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 |
|---|---|---|---|
| | 345450 | A. BUILDING _____ B. WING _____ | 09/20/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESTWOOD HEALTH AND REHABILITA | 625 ASHLAND STREET ARCHDALE, NC 27263 |

| (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 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Moore
TITLE: Executive Director
(X6) DATE: 10-29-12

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<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident and staff interviews and medical record review the facility failed to maintain contact precautions for one of one resident with symptoms of Clostridium Difficile. Resident #110<br><br>The findings were:<br><br>Review of the facility policy and procedure dated 3/12, for the subject of "Preventing Spread of Clostridium Difficile" (C. Diff) procedure: # 1. wear clean, non sterile gloves, when entering the room of a C Diff infected resident. #2. Clean, non sterile gowns shall be worn when entering the room of a C diff resident due to the environmental significance of the organism. # 8. residents will be removed from Contact Precautions when: a. Positive culture becomes negative and/or b. Resident stops having diarrhea. "<br><br>Resident # 110 was admitted to the facility on 9/12/12 with diagnoses of Clostridium Difficile.<br><br>Review of the admission orders dated 9/12/12, revealed Vancomycin (an antibiotic) was ordered to be taken daily until 9/21/12 for treatment of C. Diff.<br><br>Resident #110 was a new admission and the Minimum Data Set (MDS) was in progress and not due to be completed.<br><br>Review of the documentation by aides of bowel movements for Resident #110 for the dates of 9/12/12 through 9/19/12 revealed loose stools | F 441 | A Plan of Correction does not constitute an admission or agreement by the 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>F441<br>1- New order received for resident #110 to have stool checked for Clostridium Difficile x 3. | 11-2-12 |

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| F 441 | Continued From page 2<br>were documented on 7-3 and 3-11 shifts for 9/12/12, 9/13/12 and 9/14/12.<br><br>Based on interview with Resident #110 on 9/19/12 at 8:30 AM, she was alert and oriented, able to recall recent and past events, and answered questions appropriately. The facility had identified Resident #110 as being an interviewable resident.<br><br>Interview with Resident #110 on 9/19/12 at 8:30 AM revealed she had loose stools since her admission to the facility. During this interview, she was asked if any of the staff had worn a gown when providing care, she stated "no". Resident #110 was aware she was being treated for a diagnosis of C. Diff. Further interview revealed she had treatment started while at the hospital and was still receiving an antibiotic for this.<br><br>Observations on 9/19/12 at 8:45 AM revealed there were no disposable gowns or contact precaution signs at Resident #110 ' s door/doorway entry.<br><br>Interview with housekeeper #1 on 9/19/12 at 9:30 AM revealed housekeepers would "suit up" if a contact precaution sign was posted at a resident's door. The clarification of " suit up " was to wear a disposable gown and gloves. Continued interview revealed a sign would be posted at the door for contact precautions if a resident had C. Diff. This staff member reported no contact precaution signs had been posted at Resident #110 ' s door over the past week.<br><br>Interview on 9/19/12 at 10:55 AM with the Director of Nursing revealed she was aware | F 441 | 2- Current resident records have been reviewed for diagnosis of Clostridium Difficile and documentation has been reviewed to determine there is no one with watery diarrhea in the facility by the Director of Clinical Services and/or designee to ensure appropriate procedure is being followed per facility policy and procedure.<br>All new admission records will be reviewed in the next morning meeting by the Director of Clinical Services and/or designee for a diagnosis of Clostridium Difficile to ensure that the proper infection control procedures have been put into place.<br>All new orders for any resident will be reviewed in the next morning meeting for diagnosis of Clostridium Difficile or an order for culture for Clostridium Difficile. | 11-2-12 |

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| F 441 | Continued From page 3<br>Resident #110 was on Vancomycin to treat C Diff. Continued interview revealed the medication was started on 9/2/12 at the hospital and would be completed on 9/21/12. She explained a resident was to be on contact precaution until the diarrhea stopped. The Director of Nursing reported Resident #110 did not have diarrhea on admission.<br><br>Interview with aide #1 on 9/19/12 at 11:25 AM revealed she had taken care of Resident #110 since her admission. Continued interview revealed Resident #110 had loose stools upon admission. She wore gloves and changed them after providing bowel incontinence care. Further interview revealed Resident #110 had a soft stool on 9/19/12, and it was not loose. When asked if she knew the resident required contact precautions due to an infection, she stated "no". When asked what she would have done differently, she stated a gown would have been worn.<br><br>Interview with nurse #1 on 9/19/12 at 2:00 PM revealed she started the admission process on 9/12/12 for Resident #110. Further interview revealed she could not remember if she knew of the diagnosis of C Diff. Nurse #1 explained new admissions do not always have the discharge summary from the hospital upon admission to the facility. The discharge diagnoses would be with the discharge summary. During the interview nurse #1 stated she had completed the orders and knew Resident #110 was on Vancomycin. Nurse #1 was asked what would be done on admission for a resident with symptoms of C. Diff, she responded a contact precaution sign would be put at the doorway of a resident and personal | F 441 | 3- Staff will be re-educated on the policy and procedure entitled "Preventing spread of Clostridium Difficile".<br><br>The Director of Clinical Services / designee will monitor the morning meeting to identify the presence of a resident with a diagnosis of Clostridium Difficile.<br><br>This monitoring will be daily, with documentation of the monitoring to be daily x 2 weeks, 3 x a week x 2 weeks, weekly x 4 weeks, then monthly x 10 months. | |

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| F 441 | Continued From page 4<br>protective equipment would be available. The nurse or nurses that do the admission would be responsible for posting the sign.<br><br>An interview with aide #2 was conducted on 9/19/12 at 2:06 PM. Aide #2 reported she had taken care of Resident #110. Interview continued with aide #2 reporting Resident #110 had loose stools on admission, and she did not know about an infection that required contact precautions. When aide #2 was asked who would inform you, she just looked at the surveyor, and did not answer. Aide #2 reported there were no signs at Resident #110 ' s doorway.<br><br>Interview with nurse #2 on 9/20/12 at 8:23 AM revealed she was aware Resident #110 had C Diff. Nurse #2 reported she did not wear a gown to do the wound treatments to the buttocks because the resident had "been treated" for the C Diff. During this interview, nurse #2 reported at no time during wound care did Resident #2 have stool which required cleaning.<br><br>Interview with the Infection Control nurse on 9/20/12 at 1:00 PM revealed she was aware Resident #110 had C. Diff at the hospital. Upon admission to the facility the symptoms (loose stools with a definite odor) had stopped. During this interview, the infection control nurse spoke with aides # 1 and #2 along with the surveyor. The aides were asked to explain the type of bowel movement Resident #110 had on the days they took care of her. Both of the aides explained it was a loose stool. The infection control nurse then asked the aides if they reported the symptom to the charge nurse. Both aides replied " no. " | F 441 | The Director of Clinical Services and/or designee will monitor the proper use of the policy and procedure "Preventing spread of Clostridium Difficile". This monitoring will be stimulated by the report of Clostridium Difficile in the building and will be daily for the first week, then 3x a week for the second week, then weekly until there is formed stool and/or a negative culture. Any subsequent diagnosis of Clostridium Difficile identified over the course of the next 12 months will be monitored weekly for compliance with infection control policy and procedure.<br><br>4- The Director of Clinical Services will report findings of the Performance Improvement monitoring to the Performance Improvement Committee monthly x 12 to identify trends and need for further education and/or monitoring. | 11-2-12<br><br>11-2-12 |

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| F 441 | Continued From page 5<br><br>A second interview with Resident #110 was conducted on 9/20/10 at 2:00 PM due to information provided by the Director of Nursing. A care plan meeting had occurred on 9/20/12 with Resident #110 and the resident did not have symptoms of C. Diff.<br><br>Interview on 9/20/12 at 2:00 PM revealed Resident #110 reported she had diarrhea the first couple of days after she was admitted. As of today, she was having regular bowel movements. When asked if the DON had talked to her during the care plan meeting regarding diarrhea, she stated "yes she (DON) asked if I was having diarrhea now. " Resident #110 was asked if her symptoms of loose stools were the same on admission to the facility, as compared to what she had at the hospital. The resident reported " yes " and " it was bad for the first few days here (at the facility). " | F 441 | | |

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| | 345450 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING NOV 14 2012 | 10/24/2012 |

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| K 000 | INITIAL COMMENTS<br><br>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 facility is Type III protected construction utilizing North Carolina Special locking arrangements, and is partially equipped with an automatic sprinkler system in hazardous areas on the domestic water system.<br><br>CFR#: 42 CFR 483.70 (a) | K 000 | | |
| K 018<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by: | K 018 | K18<br>1. Pass through hardware has been installed on the door on the left side of the dietary department leading to the main dining room.<br>2. Door locks will be checked for appropriate hardware.<br>3. Maintenance Director will be re-educated that doors must have the appropriate pass through hardware installed. Maintenance Director will complete a Quality Improvement tool documenting appropriate pass through hardware is installed on doors monthly x 3 and then quarterly x 3.<br>4. Maintenance Director will report findings to the Quality Improvement Committee monthly x 3 and then quarterly x 3 to identify further repairs needed. | 11-23-12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Moore
TITLE: Executive Director
(X6) DATE: 11-9-12

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| K 018 | Continued From page 1<br>Based on the observations and staff interview during the tour on 10/24/2012 the following item was observed as noncompliant, specific findings include: The door on the left side of the dietary department leading to the main dining room did not have pass through hardware installed.<br><br>CFR#: 42 CFR 483.70 (a) | K 018 | K38<br>1. The "C" hall delayed egress door was repaired on 10-24-12. The exit door from the dietary area to the outside has been repaired.<br>2. Doors of egress have been checked for appropriate release when pressure is applied. Doors have been checked to assure proper entrance and exit without dragging.<br>3. Staff will be re-educated on the appropriate release of doors of egress. Staff will be re-educated on the appropriate function of doors upon entrance and exit without dragging. Maintenance Director will complete a Quality Improvement tool for appropriate release of doors of egress monthly x 3 and then quarterly x3. Maintenance Director will complete a Quality Improvement tool for the appropriate function of doors upon entrance and exit without dragging monthly x 3 and then quarterly x 3.<br>4. Maintenance Director will report findings to the Quality Improvement Committee monthly x 3 and then quarterly x 3. | 11-23-12 |
| K 038<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interview during the tour on 10/24/2012 the following item was observed as noncompliant, specific findings include:<br><br>1. The "C" Hall delayed egress door did not release when pressure was applied. This item was corrected by maintenance personnel before the end of the survey day.<br><br>2. The required exit door from the dietary area to the outside was dragging on the top of the metal door frame. | K 038 | | |
| K 072<br>SS=D | CFR#: 42 CFR 483.70 (a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Means of egress are continuously maintained free of all obstructions or impediments to full instant | K 072 | | |

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| K 072 | Continued From page 2<br>use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10<br><br>This STANDARD is not met as evidenced by:<br>Based on the observations and staff interview during the tour on 10/24/2012 the following item was observed as noncompliant, specific findings include: There were items stored in the egress corridor on the "B" Hall that were not in use.<br><br>CFR#: 42 CFR 483.70 (a) | K 072 | K72<br>1. Stored items in the egress corridor on "B" hall have been removed.<br>2. Egress corridors have been checked for stored items and items removed as indicated.<br>3. Staff have been re-educated to keep egress corridors clear without stored items. Maintenance Director will complete a Quality Improvement tool to assure that egress corridors remain clear without stored items monthly x 3 and then quarterly x 3.<br>4. Maintenance Director will report findings to the Quality Improvement Committee monthly x 3 and then quarterly x 3. | 11-23-12 |