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
	345404	A. BUILDING ______ B. WING ______	C **02/13/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH AND REHAB	**1403 CONNER DRIVE** **WINDSOR, NC 27983**

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #Z9PR11.	F 000		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		2/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed   TITLE   (X6) DATE: 02/28/2014

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 431	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, manufacturer specifications and facility policy review, the facility failed to label and date insulin and Aplisol (a tuberculin purified protein derivative injection) when opened in one of 3 medication carts (400 hall cart) and 1 of 2 medication refrigerators (400 hall medication refrigerator). The findings included: Manufacturer specifications per the package insert for Aplisol read in part, "Vials in use more than 30 days should be discarded." An undated facility policy entitled "Recommended Storage for Selected Items After Opening" read in part: "All Insulins - good for only 28 days after opening not refrigerator [sic]" and "All Injections - good for only 30 days in refrigerator if it is a multi-dose vial." 1. On 2/12/14 at 8:52 am, an opened, undated vial of Humalog (a type of insulin) was observed on the 400 hall medication cart. Nurse #2 was interviewed on 2/12/14 at 8:52 am. She indicated insulin should be labeled and dated when opened, and discarded 28 days after opening. Nurse #2 then discarded the undated Humalog. 2. On 2/12/14 at 9:11 am, one vial of Aplisol was observed in the medication refrigerator on the 400 hall. The Aplisol was opened but undated.	F 431	F431 Corrective Action affected resident(s) No residents were adversely affected by the action. Undated insulin and Aplisol were discarded. All medication carts and medication refrigerators were inspected by DON on 2/13/14. All multi-dose vials including insulin and Aplisol were inspected to assure they were labeled per policy. Any undated vials were discarded at that time. Corrective Action potential resident(s) All nursing staff including licensed nurses, nurse aides and medication aides were re-trained by Administrator 2/17/2014 including: 1. Preparation of Medication Administration Policy and Procedure a.Includes procedure for labeling/dating multi-dose vials 2. Recommended Storage for Selected Items after Opening from Pharmacy Policies a.Listing of expiration time periods for opened pharmaceuticals b.Also includes proper labeling/dating of opened vials 3. All attendees completed Post Test including 5 questions regarding labeling/dating of multi-dose vials. a. 100% correct was required for pass grade.	

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F 431	Continued From page 2 Nurse #2 was interviewed on 2/12/14 at 9:11 am. She said she was unsure of how long Aplisol is good after being opened. During an interview on 2/12/14 at 1:08 pm, the Director of Nursing (DON) indicated she expected insulin and Aplisol to be labeled and dated when opened. If opened and undated, she expected them to be disposed of immediately.	F 431	b. Anyone who did not achieve 100% was retrained on policies 1:1by DON c. Administrator ensured all current employees had received the training on 2/24/14. 4. Both policies will be reviewed during Monthly Nursing Department Training Session each month by DON for all nursing staff including licensed nurses, med techs and med aides for the next year. Systemic Changes to prevent recurrence 1.All new nursing staff including licensed nurses, nurse aides and medication aides will review above policies as part of the New Employee Orientation Process. a. New Employees will complete same Post Test to assure understanding of policies with 100% required pass rate. b. If staff member does not complete Post Test with 100% accuracy they will be retrained 1:1 by SDC. 2.DON or SDC will complete Medication Storage Audit to assure all multi-dose vials in use on med carts or in refrigerators have been properly dated. a. Medication Storage Audit will be completed for both Skilled Nursing and Short-Term Rehab Unit weekly thru April 25, 2014 then monthly ongoing i.Medication Storage Audit includes: *"Copy of "Recommended Storage for Selected items" is clearly posted in Med Room" * "Copy of "Preparation of Medication administration Vials and Ampules of	

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F 431	Continued From page 3	F 431	Injectible Medications" is clearly posted in Med Room" * "Open Multi-dose vials in refrigerator are properly dated / labeled per policy" * "Open Multi-dose vials in med cart are properly dated / labeled per policy" * "Other Findings" 3. 1:1 retraining will be provided based on findings of audit by SDC Evaluation of Plan / Monitoring 1. Completed Medication Storage Audits will be presented and reviewed during Monthly Quality of Life Meeting by DON for review by members of QA Committee including Administrator, DON, SDC and MDSC. 2. Any concerns or trends that are identified will have corrective actions identified and implemented according to the QA Committee recommendations.	
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;	F 441		2/24/14

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F 441	Continued From page 4 (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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff wore gloves and performed proper hand washing when working with 1 of 2 residents (Resident #123) on contact precautions for Clostridium difficille infection, and failed to ensure soiled laundry was not placed on the floor prior to being bagged for 1 of 2 residents (Resident #123) on contact precautions. The findings included:	F 441	F441 Corrective Action affected resident(s) No residents were adversely affected by the noted actions. Resident #123 had a negative stool culture on 2/12/14 and contact isolation was discontinued by Physician Order on 2/13/14. Corrective Action potential resident(s)	

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F 441	Continued From page 5 The facility policy entitled, "Clostridium Difficille (C-Diff)," last revised 10/2013, read in part, "Contact Precautions: Are appropriate when resident is colonized or infected with diarrhea, incontinence or decreased ability to perform hygiene practices." "Gloves must be worn with resident care and environmental contact. Hand washing with soap and water has demonstrated to be very important to prevent the spread of c-diff on the hands of healthcare workers." "Hand washing is with soap and water as alcohol gel is not effective against C diff." 1a. Resident #123 was readmitted to the facility on 2/6/14. Diagnoses included Clostridium difficile (C diff) infection. According to the Centers for Disease Control and Prevention website (www.cdc.gov <http://www.cdc.gov>), "C. difficile causes diarrhea linked to 14,000 American deaths each year. Those most at risk are people, especially older adults, who take antibiotics and also get medical care." A "Contact Isolation" sign was posted outside the door that read in part, "Wear gloves when entering room or cubicle, and whenever touching the patient's intact skin, surfaces or articles in close proximity." On 2/10/14 at 12:25 pm Nursing Assistant (NA) #2 was observed to deliver and set up Residents # 123's lunch tray. No gloves were worn during the tray delivery. When NA #2 placed the tray on the over bed table her hands came in contact with the table. Upon exit of the resident's room, NA #2 used hand sanitizer from the dispenser just inside the resident's room. She then pushed the food cart down the hall towards the next room.	F 441	1.All employees of every department, both full and part time, in our facility were re-trained by Administrator on 2/17/14 on the following policies: a.Clostridium Difficille b.Contact Precautions -updated policy to reflect always gown/glove when entering room c.Contaminated Laundry d.Handwashing e.Powerpoint with handouts including overview of all listed policies 2.All employees, including all full and part time employees of every department, were required to take a post-test to assure understanding of policies a.100% correct was required for passing grade on Post Test b.any employee who scored less than 100% was retrained 1:1 until 100% correct could be attained. 3.Administrator verified that all employees had received above outlined training by 2/24/14. 4.As of 2/17/14 there were no other residents on Contact Isolation. Systemic Changes to prevent recurrence 1.Review of the above-referenced policies will be included in the New Employee Orientation process for all employees. 2.Listed policies will be reviewed during Quarterly All Employee Training Sessions in March, June, September and December 2014 by SDC with Post Test	

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F 441

Continued From page 6

During an interview on 2/10/14 at 12:28 pm, NA #2 stated the resident had C-diff and required total care. She reported she had sanitized the over bed table after she completed the resident's morning care so she thought the table was not contaminated. NA #2 was observed to then wash her hands with soap and water.

During an interview with the Director of Nursing (DON) on 2/12/14 at 2:30 PM, she stated the staff members were instructed not to use hand sanitizer after caring for residents with C-diff. She also stated that the staff members were informed of the reason for the isolation therefore it was clear that the hand sanitizer should not be used. The DON reported that she expected staff to wash their hands prior to exiting the isolation room.

1b. On 2/13/14 at 12:28 pm, Nursing Assistant (NA) #1 was observed to deliver and set up Resident #123's lunch tray without wearing gloves. NA#1 touched the over bed table with both hands to position it in front of the resident.

During an interview on 2/13/14 at 12:30 pm, NA#1 indicated she thought gloves were required only when providing direct care.

During an interview on 2/13/14 at 12:47 pm, the Director of Nursing (DON) stated she expected staff to wear gloves when entering the room of a resident on contact precautions and touching anything.

1c. During an observation of 2/12/14 at 9:45 am, Nurse #1 was observed to change a dressing on Resident #123's sacrum. The resident had been

F 441

completed to assure understanding of policies.
3.New Employees will be required to complete Post Test with 100% accuracy and receive 1:1 retraining until 100% accuracy is attained as indicated.
4.All patients on contact isolation will be reviewed by Nurse Management team during Daily Clinical Quality Meeting held Monday through Friday ongoing.
a.Review will be completed by DON or SDC and include daily auditing of isolation signage, appropriate supplies readily available and staff following policy-including hand washing and handling of linens.
b.DON or SDC will complete the contact isolation review Monday through Friday on the 7A-7P shift with at least one monitoring of 7P-7A shift each week

Evaluation of Plan / Monitoring

1.Review of Daily Clinical Quality Meeting findings in regard to patients on Contact Isolation will be presented by DON and reviewed during Monthly Quality of Life Meeting attended by all QA Committee Members.

2.Any concerns or trends that are identified will have corrective actions identified and implemented according to the QA Committee recommendations.

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F 441	Continued From page 7 incontinent of stool. Nurse #1 cleaned the resident and changed the incontinent pad that was under him. In the process, a small amount of stool soiled the bottom sheet. A clean incontinent pad was applied and Nurse #1 then changed the dressing. Next, Nurse #1 changed the soiled sheet. Upon removing the sheet from the bed, she dropped in on the floor, next to the trash can that was used during the dressing change. After the clean sheet was applied and the resident positioned and covered, Nurse #1 picked up the sheet from the floor and placed it in a plastic bag. Nurse #1 was interviewed on 2/12/14 at 10:40 am. She indicated she did not realize she had dropped the sheet on the floor. She recalled the trash can was right there since she had been using it during the dressing change and thought she had dropped it in the trash can as a means of holding it until she finished taking care of the resident. Nurse #1 added she knew that linens should not be thrown on the floor. During an interview on 2/12/14 at 12 pm, the Director of Nursing (DON) stated she expected soiled linens to be bagged immediately as per the policy for handling personal contaminated laundry.	F 441		