JUN 27 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345164	A. BUILDING ______ B. WING ______	C 06/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 S HALSTEAD BLVD ELIZABETH CITY, NC 27909

(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	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. NA #2 was provided one to one in-servicing by the SDC (Staff Development Coordinator) on following Isolation Precaution Procedures for resident on Isolation Precautions. In-service included performing hand hygiene before entering and leaving the residents room, wearing gloves when entering the room, when touching the resident's intact skin, surfaces, or articles in close proximity. 2. Resident requiring Isolation Precautions have been identified as having the potential to be affected. SDC will in-service staff on the appropriate PPE to wear and when to perform hand washing when taking care of residents on Isolation Precautions. 3. DNS, ADNS, or SDC will perform an observation audit on isolated residents to validate staff is complying with Isolation Precautions including performing hand washing as appropriate and proper PPE is utilized five times a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. 4. Results of audits will be incorporated into center's PIC (Performance Improvement Committee) for a minimum of three months. PIC will make further recommendations as	07/04/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] (X6) DATE 6/27/13

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 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on policy review, observations, record review, and staff interviews, one facility staff member failed to follow posted contact precaution guidelines for one of one resident (Resident # 179) under contact isolation precautions. The findings include: A review of the facility policy for Transmission-Based Precautions (TBP) revealed that contact is one type of transmission based precaution. A review of the Hand Hygiene/Handwashing Policy for the facility revealed that hand hygiene is to be performed "before and after eating or handling food, after removal of medical/surgical or utility gloves, and intermittently after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments ... " A review of the Infection Prevention and Control Program for the facility dated 8/31/2012 in nursing centers, based on a physician's recommendations, patients are placed in appropriate transmission-based precautions that are known or suspected to be infected or colonized with infectious agents, including certain epidemiologically important pathogens, which require additional control measures to effectively prevent transmission. A review of the Contact Precautions Procedure	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* needed and determine need for further auditing.	

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

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F 441	Continued From page 2 revealed that staff should perform hand hygiene before entering and leaving the resident's room, wear gloves when entering room, when touching the resident's intact skin, surfaces, or articles in close proximity, wear gown when entering room or cubicle, and whenever anticipating that clothing will touch patient's items or potentially contaminate environmental surfaces." Resident # 179 resided in room # 114, and a review of the medical record revealed she was admitted to the facility on 5/29/2013 with diagnoses that included Methicillin-resistant Staphylococcus Aureus (MRSA), an infection treated with antibiotics which required contact isolation. A review of the Minimum Data Set (MDS) dated 3/20/13 revealed Resident #179 was independent with activities of daily living and was cognitively intact. On 6/6/2013 at 9:29 AM, a nursing assistant (NA # 2) entered Resident # 179's room (Room 114) at 9:29 AM, picked up the resident's breakfast tray off the resident's bedside table, touching the bedside table, coming into close contact with the resident's gown and bedsheets, and then exited the room and placed the tray in the dietary cart in the hallway of the facility without washing hands before or after leaving the resident's room, and without wearing a gown or gloves. In an interview at 9:40 AM on 6/6/13, NA #2 stated the typical procedure for Contact Isolation would be to use hand sanitizer before entering the room, put on gown and gloves, and then after	F 441		

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F 441	Continued From page 3 completing the task, remove the gown and gloves, then wash hands. NA #2 also stated that she would also wear a mask if she were dealing with urine. When asked whether she performed any of the stated precautions when she entered to collect the resident's breakfast tray in room #114, she stated that she did not. In an interview on 6/6/2013 at 2:30 PM with the Staff Development Coordinator (SDC), the SDC explained that a resident room with contact isolation precautions should be set up with a storage bin outside the resident's room stocked with disposable gowns, gloves, masks, and hand sanitizer, as well as with a trash bin located in the center of the resident's room to dispose of gowns, gloves, and masks. The SDC further stated that a resident on isolation generally is kept in a private room, and that equipment used is disposable or is disinfected between patient uses if equipment is non-disposable. When asked if staff should wash hands before entering and after leaving the room, the SDC stated that staff could use hand sanitizer instead of hand washing. The SDC also stated that she had provided in-service training as needed for infection control. In an interview with the Director of Nursing Services (DNS), at 5:29 PM on 6/6/2013, the DNS stated that staff members are to do hand washing prior to care, after care, when passing trays, and for residents who are on contact isolation precautions. In addition, the DNS stated that hand sanitizer is not a substitute for proper handwashing. In an interview with the Administrator on 6/6 2013 at 7:35 PM, the Administrator stated it was her	F 441		

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F 441	Continued From page 4 expectation that all staff, including nurse aids, nurses, and housekeeping staff follow all the Contact Isolation Guidelines that are posted on the Contact Isolation rooms.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345184	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETE: 6/6/2013
NAME OF PROVIDER OR SUPPLIER **KINDRED TRANSITIONAL CARE & REHAB-ELIZA**	STREET ADDRESS, CITY, STATE, ZIP CODE **901 S HALSTEAD BLVD ELIZABETH CITY, NC**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS

The facility must develop policies and procedures that ensure that--
(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal

The facility must develop policies and procedures that ensure that--
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization

This REQUIREMENT is not met as evidenced by:
Based on record review, staff interview, and policy review, the facility failed to follow its policy requiring residents or responsible parties to sign and date the Vaccination Information Sheet Acknowledgements (VIS Acknowledgements) showing that education had been provided about the influenza and flu vaccine for 2 residents (Resident #46 and Resident #105) out of 5 sampled residents.

The findings include:

A review of the Influenza Program Policy for the facility dated 10/14/2010 revealed the following procedure

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345184	MULTIPLE CONSTRUCTION A. BUILDING: B. WING	DATE SURVEY COMPLETE: 6/6/2013
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 334	Continued From Page 1

on page two of the policy:

"1. Using the current VIS (Vaccine Information Sheet) for the year, educate patients or the person authorized to act on behalf of the patient about the influenza threat, the benefits, and the general safety of receiving the vaccine."

"There is a new VIS each year and it (is) to be given to each patient and responsible party including those that chose not to take the influenza vaccine the previous year."

"The VIS acknowledgment is not a consent to administer the vaccine, but an acknowledgment that they have received the information informing them about the influenza vaccine and the pneumococcal vaccine"

"5. Offer the vaccine to the patient or person authorized to act on behalf of the patient."

A review of the Resident # 46's Minimum Data Set (MDS) dated 9/22/2012 revealed the Brief Interview for Mental Status (BIMS) score was 5 which indicated the resident was severely cognitively impaired

On 6/6/2013, review of the electronic record immunization record for Resident#46 revealed that the resident received the influenza vaccine on 10/3/2012 and the pneumococcal on 1/1/2007.

The facility provided a Vaccine Information Sheet Acknowledgment (VIS Acknowledgment) dated 10/3/2012 which had been signed with two vertical curved marks There were no witness signatures on the VIS Acknowledgment

A review of Resident #105's MDS dated 9/6/2012 revealed the BIMS score was which indicated the resident was severely cognitively impaired

On 6/6/2013 a review of the electronic immunization record for Resident#105 received the Influenza Vaccine on 10/2/2012 and the Pneumococcal Vaccine on 1/1/2011.

The facility provided a VIS acknowledgment which was signed with one vertical curved mark by Resident #105 without a date on the form. There were no witness signatures on the VIS Acknowledgment

The facility provided a second VISA for Resident #105 that was dated 2/22/12 and the signature line was blank. The name of Resident # 105's responsible party was typed below the signature line

In an interview on 6/6/2013 at 7:00 PM the Corporate Nurse Consultant (CNC) stated a signature was not needed for the influenza consent form The surveyor stated that the signed VIS acknowledgment form was needed per Influenza Policy Procedure for the facility.

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

RECEIVED JUL 16 2013 CONSTRUCTION SECTION

PRINTED: 07/08/2013
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
	345184	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ELIZABETH CITY	901 S HALSTEAD BLVD ELIZABETH CITY, NC 27909

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K 000	INITIAL COMMENTS Surveyor: 27871 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 building is Type II (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: piping penetrations through rated ceiling in kitchen are unsealed at HVAC unit in kitchen. 42 CFR 483.70(a)	K 012	1. Identified pipe penetration through the rated ceiling in kitchen was sealed at HVAC unit in the kitchen. All pipe penetrations through rated ceiling are sealed at HVAC units. 2. Maintenance Director or Maintenance Assistant will make rounds in the center to ensure pipe penetrations near HVAC units are sealed. 3. Maintenance Director or Maintenance Assistant will perform an audit weekly for 2 weeks to ensure pipe penetrations new HVAC units in facility are sealed. 4. Results of audits will be incorporated into facility's Performance Improvement Committee for a minimum of 3 months.	7/19/13
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 056	1. The tamper switch in break room was serviced and sends signals to fire alarm control panel when tested. 2. The alarm device on the sprinkler control valve (on outside of building) was changed and now meets the National Fire Protection Association standards. 3. Maintenance Director or Maintenance Assistant will make rounds in the center to ensure tamper switch in break room sends signal to fire alarm panel when tested. Maintenance Director or Maintenance Assistant will make rounds in the center to ensure all sprinkler control valves meet the	8/16/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	7.12.13

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CW

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K 056	Continued From page 1 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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: 1. tamper switch in break room did not send signal to fire alarm control panel when tested. 2. the alarm device being used on sprinkler control value(on outside of building) does not meet National Fire Protection Association standards. 42 CFR 483.70(a)	K 056	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* National Fire Protection Association standards. 4. Maintenance Director or Maintenance Assistant will perform an audit weekly for 4 weeks to ensure tamper switch in break room sends signal to fire alarm panel when tested and all sprinkler control valves meet the National Fire Protection Association standards. 5. Results of audits will be incorporated into center's Performance Improvement Committee for a minimum of 3 months.	
K 062 SS=E	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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at	K 062	1. Identified sprinkler head on service hallway from main corridor was removed and replaced. 2. Maintenance Director or Maintenance Assistant will make rounds in the center to ensure all sprinkler heads are free from paint. 3. Maintenance Director or Maintenance Assistant will perform an audit weekly for 4 weeks to ensure all sprinkler heads are free from paint. 4. Results of audits will be incorporated into center's Performance Improvement Committee for a minimum of 3 months.	8/16/13

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K 062	Continued From page 2 approximately 8:30 am onward, the following items were noncompliance, specific findings include: first sprinkler head coming into service hallway from main corridor had paint on orifice. 42 CFR 483.70(a)	K 062		