| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345403 | A. BUILDING _____ B. WING _____ | C 04/14/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CARY HEALTH AND REHABILITATION** | **6590 TRYON ROAD CARY, NC 27518** |

| (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 |
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| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services:<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, and observations, the facility failed to use sterile technique to provide tracheostomy care, and failed to change the inner cannula for 1 of 2 sampled residents (Resident #8).<br>Findings included:<br>A review of the facility provided Policies and Procedures for Tracheostomy care revealed: 1. Remove and dispose of soiled inner cannula. 2. Clean around the stoma site with sterile water or saline with cotton tipped applicators and/or sterile 4x4 (gauze), dry with sterile gauze if needed. 3. Insert new disposable inner cannula and lock into place.<br>A review of the facility provided Standard Precautions Policy revealed in part: " Standard precautions will apply to all residents receiving care in all facilities, regardless of their diagnosis or presumed infection status. " Procedures included: " Handwashing- Wash hands immediately after gloves are removed, between resident contacts, and when otherwise indicated | F 328 | 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.<br><br>F328<br>1.Resident #8 continues to reside at facility with a tracheostomy, tracheostomy care was observed using sterile technique and inner cannula was changed per manufacturers protocol completed by the Director of Clinical Services and Assistant Director of Clinical Services completed on 4/14/15.<br>2. All residents with tracheostomy have the potential to be affected by this citation. A review of residents with tracheostomy was completed on 4/14/15 by the Director of Clinical Services to ensure observation | 4/30/15 |

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

Electronically Signed | 04/30/2015

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| F 328 | Continued From page 1<br>to avoid transfer of microorganisms to other residents or environments. " " Resident Care Equipment- Single use items are to be discarded properly after use. "<br>Resident #8 was admitted to the facility on 5/12/2014 with diagnoses which included: Respiratory Failure, and Status Post (S/P) Tracheostomy (trach) (an opening created in the trachea (windpipe) to assist breathing).<br>A review of the Quarterly Minimum Data Set (MDS) dated 1/29/2015 revealed Resident #8 was totally dependent for activities of daily living (ADLs). A review of a care plan, revised 2/3/15 revealed approaches to address a potential for alteration in respiratory status included " trach care as ordered " , and on 2/16/15 " ABT (antibiotics) as ordered was added.<br>A review of the Medical Doctor (MD) Orders dated 3/1/2015 through 3/31/3015 included: Suction canister and catheters in room at all times; Tracheostomy care (trach) every shift and as needed (PRN) for shortness of breath or respiratory distress (including cleaning around outer trach, cleaning of inner cannula using sterile technique and changing of trach dressing).<br>An observation of trach care for Resident #8 was made on 4/14/2015 at 10:10 AM and revealed: Nurse #1 was preparing to provide wound care and found Resident #8 had developed respiratory difficulty related to a large amount of secretions from his trach. Nurse #1 had gloves on, took gauze from an opened package of gauze on the windowsill, lifted the trach collar, and wiped copious (a large amount) secretions from around the stoma site and trach opening. Nurse #1 called for Nurse #2 (the nurse who typically provided trach care for Resident #8) and Nurse #2 entered the room. Nurse #2 moved the bedside table, was not observed to perform hand washing, picked up | F 328 | and education have been provided to all staff regarding providing sterile tracheostomy care and inner cannula was changed per manufacturers protocol.<br>3. Licensed Nurses including nights, weekends and prn were in-serviced by the Director of Clinical Services, Unit Manager and Assistant Director of Clinical Services regarding policy and procedure for performing tracheostomy care using sterile technique and changing inner cannula per manufacturers protocol 4/14/15 to 4/30/15. No licensed nurse will return to work prior to receiving in-service training for performing tracheostomy care using sterile technique and changing inner cannula per manufactures protocol.<br>4. The Director of Clinical Services and Assistant Director of Clinical Services will conduct Quality Improvement monitoring of all residents requiring tracheostomy care to ensure utilization of sterile technique and replacing inner cannula per manufacturers protocol via observation and documented on audit tool 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 6 months and/or until substantial compliance is obtained. | |

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| F 328 | Continued From page 2<br>a single pair of gloves that were not wrapped in any packaging except paper, donned the non-sterile gloves, took gauze from an opened, non-sterile package of gauze located on the windowsill, wiped around the stoma site and inside the trach opening, replaced the trach collar, removed her gloves, washed her hands and left the room. She did not change the inner cannula.<br>An observation made on 4/14/2015 at 10:15 AM of Resident #8 ' s room revealed 2 boxes of [Brand name] sterile inner cannulas located in a dresser drawer marked " Sterile " . Inside the clear plastic container an inner cannula was visible and marked in red " Do not clean or reuse. "<br>An interview with Nurse #2 on 4/14/2015 at 10:20 AM revealed she provided trach care " as needed " , and Nurse #2 also stated she cleaned the inner cannulas and reused them. Nurse #2 stated she only changed the inner cannula when it was " really dirty. " After she checked the facility policy she stated trach care was done every shift and PRN. She read from the policy, " Trach care should be done with a sterile technique. "<br>An interview with Unit Manager 1 (UM #1) on 4/14/15 at 10:30 AM revealed the disposable inner cannulas should be disposed of each time a trach was cleaned. UM #1 also stated gloves not wrapped in sterile packaging were not considered sterile.<br>An interview with the Director of Nurses (DON) on 4/14/15 at 10:40 AM revealed sterile gloves must be worn if an order called for a sterile procedure. The DON also stated MD orders were to be followed as written. The DON also stated the expectation for trach care was for it to a sterile procedure related to the risk for infection. | F 328 | | |

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| F 328 | Continued From page 3<br>A telephone interview on 4/14/15 at 11:00 AM with a representative from the manufacturer of the inner cannulas used for Resident #8 revealed the inner cannulas used for Resident #8 were to be disposed of and not cleaned. " They are for single use and should never be cleaned or reused. "<br>An interview on 4/14/15 at 11:20 AM with Nurse #3 revealed Nurse #3 performed trach care 1 time per shift and " as needed " and used a " trach care kit " the facility provided which contained everything needed for trach care. Nurse #3 stated she cleaned around the outside first, removed the inner cannula, and placed a new inner cannula and dressing. She further stated it was a sterile procedure.<br>A telephone interview was conducted on 4/15/15 at 10:48 AM with the facility MD who cared for Resident #8 and revealed his expectation for a sterile procedure is for it to be completed as a sterile procedure and if an inner cannula was disposable it would be disposed of after a single use. | F 328 | | |