STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345447	A. BUILDING _____ B. WING _____	C 03/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD RIDGE REHAB AND CARE C	25 REYNOLDS MOUNTAIN BOULEVARD ASHEVILLE, NC 28804

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F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	PLAN OF CORRECTION	

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.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with this statement of deficiency. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulation.

1. a. Resident #1 suffered no harm.
b. Resident #7 suffered no harm.
c. Nurse was immediately re-educated on 3-19-13, by the Director of Clinical Services.
2. All current facility residents with physician's orders for wound care treatments were reviewed to ensure that they are stable per their vital signs and their wounds are without signs and symptoms of infection by the facility's Director of Clinical Services on 4/16/13.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Thomas S Hagen — TITLE: EXECUTIVE DIRECTOR — (X6) DATE: 4/12/13

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.

Original Signature Date: 4/10/13

DHSR MH WPD Received APR 11 2013 by: MMH

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F 441	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to wash hands during and after dressing changes and between residents for 2 of 2 residents and placed a contaminated bottle of wound cleanser back in the treatment cart (Residents # 1 and #7). The findings included: Review of the facility's dressing change policy revealed staff should put on gloves before beginning the dressing change. After soiled dressings were removed, staff should remove the gloves, wash their hands and put on new gloves. Staff should also remove the gloves and wash their hands after applying the clean dressings and after finishing the dressing change. 1. During an observation on 03/19/13 at 1:52 PM the facility's Wound Care Nurse (WCN) was observed preparing to change a dressing on Resident #7's right gluteal cleft. The nurse gathered supplies from the treatment cart located at the nurse's station on the Alzheimer's unit. She placed a spray bottle of wound cleanser, packs of gauze, calcium alginate, and bordered self-adhesive gauze in a wash basin. She carried the wash basin into the resident's room and placed it on the overbed table. She put on gloves without first washing her hands. She then removed the soiled dressing and packing from the wound. Blood was visible on the packing and the dressing. Without changing gloves or washing her hands, she picked up a bottle of wound cleanser and sprayed cleanser on a 4 X 4 gauze	F 441	3. The Director of Clinical Services/Assistant Director of Clinical Services/Nurse Unit Manager have re-educated all current facility staff on the facility's policies and procedures for infection control and hand washing. The Director of Clinical Services/Assistant Director of Clinical Services/Nurse Unit Manager have re-educated current facility Licensed Nurses on the facility's policy and procedure for wound care to include infection control and hand washing during the provision of wound care along with validation of education via return demonstration.	

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F 441	Continued From page 2 and cleaned the wound. Without changing gloves or washing her hands, she packed the tunneling wound with a calcium alginate 2 X 2 dressing then covered the wound with a 2 X 2 bordered, self-adhesive gauze. She then removed her gloves and put them in the bag with the soiled dressings. She placed the bottle of wound cleanser back in the basin with other unused supplies. Without washing her hands, she opened the door to the resident's room and carried the bag down the hall to the nurse's station and discarded it. Without washing her hands, she placed the wash basin on top of the treatment cart and removed additional supplies from the treatment cart needed to complete wound care for Resident #1. She placed the additional supplies in the wash basin and left the same bottle of wound cleanser in the wash basin. She went directly from the nurse's station to Resident #1's room. During an interview on 03/19/13 at 2:15 PM the WCN stated she should have changed gloves and washed her hands after removing the soiled dressing and before cleaning the wound, then again after cleaning the wound before applying the clean dressing. She also stated she should have washed her hands when she finished the dressing change. When asked what she usually did, she stated she usually washed her hands in the resident's bathroom before starting the dressing change then went to the bathroom in the nurse's lounge and washed her hands after she finished. During an interview on 03/19/13 at 2:39 PM the WCN stated she usually used the same bottle of wound cleanser for all the treatments on the	F 441	4. DCS/ADCS/Nurse Unit Manager will conduct Quality Improvement Monitoring of infection control, hand washing, and wound care including infection control and hand washing 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. The DCS will report results of Quality Improvement Monitoring to the Quality Assurance/Performance Improvement Committee monthly x 12 months for substantial compliance and/or revision. 5. Allegation of Substantial Compliance 4-16-13.	

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F 441	Continued From page 3 Alzheimer's unit. She stated she usually washed her hands after removing the soiled dressing and before cleaning the wound but just got nervous and forgot. She stated she could see how she might have contaminated the bottle of wound cleanser by not changing her gloves after removing the soiled bandage and before cleaning the wound. During an interview on 03/19/13 at 4:58 PM the Director of Nursing (DON) stated her expectation was for the nurse to wash her hands before assembling the supplies then again when entering the resident's room. She stated the nurse should then put on gloves, remove the soiled dressing, packing or anything covering the wound. The DON stated the nurse should then remove the gloves, wash her hands and put on clean gloves. After cleaning the wound, the nurse should remove the gloves, wash her hands and put on clean gloves. After applying the new dressing, the nurse should remove the gloves and wash her hands before leaving the resident's room. The DON stated the bottle of wound cleanser should not have been put back in the treatment cart. When asked about any training provided to the WCN, the DON stated the Assistant Director of Nursing had reviewed the Wound Care protocol with the WCN when she started about 2 weeks ago. 2. During an observation on 03/19/13 at 2:00 PM the facilty's Wound Care Nurse (WCN) was observed entering Resident #1's room to do wound care. She placed a wash basin with supplies on Resident #1's overbed table. Without washing her hands, the WCN started to put on gloves to do the dressing change. When asked	F 441		

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F 441	Continued From page 4	F 441		

about her usual practice for washing hands between residents, she stated she forgot and then went in Resident #1's bathroom and washed her hands. She put on gloves and picked up the same bottle of wound cleanser she had handled with soiled gloves when doing Resident #7's treatment. She sprayed cleanser on a 4 X 4 gauze and cleaned a 3 cm X 6 cm area of black eschar on Resident #1's left heel. Without changing gloves or washing her hands, the WCN removed a hydrogel gauze from the pack and placed it on Resident #1's left heel. She then covered the area with a bordered, self-adhesive 4 X 4 gauze. The WCN removed her gloves, washed her hands and put on clean gloves then applied skin prep to Resident #1's right heel. She removed her gloves, opened the door to Resident #1's room and walked down the hall to the nurse's station on the Alzheimer's unit without washing her hands. She placed the bottle of wound cleanser back in the treatment cart and put the cart in a closet at the nurse's station. She left the Alzheimer's Unit with a bag of soiled supplies and discarded them; then, went to the employee lounge and washed her hands.

During an interview on 03/19/13 at 2:15 PM the WCN stated she should have changed gloves and washed her hands after cleaning the wound, then again after applying the clean dressing. When asked what she usually did, she stated she usually washed her hands in the resident's bathroom before starting the dressing change then went to the bathroom in the nurse's lounge and washed her hands after she finished.

During an interview on 03/19/13 at 2:39 PM the WCN stated she usually used the same bottle of

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F 441	Continued From page 5 wound cleanser for all the treatments on the Alzheimer's unit. During an interview on 03/19/13 at 4:58 PM the Director of Nursing (DON) stated her expectation was for the nurse to wash her hands before assembling the supplies; then, again when entering the resident's room. She stated the nurse should then put on gloves, remove the soiled dressing, packing or anything covering the wound. The DON stated the nurse should then remove the gloves, wash her hands and put on clean gloves to clean the wound. After cleaning the wound, the nurse should remove the gloves, wash her hands and put on clean gloves. After applying the new dressing, the nurse should remove the gloves and wash her hands before leaving the resident's room. The DON stated the bottle of wound cleanser should not have been put back in the treatment cart. When asked about any training provided to the WCN, the DON stated the Assistant Director of Nursing had reviewed the Wound Care protocol with the WCN when she started about 2 weeks ago.	F 441		