified will be corrected maintain compliance.	4/18/13

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F 441	Continued From page 2 In an interview with ICN #2 at 9:30 AM on 3/21/13 she stated that the isolation rooms for resident #57 should have had contact precaution signs on the doors. The nurses and supervisor should have noticed that the incorrect signs were posted. In an interview with ICN #1 on 3/21/13 at 9:50 AM she stated that contact isolation signs should have been placed on the resident ' s door. 2. Resident # 185 had a diagnosis of shingles. Review of the nurses' notes dated 3/13/13 revealed the resident was placed on isolation for shingles. Review of the Infection Report dated 3/13/13 noted that resident # 185 required contact isolation. Observations on 3/18/13 at 8:20 AM, 3/19/13 at 9:00 AM and 1:00 PM, 3/20/13 at 9:10 AM and 3/21 at 9:30 AM revealed a sign was posted on the resident's door which read "Isolation-Please check with nurse before entering." The type of precautions was not identified on the sign. In an interview with ICN #2 at 9:30 AM on 3/21/13 she stated that the isolation room. 0 for resident #185 should have had contact precaution signs on the doors. The nurses and supervisor should have noticed that the incorrect signs were posted. In an interview with ICN #1 on 3/21/13 at 9:50 AM	F 441		

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F 441	Continued From page 3 she stated that contact isolation signs should have been placed on the resident ' s door. An interview with the 100 hall supervisor at 10:14 AM on 3/21/13 revealed a Nursing Assistant (NA) set up the isolation rooms. She informed NA #1 that the residents were on contact isolation. In an interview with the NA #1 at 10:20 AM on 3/21/13 she stated that she set up the rooms but did not place the signs on the doors. An interview with Nurse #2 at 10:24 AM on 3/21/13 revealed she did not notice the incorrect signs were posted on the isolation rooms. An interview with the Director of Nursing (DON) on 3/21/13 at 11:17 AM revealed her expectation was that signs indicating the type of precautions were to be posted on isolation rooms	F 441		

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type protected. construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	Submission of this Plan of Correction does not constitute admission of the under-signed that the deficiency was correctly cited or required correction.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 4/3/2013 the following item was observed as noncompliant, specific findings include: The facility had a buildup of dust and lint in the combustion chamber of the gas fired dryers in the laundry.. CFR#: 42 CFR 483.70 (a)	K 029	K: 29 It is the intent of the facility that the the combustion chamber of the gas fired dryers be free from any Build-up of dust and lint. On 4/3/13 the lint and dust was removed from the combustion chamber of the dryer. All other dryers were cleaned. On 4/3/13 the PM schedule was reviewed and the monitoring for lint and dust was changed from bi-weekly to weekly. The PM tool was revised on 4/4/13. Maintenance Director/designee will monitor weekly.	4.18.13
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Barnett TITLE: NHA (X6) DATE: 4/21/13

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K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 4/3/2013 the following item was observed as noncompliant, specific findings include: The facility had a buildup of dust and lint in the combustion chamber of the gas fired dryers in the laundry. CFR#: 42 CFR 483.70 (a)	K 029		
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056 SS=D	Continued From page 1 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 4/3/2013 the following Life Safety item was observed as noncompliant, specific findings include: The sprinkler in the nurses supply room on the right hand side of the back of the room was blocked by bed mattress stacked at that location. CFR#: 42 CFR 483.70 (a)	K 056	K: 056 It is the intent of the facility to keep the sprinklers from being blocked so they will freely operate. 4/3/13 the mattresses were removed. 4/4/13 supply clerk/designee were in-serviced on: " Sprinkler System: Keeping the sprinklers from being blocked so they can work freely". QI nurse/designee will monitor Bi weekly. Any identified issues will be taken to the monthly Performance Improvement Committee for review. Identified issues will be corrected to maintain compliance.	4-18-13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 2 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 4/3/2013 the following item was observed as noncompliant, specific findings include: The sprinkler heads installed at the the men's and women's bathrooms just across from the conference room in the egress corridor were a mix of a quick response head and a standard fused head, all sprinkler heads in a smoke compartment are required to be of the same type so that the sprinkler system in that space can work in unison. Actual NFPA Standard: NFPA 13,5-3.1.5.2 CFR#: 42 CFR 483.70 (a)	K 062	K062 It is the intent of the facility to maintain similar sprinkler heads in the smoke compartments so that all of the sprinklers will work in unison. On 4/16/13 BFPE installed sprinkler heads at the men's and women's bathrooms across from the conference room making them similar so that they would work in unison. All other sprinklers were monitored by the Maintenance Director. Any identified issues will be taken to the monthly Performance Improvement Committee for review. Identified issues will be corrected to maintain compliance.	4-18-13

MB