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

PRINTED: 11/28/2011

NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS NURSING HOME FACTORY OR LISC IDENTIFYING INFORMATION) FACTORY OR LISC IDENTIFY INFORMATION IN CARD OR CARD OR CORRECTION OF THE APPROPRIATE COMMITTED IN USUS INSUREDANT OR LISC IDENTIFY IN CARD OR COMMITTED IN USUS INSUREDANT OR LINE OF THE APPROPRIATE COMMITTED IN USUS INSUREDANT OR LISC IDENTIFY IN CARD OR LIVE	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING (X3) DATE SHAVE!				
COUNTIED COUNTIES			345492	B. WN	G	DEC ● 7 2011		
COUNT Program under which it - (1) Investigates, controls, and prevents in fections in the facility. (2) Decides what procedures, such as isolation, should be applied to an individual resident to prevent the spread of infection to prevent the spread of infection to prevent the spread of infection to micrate contact with residens or their food, if direct contact with residens. (2) The facility must require staff to wash their hands after each direct resident. (2) The facility must require staff to wash their hands after each direct resident contact of which hand washing is indicated by accepted professional practice. (c) Linens Payenter Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at the monthly meeting for review and recommendations as needed Provement (PI) Committee at	NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
C41 D PRETEX SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST SEPRECECED BY FULL TAGE PROVIDER'S FLAND CORRECTION (PACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OF THE PROVIDER'S FLAND SHOULD BE CROSS-REFERENCE OF THE PROVIDER'S FLAND SHOULD BE CROSS-REFERENCE OF THE PROVIDER'S CROSS-REFERENCE OF THE PROVIDER CROSS-REFERENCE OF TH	NC STATE VETERANS NURSING HOME							
FAST TAG REGULATORY OR LISC IDENTIFYING INFORMATION) F 441 SS=D 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 infection. (b) Preventing Spread of Infection (c) Preventing Spread of Infection (d) When the infection Control Program determines that a resident needs isolation to prevent the spread of infections, 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.					FA	AYETTEVILLE, NC 28301		
SPREAD, LINENS SPRE	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
infection. recommendations as needed	SS=D	SPREAD, LINENS The facility must estate Infection Control Progsafe, sanitary and conto help prevent the desort of disease and infection (a) Infection Control P. The facility must estate Program under which (1) Investigates, control in the facility; (2) Decides what processould be applied to a (3) Maintains a record actions related to infection determines that a resident (b) Preventing Spread (1) When the Infection determines that a resident (2) The facility must procommunicable disease from direct contact will trans (3) The facility must rechands after each direct hand washing is indicated professional practice. (c) Linens Personnel must handle	olish and maintain an ram designed to provide a infortable environment and velopment and transmission on. rogram olish an infection Control it - ols, and prevents infections edures, such as isolation, in individual resident; and of incidents and corrective itions. of Infection Control Program dent needs isolation to infection, the facility must on infected skin lesions in residents or their food, if mit the disease, quire staff to wash their resident contact for which ited by accepted	F	441	F-441 1. Nursing assistant #1 and #2 were in-serviced on 11/18/2011 on Proper Hand Washing and Infection Control Measures. 2. All nursing assistants were in-serviced on the Proper Hand Washing and Infection Control Measures by the Clinical Competency Coordinator and Nursing Supervisors. 3. Nursing assistants will be monitored each shift, daily to ensure Proper Hand Washing and Infection Control measures are practiced for 2 weeks for their understanding of Infection Control practices. Monitoring will continue by The Director of Nursing, Performance Improvement, Nursing Supervisor, Patient Care Coordinators, and Clinical Competency Coordinator three times per week x 2 weeks, and weekly thereafter x 3 months and reported to the Performance Improvement (PI) Committee at the monthly	12/2/11	
			o prevent the spread of			recommendations as needed		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

TITLE

2/5/11

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.

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

PRINTED: 11/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l'	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		345492		B. WING		C 11/17/2011		
	ROVIDER OR SUPPLIER E VETERANS NURSING I		1	214	T ADDRESS, CITY, STATE, ZIP CODE COCHRAN AVENUE (ETTEVILLE, NC 28301		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE	
F 441	Continued From page This REQUIREMENT by: Based on observation Interviews the facility of remove their gloves an incontinent care and printhe room for 2 of 5 of incontinent care (Resing The findings include: 1. The facility policy do Using Gloves under If gloves must be replace when contaminated." 02/01/2000 and titled fread: "Handwashing most important single nosocomial infections. Resident #5 was admit 04/03/09 and had diags and pementia. On 11/16/11 at 3:46 Pleading the resident. The NA we gloves and remove the brief. The resident of stooresident and applied a while wearing the same the incontinent care, the adjust the resident of the lighter than the resident of the lighter than the same than the lighter than the resident of the lighter than t	is not met as evidenced as, record review and staff failed to ensure that staff and wash their hands after prior to handling clean items residents observed during dent # 5 and Resident #6). ated 02/01/2000 and titled F read: "Disposable ed as soon as practical The facility policy dated Handwashing under Policy is generally considered the procedure for preventing " tted to the facility on moses including Alzheimer M Nursing Assistant (NA) ovide incontinent care for vas observed to put on resident's incontinent orief was wet and contained I. The NA cleaned the clean incontinent brief, e gloves used to provide e NA was observed to bed covers, touch the side tt at the head of the		441				
		A then removed the gloves	111111111111111111111111111111111111111					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345492	B. WNG		11	C /17/2011	
NAME OF PROVIDER OR SUPPLIER NC STATE VETERANS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODI 214 COCHRAN AVENUE FAYETTEVILLE, NC 28301				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 441	PM that she should h washed her hands pri the room. The Director of Nursii interview on 11/17/11 should have removed hands prior to handlin The DON stated that issue. 2. The facility policy d Using Gloves under II gloves must be replace when contaminated." 02/01/2000 and titled read: "Handwashing most important single nosocomial infections Resident #6 was adm 11/12/04 and had diag Dementia. On 11/17/11 at 12:00 (NA) #2 was observed for the resident. The Nather resident is inconticulated a moderate cleaned the resident, a clean incontinent bri While wearing the san observed to handle the to cover the resident, ja bottle of soap in the	terview on 11/16/11 at 4:00 ave removed her gloves and ior to touching clean items in Ing (DON) stated in an at 3:40 PM that the NA I her gloves and washed her ag other items in the room. this was an infection control ated 02/01/2000 and titled IF read: "Disposable ted as soon as practical The facility policy dated Handwashing under Policy Is generally considered the procedure for preventing itted to the facility on gnoses including Advanced Noon, Nursing Assistant I to provide incontinent care IA was observed to remove nent brief that was wet and amount of stool. The NA applied a barrier cream and ef.	F 4	41			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345492	B. WNG		11/	C 17/2011	
NAME OF PROVIDER OR SUPPLI NC STATE VETERANS NUI	ER	214	ET ADDRESS, CITY, STATE, ZIP CODE COCHRAN AVENUE YETTEVILLE, NC 28301		1772011	
PREFIX (EACH DE	IARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE COM ERENCED TO THE APPROPRIATE DEFICIENCY)		
PM that she had gloves and was prior to handling. The Director of interview on 11 should have replaced by the should have replaced by the should have the should be should by the should be should be should by the should be sho	n an interview on 11/17/11 at 12:15 d been trained to remove her sh her hands after incontinent care	F 441				