STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVE NW LENOIR, NC 28645

(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 does not constitute an admission or agreement by provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and federal law. **F441** 1. Resident #39 no longer resides at the facility. Resident #27 and Resident #143 continues to reside at facility with contact precautions and observation and education have been provided to all staff regarding donning person protective equipment (PPE) during direct resident contact and indirect contact with environmental surfaces or items in resident room by the Director of Clinical Services and Assistant Director of Clinical Services completed from 5/22/14 to 6/9/14. Residents #39, #27 and #143 suffered no harm.	6/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Retta Madden | TITLE: Administrator | (X6) DATE: 6-10-14

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.

DHHS Received JUN 11 2014 by: PAM

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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 follow contact precautions by not donning person protective equipment (PPE) during a wound dressing, while feeding a resident, and while helping a resident reposition for 3 of 3 residents reviewed for infection control (Resident # 143, Resident # 39, and Resident # 27). The findings included: The facility's policy entitled Transmission Based Precautions: Contact precautions, revised 09/01/2011, read in part: Contact precautions will be used for residents with known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident (hand or skin-to-skin contact that occurs when performing resident care activities that require touching the resident's dry skin) or indirect contact (touching) with environmental surfaces or resident care items in the resident environment. Procedure: Gloves will be worn when entering the room. Wear a gown upon entering the residents room if you anticipate that your clothing will have substantial contact with the resident or environmental surfaces or items in the resident's room. 1. Resident #143 was admitted to the facility on 03/13/14 with diagnosis including recent Clostridium difficile I. Review of Resident #143's laboratory results revealed 04/04/14 Clostridium difficile I (c. diff) in stool, 04/05/14 Extended spectrum beta	F 441	2. All residents have the potential to be affected by this citation. A review was completed on 5-23-14 for current residents to ensure those needing transmission based precautions currently had them in place. Any discrepancies were immediately corrected by the Director of Clinical Services/Assistant Director of Clinical Services and the Physician was notified. A review of residents' currently on transmission based precautions was completed on5/22/14 to 6/9/14 by the Director of Clinical Services and Assistant Director of Clinical Services to ensure observation and education have been provided to all staff regarding donning person protective equipment(PPE) during direct resident contact and indirect contact with environmental surfaces or items in resident room. 3. Staff in all departments was in-serviced by the Director of Clinical Services and Assistant Director of Clinical Services from 5/22/14 – 6/9/14 regarding donning person protective equipment (PPE) during direct resident contact and indirect contact with environmental surfaces or items in resident room.	

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F 441	Continued From page 2 lactamase (ESBL) in urine, and 05/04/14 Vancomycin resistant enterococcus (VRE) in stool. Resident #143 had remained on contact isolation since admission. Physician orders revealed Resident #143 was treated with antibiotics and placed on contact precautions. An observation on 05/21/14 at 09:39 AM revealed Nurse #1 changing a wound dressing on Resident #143. Resident #143 had a contact precaution sign on the outside of the door and a caddy with personal protective equipment (PPE) hanging on the outside of the door which held gowns and gloves. Nurse #1 was observed entering Resident #143's room without donning a gown. Nurse #1 cleansed and dressed Resident #143's wound with no gown. An interview was conducted on 05/22/14 at 10:26 AM with Nurse #1 revealed she did not don a gown to dress Resident #143's wound. Nurse #1 explained she did not feel like she needed to don a gown because she was not going to be in contact with bodily fluids and the resident was no longer showing signs or symptoms of the bacteria. An interview was conducted on 05/22/14 at 2:19 PM with the Assistant Director of Nursing (ADON) who also was over the infection control program. The ADON stated when a resident was on contact precautions they had a contact precautions sign and PPE hanging on the door for staff to wear. The ADON continued by stating when staff or family members enter the residents room they needed to wear the appropriate PPE while in the residents room. When staff or family members entered the room and were touching surfaces or providing patient care they needed to	F 441	4. The Director of Clinical Services and Assistant Director of Clinical Services will conduct Quality Improvement monitoring of all resident requiring transmission based precautions to ensure proper donning of personal protective equipment (PPE) by staff during direct resident contact and indirect resident contact with environmental services or items in resident room three times a week for one month, two times a week for two months, one time a week for one month. The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee for 4 months and/or until substantial compliance is obtained.	

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F 441	Continued From page 3 gown and glove. The ADON further stated when a staff member was changing a wound dressing and the resident was on contact precautions the staff member should wear a gown and gloves. The ADON stated staff should follow the contact isolation precaution signs and follow what they advised. An interview was conducted on 05/22/14 at 2:57 PM with the Director of Nursing (DON). The DON stated contact precautions should be followed if there was a potential for staff to touch surfaces in the residents room or the resident. She stated she would have expected Nurse #1 to wear her PPE while changing Resident #143's dressing. The DON further stated Nurse #1 should have worn gown and gloves and it is staffs' responsibility to have followed the contact precautions when it was posted. 2. Resident #39 was admitted to the facility on 10/10/12 with diagnoses which included pressure ulcer, diabetes, and dementia. A lab report dated 05/01/14 revealed Resident #39's urine culture was positive for ESBL (Extended Spectrum B-lactamase). Physician orders revealed Resident #39 was treated with antibiotics and placed on contact precautions. On 05/22/14 at 12:30 PM an observation was made of Nursing Assistant #1 feeding Resident #39. Resident #39 had a Contact Precaution sign on the outside of the door and a caddy with personal protective equipment (PPE) hanging on the outside of the door which held gowns. NA #1 was observed seated in a chair in Resident #39's room and was feeding her. NA #1 was not	F 441		

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F 441	Continued From page 4 wearing any PPE during this time. On 05/22/14 at 1:29 PM an interview was conducted with NA #1. When asked about the importance of wearing PPE when caring for Resident #39 she stated you always needed to wear your gown and gloves while working with the resident and make sure you wash your hands when removing her gloves. When asked about wearing PPE while feeding Resident #39 she stated she assumed she did not have to wear PPE if she was not touching bodily fluids and that she did not need to wear PPE while feeding resident #39. On 05/22/14 at 1:35 PM an interview was conducted with Nurse #1. Nurse #1 stated staff should wear their PPE when ever providing care for a resident who was on contact precautions. She stated if staff was feeding the resident that would be considered care. She stated NA #1 should have worn her PPE while feeding Resident #39. On 05/22/14 at 2:19 PM an interview was conducted with the Assistant Director of Nursing (ADON) who also was the over the infection control program. The ADON stated when a resident is on contact precautions they have PPE hanging on the door of the room for staff to wear. He stated when staff enters or family members enter the resident's room they need to wear the appropriate PPE while in the resident's room. When staff or family members enter the room and are touching any surfaces they would need to gown and glove. If a staff member was in the room feeding the resident who was on contact precautions the staff should be wearing a gown and gloves. The ADON stated staff should follow	F 441		

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F 441	Continued From page 5 what the signs for isolation precautions advise. On 05/22/14 at 2:57 PM an interview was conducted with the Director of Nursing (DON). The DON stated contact precautions should be followed if there is a potential for staff to touch surfaces in the room or the resident, gown and gloves are to be worn. She stated she would have expected NA #1 to wear her PPE while feeding Resident #39. She further stated it is staffs' responsibility to follow the contact precautions when it is posted. 3. Resident #27 was readmitted to the facility on 12/22/11 with diagnoses including non-Alzheimer's dementia. Review of a laboratory test result dated 12/13/13 revealed Resident #27's stool specimen tested positive for Vancomycin-Resistant Enterococci (VRE- a bacteria that has acquired resistance to the antibiotic vancomycin). A subsequent laboratory test result dated 03/23/14 noted Resident #27 stool specimen had a heavy growth of VRE. During a continuous observation on 05/21/14 at 10:57 AM revealed nurse aide (NA) #2 repositioned Resident #27's feet on pillows and covered her legs with a sheet. NA #2 was not wearing a disposable gown or gloves while she assisted the resident. A contact precaution sign with instructions regarding personal protection equipment (PPE) and hand hygiene was observed to the right hand side of the Resident #27's door frame in the hall. A caddy containing PPE including disposable gowns and gloves hung on the outside of Resident #27's door.	F 441		

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F 441	Continued From page 6 An interview was conducted with NA #2 when she exited Resident #27's room on 05/21/14 at 10:58 AM. NA #2 stated she was aware Resident #27 was on contact precautions and only wore a disposable gown and gloves when she provided care that involved contact with body fluids. On 05/22/14 at 2:19 PM an interview was conducted with the Assistant Director of Nursing (ADON) who was also was the coordinator for the facility's infection control program. During the interview the ADON confirmed Resident #27 had been on contact precautions continuously since 12/13/13 due to stool positive for VRE. The ADON stated when a resident was on contact precautions they had a sign posted outside the room and PPE hanging on the door of the room for staff and visitors to wear. The ADON further stated he expected staff members to follow the instructions listed on the contact precaution sign and don a disposable gown and gloves before they entered the resident's room. On 05/22/14 at 2:57 PM an interview was conducted with the Director of Nursing (DON). The DON stated she expected staff members to follow the instructions listed on the contact precautions sign when they provided care to a resident on contact precautions. The DON further stated PPE should be worn any time there was the potential for a staff member touch the resident or any surfaces in the room when contact precautions were in place.	F 441		